

North Dakota

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/01/2017 11.34.17 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2017

End Year 2019

State SAPT DUNS Number

Number 802743534

Expiration Date

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

Agency Name North Dakota Department of Human Services

Organizational Unit Behavioral Health Division

Mailing Address 1237 West Divide Avenue, Suite 1C

City Bismarck

Zip Code 58501

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

First Name Pamela

Last Name Sagness

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

Mailing Address 1237 West Divide Avenue Suite 1C

City Bismarck

Zip Code 58501

Telephone 701-328-8824

Fax 701-328-8969

Email Address psagness@nd.gov

State CMHS DUNS Number

Number 802743534

Expiration Date

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

Agency Name North Dakota Department of Human Services

Organizational Unit Behavioral Health Division

Mailing Address 1237 West Divide Avenue Suite 1C

City Bismarck

Zip Code 50501

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

First Name Pamela

Last Name Sagness

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

Mailing Address 1237 West Divide Avenue Suite 1C

City Bismarck

Zip Code 58503

Telephone 701-328-8824

Fax 701-328-8969

Email Address psagness@nd.gov

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

From

To

IV. Date Submitted

Submission Date 9/1/2017 11:33:04 AM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Laura

Last Name Anderson

Telephone 701-328-8918

Fax

Email Address lauranderson@nd.gov

Footnotes:

State Information

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

Fiscal Year 2018

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

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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
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

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

Signature of CEO or Designee¹: _____

Title: Director, Behavioral Health Division

Date Signed: _____

mm/dd/yyyy

Footnotes:

State Information

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Fiscal Year 2018

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

Signature of CEO or Designee: 

Title: Behavioral Health Division Director

Date Signed: 8-24-17
mm/dd/yyyy

Footnotes:

State Information

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

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Title XIX, Part B, Subpart II of the Public Health Service Act		
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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
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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.
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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).

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

Signature of CEO or Designee¹: _____

Title: Director, Behavioral Health Division

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee:

Pamela Sagness

Signature of CEO or Designee¹:



Title: Director Behavioral Health Division

Date Signed:

8-24-17

mm/dd/yyyy

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

State Information

Disclosure of Lobbying Activities

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

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

Name

Title

Organization

Signature:

Date:

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

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GENERAL STATE DEMOGRAPHICS

North Dakota is a vastly rural and frontier state with a relatively small population. North Dakota covers 69,000.80 square miles and has a 2015-estimated population of 756,927 people. As of 2010, North Dakota had 9.7 people per square mile compared to the United States at 87.4 people per square mile. According to the 2010 Census, North Dakota has 357 incorporated communities. Fifty-five percent of these communities have 200 people or less. The state's largest cities are Fargo (115,523), Bismarck (71,167), Grand Forks (57,011), and Minot (49,450) (2015 Estimate).

In 2014, the state's median age was 35.9 years. Eleven percent of persons live below the poverty level, compared to 13.5% nationally. According to the U.S. Census Bureau, 88.6% of the state's population is white, 5.5% is American Indian/Alaska Native, 2.4% is Black or African American and 3.5% is of Hispanic/Latino origin (2015 Estimate). There are five federally recognized American Indian Tribes located at least partially within the State of North Dakota: Mandan, Hidatsa, & Arikara Nation (Three Affiliated Tribes); Spirit Lake Sioux Tribe; Standing Rock Sioux Tribe (bestrides North Dakota and South Dakota); Turtle Mountain Band of Chippewa Indians (including Trenton Indian Service Area); and Sisseton-Wahpeton Oyate Nation (majority located in South Dakota).

The western half of North Dakota consists of many small communities spread across thousands of acres of farmland, with farming as one of the primary sources of income. A "Virginia-sized", 24,000 square mile oil reserve of an estimated 4.3 billion barrels lies 10,000 feet below the surface of western North Dakota creating an "oil boom." Production rates of ND oil began to rise in 2004, but increased dramatically in 2007 with advancements in technology and higher oil prices. This led to dramatically increased population, which taxed the surrounding infrastructure and community-based systems. In 2015, expansion of oil production began to slow steadily, leading to economic shifts that have equally impacted these same communities.

There are 52,035 civilian veterans in North Dakota, comprising approximately 9.6% of the adult population. North Dakota has two Air Force Bases which consist of 8,206 active duty and civilian personnel. As of May 2012, a total of 10,095 North Dakotans have been deployed since the 2001 terrorist attacks on America.

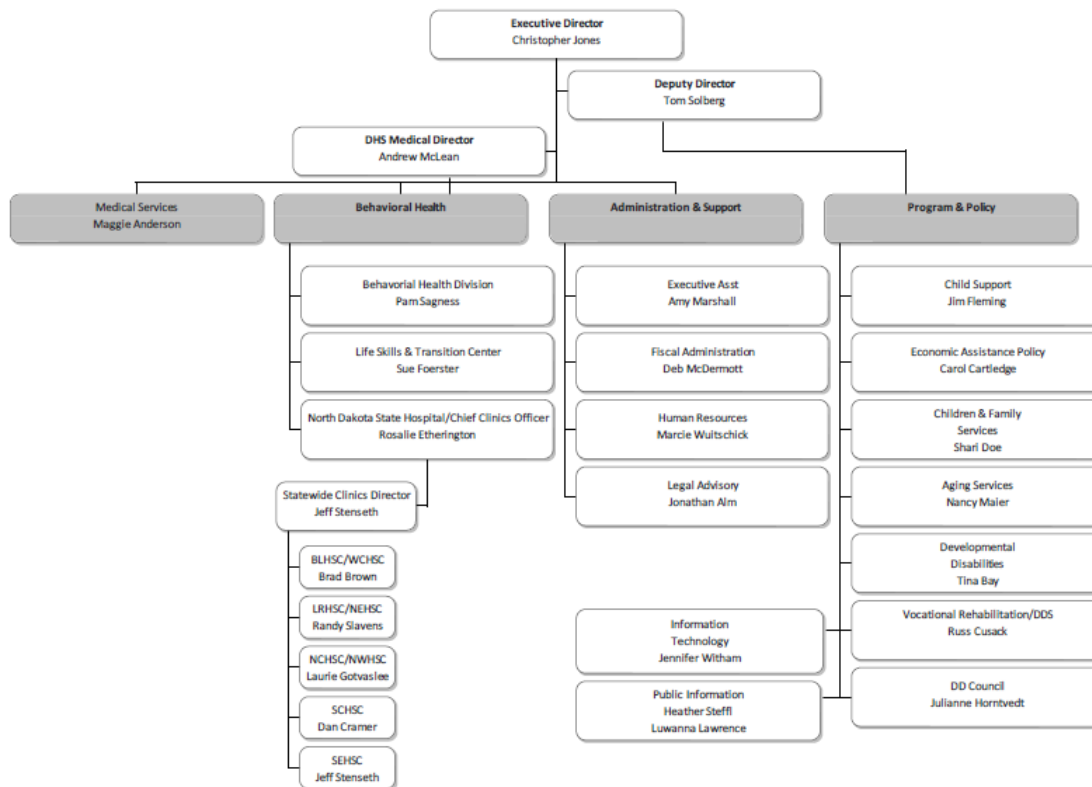
STRUCTURE OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM

THE NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

The Department of Human Services is the state governmental administrative agency that provides services to assist vulnerable North Dakotans of all ages maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. The Department supports the provision of services and care as close to home as possible to maximize each person's independence while preserving the dignity of all individuals and respecting their constitutional and civil rights.

The Department is an umbrella agency headed by Executive Director Christopher Jones who was appointed by Governor Doug Burgum on Feb. 3, 2017. Comprised of over 2,200 employees, the Department of Human Services is organized into four major subdivisions consisting of Medical Services, Behavioral Health, Administration & Support, and Program & Policy. The Department receives and distributes funds furnished by the North Dakota Legislature and Congress. The Department, through the ND State Hospital, Life Skills and Transition Center and Statewide Community Clinics (Human Service Centers), is a direct provider of human services and the state institution for individuals needing inpatient psychiatric services.

North Dakota Department of Human Services

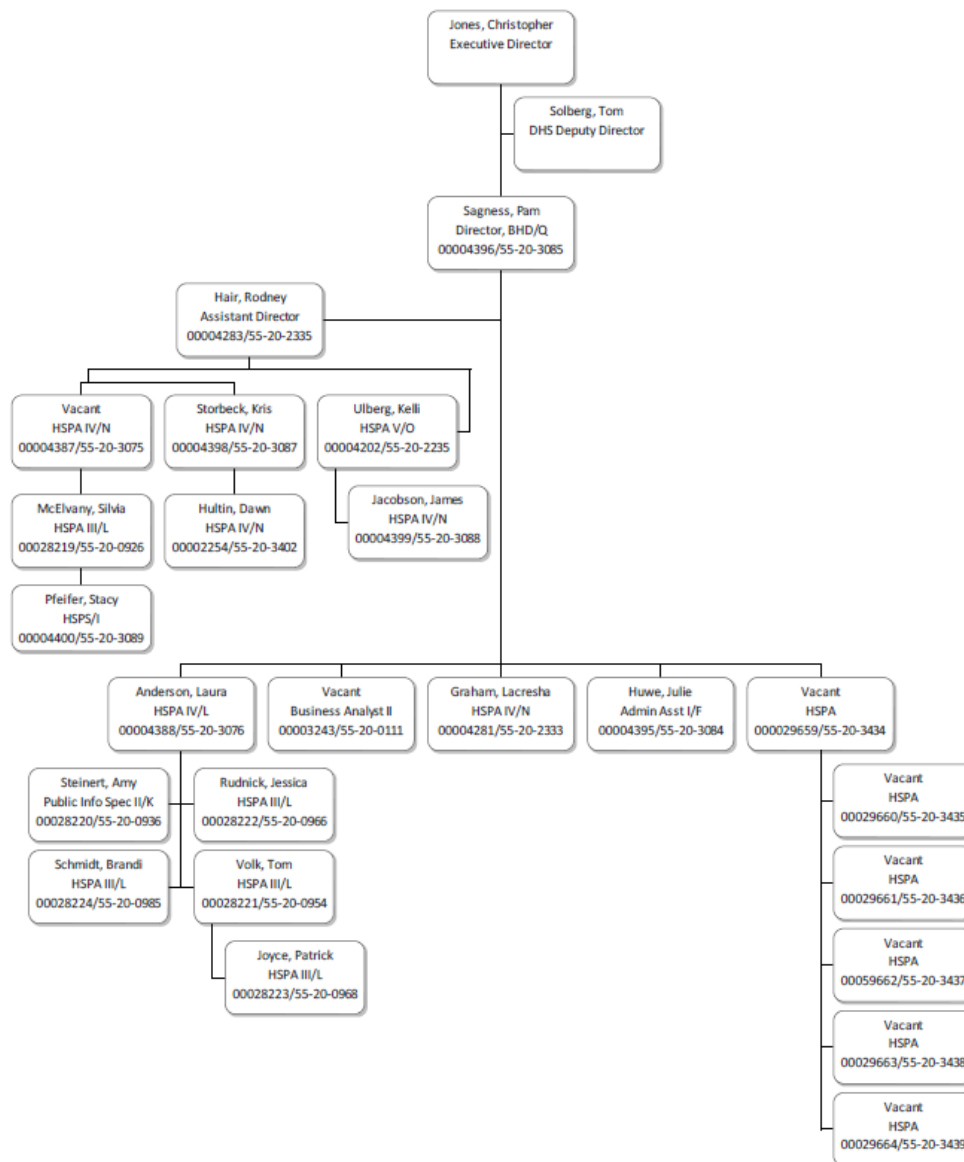


Updated: 3-2017

THE BEHAVIORAL HEALTH DIVISION

The Behavioral Health Division (see organizational chart below) is a part of the Behavioral Health subdivision of the Department of Human Services. The Division serves as the State Mental Health Authority (SMHA), State Substance Abuse Authority (SSA), and the State Opioid Treatment Authority (SOTA). The Behavioral Health Division (NDCC 50-06-01.4) is a policy division responsible for reviewing and identifying service needs and activities in the state's behavioral health system in an effort to ensure health and safety, access to services, and quality of services. The Division is also responsible for establishing quality assurance standards for the licensure of substance use disorder program services and facilities and providing policy leadership in partnership with public and private entities. The Behavioral Health Division does not provide direct services, rather the role of the Division is to ensure health and safety and access to a wide-range of quality behavioral health services across the state.

ND Department of Human Services
Behavioral Health Division



More specifically, the Division has identified two primary functions in which its work falls:

- **Regulation:** The Behavioral Health Division is responsible for licensing all substance use disorder treatment programs in North Dakota, the regional human service centers, Opioid Treatment Programs, DUI seminar programs, and all psychiatric residential treatment facilities for children.
- **Administration:** The Division develops behavioral health policies and administers both federal and state funding to support the state's behavioral health system. The Division administers such programs as brain injury services, First Episode Psychosis services, problem gambling, and the Substance Use Disorder (SUD) Voucher program. The SUD Voucher Program provides funding for individuals to access treatment. This service creates an additional opportunity to access treatment and recovery support for substance use disorders. As the SSA, the Division acts as the primary organization to administer funding related to substance abuse prevention. This includes the administration of the SAPT BG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The Division also administers the SPF-PFS.

Throughout the implementation of regulation and administration functions, the Division has a focus on partnerships, workforce development and communication:

- **Workforce Development:** The Division provides training, technical assistance and consultation concerning best practice behavioral health prevention, intervention and treatment services to North Dakota citizens, behavioral health professionals, and behavioral health organizations (both public and private). The Division funds and assists in the planning for the annual Behavioral Health Conference, each of which are attended by over 300 behavioral health stakeholders. The Division has three staff trained and able to provide the Substance Abuse Prevention Skills Training (SAPST) on a regular basis to individuals working in community-level prevention across the state. Through the SPF SIG and SPF-PFS (and continuing through the SAPT BG), the prevention system's training and technical assistance staff has enhanced their capacity to provide trainings and technical assistance on the Strategic Prevention Framework and evidence-based strategies.
- **Partnerships:** The Behavioral Health Division works closely with a number of entities to ensure that quality, efficient, and effective behavioral health services are available statewide. These include (but not limited to) the Behavioral Health Planning Council, Brain Injury Advisory Group, and the Problem Gambling Advisory Council. The ND Substance Abuse Prevention System leads and is a participant in many state-level partnerships in an effort to eliminate duplication of services and streamline goals. These partnerships include all levels, from department directors (Governor's Prevention Advisory Council), to program administrators (Prevention Expert Partners Workgroup), to data analysts (State Epidemiological Outcomes Workgroup). Other partners include the ND Cares Coalition, the Non-Medical Use of Pharmaceuticals Task Force, Healthy ND, ND Board of Realtors, Indian Affairs Commission, Injury Prevention coalition, and the State Suicide Taskforce.
- **Communication:** The Behavioral Health Division works to increase knowledge and skills of both professionals and the general public related to behavioral health topics. This is implanted through a wide variety of communication mediums: print, electronic, social media, etc. The Behavioral Health Division updated its website and developed a social media platform via Facebook in the spring of 2017.

In the fall of 2016, the Division published the "North Dakota Behavioral Health Assessment: Gaps and Recommendations". The purpose of the North Dakota Behavioral Health Assessment was to identify priority recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting North Dakota's children, adults, families and

communities in health and wellness, to reach their full potential. In previous years, the state'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. This important work was considered through the development of this Behavioral Health Assessment. However, this Behavioral Health Assessment took into consideration some important factors that have not been previously reviewed: epidemiological data identifying the prevalence of behavioral health needs among children and adults in the state; a review of the full Continuum of Care (from promotion and prevention through recovery); and global systems infrastructure perspective. The Behavioral Health Assessment identified the following recommendations as vital foundational pieces on which further efforts can continue to be made and be sustained:

- Continuous collection, analysis and utilization of comprehensive behavioral health data.
- Development of a formal Children's Behavioral Health Leadership group.
- Support substance use disorder early intervention services.
- Mental health promotion and early identification of mental illness.
- Continue to support public service delivery system changes relating to core services and population.
- Recognition of behavioral health conditions as a chronic disease.

PUBLIC BEHAVIORAL HEALTH SYSTEM

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

Each Human Service Center serves a designated multi-county area, providing counseling and mental health services, substance abuse treatment, disability services, and other human services. The Regional Human Service Centers are the access point for State Hospital admissions. Human service center employees also provide direction and oversight for services offered through county social service offices and other providers. Crisis lines are answered 24 hours a day, seven days a week. Contact information, including the counties served, is provided below.

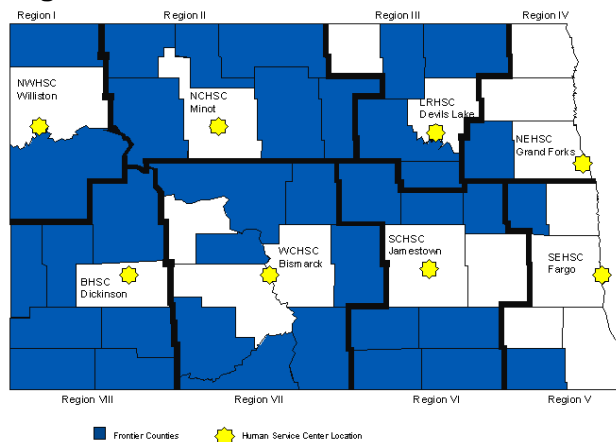
Delivering human services involves a partnership between the Department, counties, tribes, and service providers. In addition to providing direct services themselves, the regional human service centers also contract with private non-profit providers for crisis residential services, most residential services,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

North Dakota Human Service Centers

<p>Region I: Northwest Human Service Center - Williston 316 2nd Ave W, PO Box 1266, Williston, ND 58802-1266</p> <p><i>Counties served for human service programs: Divide, McKenzie, and Williams.</i></p>	<p>701-774-4600 Fax: 701-774-4620 Toll Free (ND only): 1-800-231-7724 Crisis Line: 701-572-9111 TTY: 701-774-4692 E-mail: dhsnwhsc@nd.gov</p>
<p>Region II: North Central Human Service Center - Minot 1015 S. Broadway, Suite 18, Minot, ND 58701</p> <p><i>Counties served for human service programs: Bottineau, Burke, McHenry, Mountrail, Pierce, Renville and Ward.</i></p>	<p>701-857-8500 Fax 701-857-8555 TTY: 701-857-8666 Crisis Line: 701-857-8500 OR Toll Free 1-888-470-6968</p>

	E-mail: dhsnchsc@nd.gov
Region III: Lake Region Human Service Center - Devils Lake 200 Hwy 2 SW, Devils Lake, ND 58301 <i>Counties served for human service programs: Benson, Cavalier, Eddy, Ramsey, Rolette, and Towner.</i>	701-665-2200 / Toll Free: 888-607-8610 Fax: 701-665-2300 TTY: 701-665-2211 Crisis Line: 701-662-5050 E-mail: dhslrhsc@nd.gov
Outreach Office - Rolla 113 Main Ave. East, Rolla, ND 58367-0088	701-477-8272 Fax: 477-8281
Region IV: Northeast Human Service Center - Grand Forks 151 S 4th St Suite 401, Grand Forks, ND 58201-4735 <i>Counties served for human service programs: Grand Forks, Nelson, Pembina, and Walsh.</i>	701-795-3000 Fax: 701-795-3050 TTY: 1-800-366-6889 Crisis Line: 701-775-0525 or -0526 OR 1-800-845-3731 E-mail: dhsnehsc@nd.gov
Outreach Office 5th & School Road, Grafton, ND 58237	701-352-4334 Toll Free: 888-845-2215
Region V: Southeast Human Service Center - Fargo 2624 9th Ave South, Fargo, ND 58103-2350 <i>Counties served for human service programs: Cass, Ransom, Richland, Sargent, Steele and Traill. Day care licensing services are provided to Barnes, Cass, Dickey, Eddy, Foster, Griggs, LaMoure, Logan, Ransom, Richland, Sargent, Steele, Traill, and Wells.</i>	701-298-4500 Fax: 701-298-4400 Toll Free: 1-888-342-4900 Crisis Line: 701-298-4500 Suicide Prevention: 1-800-273-TALK (8255) E-mail: dhssehsc@nd.gov
Region VI: South Central Human Service Center - Jamestown 520 3rd St NW, Box 2055, Jamestown, ND 58402 <i>Counties served for human service programs: Barnes, Dickey, Foster, Griggs, LaMoure, Logan, McIntosh, Stutsman, and Wells.</i>	701-253-6300 Fax: 701-253-6400 TTY: 701-253-6414 Crisis Line: 701-253-6304 Toll Free: 1-800-260-1310 E-mail: dhsschsc@nd.gov
Region VII: West Central Human Service Center - Bismarck 1237 W Divide Ave Suite 5 Bismarck, ND 58501-1208 <i>Counties served for human service programs: Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux.</i>	701-328-8888 Toll Free: 1-888-328-2662 Fax: 701-328-8900 TTY: 1-800-366-6888 (Relay ND) Crisis Line: 701-328-8899 OR Toll Free 1-888-328-2112 E-mail: dhswhsc@nd.gov
Region VIII: Badlands Human Service Center - Dickinson 300 13th Ave W, Suite 1, Dickinson, ND 58601 <i>Counties served for human service programs: Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark.</i>	701-227-7500 Fax: 701-227-7575 Toll Free: 1-888-227-7525 Crisis Line: 866-491-2472 OR 701-290-5719 TTY: 701-227-7574 E-mail: dhsblhsc@nd.gov

Regional human service center locations and frontier counties in North Dakota



The North Dakota State Hospital, located in Jamestown, is the only state hospital in North Dakota. It is fully accredited by the Joint Commission on Accreditation of Health Care Organizations and is also Medicare certified. The North Dakota State Hospital provides service to individuals aged 18 year and older and is utilized only when it has been determined by the regional human service center to be the most appropriate option. It serves as the safety net for the public system in North Dakota. The North Dakota State Hospital provides total care consisting of physical, medical, psychological, substance abuse, rehabilitative, social, educational, recreational and spiritual services through a variety of clinical and non-clinical staff. The goal of the treatment process is to implement appropriate therapeutic modalities at the earliest time so that the period of hospitalization can be reduced to a minimum.

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

ADDITIONAL RESOURCES IN THE STATE’S BEHAVIORAL HEALTH SYSTEM OF CARE

PRIVATE BEHAVIORAL HEALTH PROVIDERS

North Dakota Century Code requires the Behavioral Health Division to license substance use disorder treatment programs in operation in the state. Approximately 80 programs are licensed throughout the state. Because all substance use disorder programs are required to be licensed, there is the ability to identify the levels of services available in various areas of the state to identify gaps. This same information regarding mental health providers is not available because there is no centralized registry.

LOCAL PUBLIC HEALTH

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

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

Through North Dakota's SPF SIG, twenty-five community grantees (twenty-one Local Public Health Units [LPHUs] and four Tribes) were funded to build local infrastructure and implement evidence-based prevention strategies targeting underage drinking and/or adult binge drinking, following the SPF model. The four tribes are also funded through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) to provide local-level, culturally-appropriate, evidence-based substance abuse prevention infrastructure. By partnering with Local Public Health Units and Tribes the state continues to align and leverage prevention funds, resources (including both local SPF SIG, SPF-PFS and SAPT BG funding) and priorities around the issue of underage drinking among persons aged 12 to 20.

THE COUNTY SOCIAL SERVICE BOARDS

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

North Dakota Century Code requires each human service center to have a human services advisory group consisting of the county social service directors of the region served, the public health directors of the region served, two current county commissioners appointed by the executive director of the department, and five additional members appointed by the executive director of the department.

PROTECTION AND ADVOCACY SERVICES

Protection and Advocacy (P&A), a vital service in North Dakota, ensures the quality of services provided to consumers. P&A is an independent state agency established in 1977 to advance the human and legal rights of people with disabilities. P&A strives to create an inclusive society that values each individual.

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

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

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

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

INITIATIVES OF THE BEHAVIORAL HEALTH SYSTEM OF CARE

PREVENTION AND PROMOTION

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

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

The Behavioral Health Division funds Tribal Prevention Programs in the state. These Tribal Prevention Programs are required to follow the Strategic Prevention Framework as they provide culturally-appropriate substance abuse prevention coordination and implementation of evidence based programs, practices and strategies. This work is one of the strengths of the ND Substance Abuse Prevention System – longstanding collaboration with the tribes in the state.

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

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

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

prevention specialists completed the train-the-trainer program with CAPT for the SAPST and plan to hold regular SAPST to continue building the community-level workforce.

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

See **Appendix A** for the North Dakota Behavioral Health Division Substance Abuse Prevention Strategic Plan 2016-2020.

EARLY IDENTIFICATION/INTERVENTION

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

In the 2017 ND Legislative Session, House Bill 1040 passed which gave the Behavioral Health Division authority to write administrative rules setting a minimum standard for Minor in Possession education classes. This effort is in early development.

TREATMENT AND RECOVERY SUPPORT SERVICES

PUBLIC BEHAVIORAL HEALTH SYSTEM

Mental Health Block Grant Criterion 1

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

- **Case Management:** All individuals presenting for services at the regional human service centers are screened during the intake or multidisciplinary case staffing to determine if they have a serious mental illness and meet criteria for case management services. Clients meeting the diagnostic and additional criteria are offered case management services. If consumers are interested in receiving such services, a case manager is assigned to work with them. The case manager begins the process of completing the Daily Living Activities (DLA-20): Adult Mental Health, a functional assessment with the client. The assessment focuses on 20 daily living activities. The completion of this assessment determines what areas of daily living the client needs assistance with, level of case management service, assists with determining which services and supports the client wants and needs, and assists with the development of the person-centered treatment plan.
- **Supported Employment and Extended Service:** Case management staff work closely with Vocational Rehabilitation (VR) to offer employment support services to consumers who desire to work. Those who go through the traditional VR Supported Employment Program transition into Extended Services. This is a service designed to provide ongoing employment-related support for individuals in supported employment upon completion of training which may include job development, replacement in the event job loss occurs, job training contacts, and other support services as needed to maintain employment. In

addition, the Department has implemented the evidence-based practice of Supported Employment in conjunction with the IDDT program at three of the eight regional human service centers. This model emphasizes rapid job search, zero exclusion and time-unlimited supports and has been met with very positive results. Individuals involved in the EBP model of Supported Employment can transition to extended services

- Other Supportive Services: Adults served through the serious mental illness system of care access supportive services through other units of the human service centers. These services include group, individual, and family therapy, psychological services, and medication monitoring.
- Community Residential Options: Housing options available to adults diagnosed with a serious mental illness who are receiving services through the regional human service centers include:
 - Nursing Facility - A twenty-four hour highly supervised facility for consumers with medical problems. The human service center provides consultation/technical assistance and case management as requested.
 - Long-Term Residential - Twenty-four hour supervised care providing room and board for five years or longer. The human service center provides or contracts for consultation/technical assistance and case management as requested.
 - Transitional Living - Twenty-four hour minimal supervision, six to eight consumers in a group setting, room and board provided up to one year. This is provided by the human service center or through a contract with a local provider.
 - Homeless Shelters - Minimal supervision, one night to several months as needed, room and board provided. The human service center provides case management as requested.
 - Single Room Occupancy - House managers live in the facility and provide minimal supervision. Peer support and case management is provided by the agency operating the facility. The human service center provides case management as requested.
 - Supported Housing - Independent living arrangement with staff and financial support from the agency operating the facility. The human service center provides case management and financial support as needed and requested.
 - Independent Living - Independent living apartment rented by the consumer with case management and skills training provided if requested by the consumer.
 - Fairweather Lodge Program - a program dedicated to improving the lives of adults with mental illness by providing safe, affordable housing, employment and social services. The program operates with minimal staff supervision and through peer support.

Mental Health Block Grant Criterion 3

Key to the children's mental health system of care is a strong partnership with families and integrating services across systems. The wraparound process, which uses a strength-based approach to service delivery, is used in the public behavioral health service delivery system and is a method shown to improve the functioning of children who have complex needs. The process is used to help communities develop individualized plans of care.

Working with the family, formal and natural supports (the child and family team) are wrapped around the family to provide them with the services/supports required to meet their needs. The wraparound process includes a set of core elements: 1) individualized plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, 5) least restrictive setting.

Below is the array of services provided through the Partnerships Program within the children's mental health system of care:

- Care Coordination: Care coordination assists children with serious emotional disturbances and their parents with accessing the various services they need and helps them make informed choices about opportunities and services in the community. The care coordinator helps ensure the child and parents receive timely access to needed assistance, provides encouragement and opportunities for self-help activities, and provides overall coordination of services enabling the child and parents to meet their own goals.
- Case Aide: This service is designed to provide behavioral management assistance and role modeling. Certified Mental Health Technicians help individuals stabilize, reduce, and eliminate undesirable behaviors that put them at risk of being served in restrictive settings. Certified Mental Health Technicians also help individuals observe and learn appropriate behavioral responses to situations that trigger their symptoms.
- Crisis Residential Services: This service provides a short-term, safe place to stabilize behaviors in a 24-hour supervised setting. The goal is to promote rapid stabilization and return to the home or community.
- Substance Abuse/Dual Diagnosis Services: When a child diagnosed with a severe emotional disturbance requires substance abuse treatment, a substance abuse provider becomes involved in the team process. With enhanced services made available through the SAPT Block Grant funding for adolescent services, service choices for the teams to consider are increased.
- Flexible Funding: This service is available when no other resources are available to meet specific needs and threaten the child's ability to remain in the least restrictive setting.

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

- Inpatient Psychiatric Facility: This service component provides a short-term episode of care in a hospital setting for the purpose of crisis stabilization that cannot be managed in a non-medical setting, and for comprehensive assessment. The use of this service is reserved for extreme situations for youth who are showing serious acute disturbances or who have particularly perplexing behavior problems.
- Psychiatric Residential Treatment Facilities: A facility or a distinct part of a facility that provides to children and adolescents with twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own home, in another home, or in a less restrictive setting.
- Voluntary Out-of-Home Treatment Program: The Voluntary Treatment Program provides out-of-home treatment services for Medicaid eligible children with a serious emotional disorder without requiring parents to relinquish custody.
- Therapeutic Foster Care: Specially trained and supported foster parents who provide a home for generally one child at a time. The child may remain in the foster home indefinitely. Intensive training for the foster parents is provided, along with on-going intensive support and back-up by mental health professionals and care coordinators.
- Residential child care facilities: a less intensive service setting than a residential treatment center that provides 24-hour care.
- Employment Assistance: Children of working age in the system of care can receive employment assistance through the Individual Educational Plan process at their school. Once they have left the school system, Vocational Rehabilitation services are available. Partnership staff assist the child and family with accessing these services when needed.
- Respite/Parent Support: Respite services provide families of children diagnosed with serious emotional disturbances with periodic relief or back-up assistance. These services

may be on a planned or emergency basis and can be provided either in the family's home or in another setting.

- Intensive In-home Therapy: This service component provides crisis resolution and family therapy oriented services on an outreach basis to work intensively with children and families in their homes. Families that receive these services have a child who is at risk for out of home placement. The services are intensive with 24-hour availability. Services include (but not limited to) skills training and counseling.
- Transition to Independence Program: The Transition to Independence Program (TIP) started on July 1, 2011 and provides transition to independence process – wraparound case management services to transition aged individuals who are at risk between the ages of 14-24, at all eight of the human service Centers. The Transition to Independence Program also provides technical assistance to service providers and community partners who are working with transition aged individuals to assist in guiding youth successfully into adulthood.
- Other Supportive Services: Acute, Psychological Services, and psychiatric services are available through the regional human service centers.

Mental Health Block Grant Criterion 4

Homelessness continues to be an issue in North Dakota. The state lacks sufficient affordable housing, especially for low and extremely low-income brackets. There is a severe shortage of homeless shelter options available in at least five of North Dakota's eight regions. The availability of housing options that serve people with differing levels of need is also very limited – transitional units, low demand housing, and supported permanent housing are in very short supply. Housing subsidy funds are limited and waiting periods of 6 months to more than 1 year are common. Some zoning laws in the state contain provisions that make it difficult to construct group living facilities, which is the category most permanent supportive housing projects fall into.

The specific regulatory language often involves definition of “non-household” living, rules regarding the number of unrelated individuals per unit, and the requirement for public hearings associated with conditional use permits process. Rental and credit history requirements create significant barriers for people to transition out of homelessness. Regions report that minimum credit scores of 600 are common for people to access housing. There continues to be barriers, particularly with HUD subsidized housing, for people with criminal histories and finding housing for individuals with a history of sexual offenses is particularly problematic. In addition, the employment opportunities are decreasing in the areas of the state impacted by the oil industry, due to the decline in activity, but the housing costs have not shown a similar decline. This has resulted in less potential for people who are homeless to enter the job market while the lack of affordable housing has maintained. The ND Housing Finance Administration Director reports that there is a continued shortage of affordable housing.

Even with some decrease in the oil industry activity, North Dakota's estimated population on December 21, 2016 was 757,952. This estimate makes North Dakota the state with the highest percentage growth rate in the nation since the 2010 census.¹ According to North Dakota's Housing Finance Agency's Executive Director, affordable housing continues to be a concern statewide in which homelessness is often a result. According to Reuters (2015), though the fall in oil prices has led to a decline in housing demand and rental costs, the demand for housing still outpaces the supply in western North Dakota. There are no homeless shelters in the two

¹ <https://www.commerce.nd.gov/news/NorthDakotaPopulationReachesanAllTimeHighof757952Residents/>

major western North Dakota communities and the slowdown in the oil industry has led to an increase in unemployment.

The most recent Point-In-Time (PIT) Survey conducted in January 2017 found 1,089 people were experiencing homelessness on that night in North Dakota, including 991 adults and 178 children. Of these, 69 were identified as having a serious mental illness and 70 chronic substance abuse. However, due to the limitations with the survey, it is believed this data underrepresents the true picture of homeless in North Dakota.

Eight regionally-based coordinators funded under the Projects for Assistance in Transition from Homelessness (PATH) Grant provide persons who are homeless or at risk of homelessness and are mentally ill or have a co-occurring mental illness and substance use disorder with intensive case management services including therapy, skills training, supportive residential services and coordinate obtaining other community mental health and addiction services from staff of the human service centers. Persons who are homeless and mentally ill are provided outreach services, screening for treatment services, housing services, and referral for health, education, and entitlements.

Substance Abuse Prevention and Treatment Block Grant Priority Populations

(excluding Individuals in Need of Primary Substance Abuse Prevention)

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

North Dakota faces significant workforce shortages at all levels of the behavioral health profession. Allocations from the SAPT Block Grant base funds for treatment services are allocated by a formula among the eight regional human service centers. Based on need, each center provides or contracts for appropriate services, offering a continuum of care.

The regional human service centers screen all admissions for preference as required in 45 C.F.R. 96.131 at initial contact. All regional human service centers have toll-free phone numbers. If the client identified as being a pregnant woman or injection drug user they are scheduled or offered appointments within 48 hours.

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

As identified in the assurance, North Dakota has a capacity management plan for pregnant women. Human service centers, upon reaching 90% of its capacity to admit pregnant women, shall provide written notification of that fact to Division within 7 days. If the human service

center does not have the capacity to admit or refer a pregnant woman to the clinically appropriate modality of care within 48 hours of requesting treatment, the human service center is required to:

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

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

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

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

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

Items included in this assurance include:

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

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

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

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

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

reviews 12-25 percent of the human service centers annually and assesses compliance with requirements as part of the reviews.

North Dakota currently has two women specific substance abuse treatment programs. These programs are North Central Human Service Center (NCHSC) and Northeast Human Service Center (NEHSC) and are providing services to pregnant women, woman and their infants, and women with dependent children from all regions of the state. The Division will be re-procuring these services in the upcoming year.

TRIBAL CONTRACTS

The North Dakota Behavioral Health Division continues to partner and work with the American Indian Tribes in the state to ensure culturally-relevant behavioral health services are accessible. The Tribes in the state are represented on many state coalitions/task forces, which the Behavioral Health Division leads or participates in, including the State Epidemiological Outcomes Workgroup (SEOW), Prevention Expert Partners Workgroup (PEPW), the Governor's Prevention Advisory Council (GPAC), Problem Gambling Advisory Council, Mental Health and Substance Abuse Planning Council and Olmstead Commission.

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

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

WITHDRAWAL MANAGEMENT

Withdrawal management has been an area of focus for the state for several years. In 2016, the North Dakota Department of Human Services' Behavioral Health Division (DHS) requested technical assistance (TA) from SAMHSA's Center for Substance Abuse Treatment (CSAT) to help the State identify opportunities to improve, enhance and expand the State's capacity for withdrawal and intoxication management services throughout Region 7. In the 2017 ND Legislative Session, Senate Bill 2042 was passed which added clarifications to Century Code to ensure there is constant monitoring in jails, specifically related to social detoxification.

Currently, the Division is in contract with the three existing Opioid Treatment Programs (OTPs) in the cities of Minot, Fargo, and Bismarck to enhance withdrawal management services specifically within county jails across the state. These ND OTPS will be identifying and educating system partners within the correctional system, enhancing policies and procedures for withdrawal management and MAT integration completed for the state Department of Corrections and Rehabilitation and interested correction facility partners. Other activities include

providing training and support for withdrawal management for correctional health facility partners.

Also through the Substance Abuse Prevention and Treatment Block Grant, medical detoxification services are provided via contract through the Southwest Human Service Center in Fargo, ND.

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN IN NEED OF TREATMENT

The 2015 North Dakota legislative session enacted a bill (SB 2367) related to the establishment of a substance exposed newborn task force for the purpose of researching the impact of substance abuse and neonatal withdrawal syndrome, evaluating effective strategies for treatment and prevention, and providing policy recommendations. This task force was comprised of representatives from state agencies, the legislature, medical providers, nonprofit entities focused on children's health and wellbeing, Indian tribes, law enforcement, and the foster care community. This task force developed a report with the following four goals:

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

The Division will be working in collaboration with the public behavioral health system to post a Request for Proposal for specific programs focused on best practice to treat pregnant women and women with dependent children in need of treatment.

MEDICATION ASSISTED TREATMENT

North Dakota was one of the last two states in the nation to provide Opioid Treatment Programs (OTP). On August 10, 2016, Community Medical Services began serving patients at the first OTP in Minot, North Dakota. As of May 1, 2017, they were serving 70 patients. Client demographics show an age range from 19 to 62. The state's second OTP opened in Bismarck, North Dakota, on March 8, 2017, and as of May 1, 2017, they were serving 20 patients. On April 18, 2017, North Dakota's third OTP opened in Fargo, North Dakota, and is currently serving 17 patients.

Despite the availability of such programs, the majority of the state's population currently does not have access to evidence-based medication-assisted treatment (MAT) practices. The state's three OTPs are easily accessible to approximately 17.6 percent of the state's population, with the other 82.4 percent of the population needing to travel, some around 300 miles, in order to receive this service.

The Division continues efforts to partner with community stakeholders with the goal of increasing access to medication assisted treatment. The Behavioral Health Division was awarded the State Targeted Response to the Opioid Crisis Grant (Opioid STR) in May 2017. The Substance Abuse Prevention and Treatment Block Grant will continue to support efforts implemented through the state's Opioid STR. Training needs will be addressed through the Behavioral Health Conference, agency presentations, webinars, and other training and technical assistance opportunities.

RECOVERY SUPPORT SERVICES

As one of its foremost priorities, the Division promotes a recovery-oriented service system for persons at risk of, or who have psychiatric or substance use disorders. The Division continually strives to address the needs of people over time and across different levels of disability, and to apply recovery principles to the full range of engagement, intervention, treatment, rehabilitative and supportive services that an individual needs. Recovery principles are also applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders.

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

North Dakota's First Lady Kathryn Helgaas Burgum has announced her priority and plans to work to erase the social stigma around addiction and spread the word that it's a chronic disease, not a character flaw. The goal of this RFP is to support the First Lady's platform of "Recovery Reinvented" through communication and mass media strategies, creating a social movement decreasing stigma surrounding the chronic disease of addiction. The Behavioral Health Division is working with the First Lady to develop and disseminate messages surrounding the Recovery Reinvented platform. These messages include:

- *We can support individuals in recovery and prevent individuals from developing a substance use disorder by developing healthy families, businesses, and communities.*
- *Reducing stigma will break down barriers to providing and receiving effective prevention, treatment, and recovery services. "Anyone" can become addicted.*
- *Addiction is a chronic, but treatable disease that requires medical intervention, not moral judgment.*

Other specific recovery initiatives include the following:

- **Telephone Recovery Support:** The "Recovery Talk", North Dakota's Telephone Recovery Support Program, was implemented statewide in June, 2008. The Department of Human Services currently contracts with ADAPT, Inc. a private agency located in Bismarck, North Dakota to administer the program. Recovery Talk is geared towards providing additional support to individuals in recovery from substance use disorders who live in rural areas. Individuals receive a phone call on a frequency they determine from trained recovery coaches for a "check-in". The recovery coach provides support to individuals in the early stages of recovery and provides referral sources to access other community supports. In 2015, the program was expanded to include a 24/7 call in feature for participants to utilize anytime they may need additional support.
- **Peer Support:** The Behavioral Health Division is under contract with the University of North Dakota Center for Rural Health (the Center) to create and initiate the implementation of a strategic plan to increase the availability of all types of behavioral health workforce in all regions of the state. The Center will develop deliverables for the project that will include outcome and strategic recommendation reports and fact sheets/policy briefs. Implementation of the strategic plan will begin with the development of a state approved Peer Support Specialist Certification. The Center will facilitate the creation certification standards, development of application and certification processes, and provide technical assistance to support the adoption of peer support services.

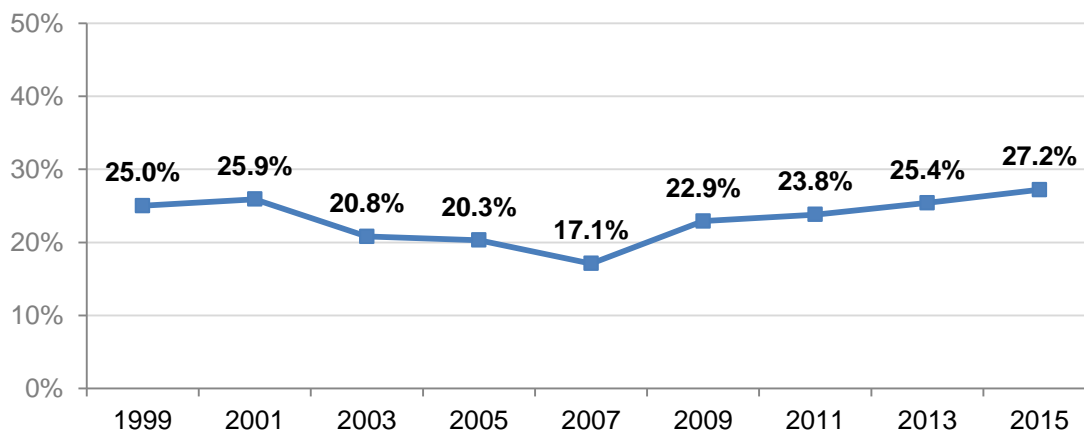
- **Consumer Family Network:** The Behavioral Health Division provides funding to Mental Health America of North Dakota to administer the North Dakota Consumer Family Network (CFN). The CFN is a collaboration consisting of individuals, family members, and advocacy organizations dedicated to education, support, advocacy, and empowerment in the interest of promoting mental health. Goals of the CFN include consumers being well-informed of their choices and possibilities beyond those presently available and for mental health care to be consumer and family driven. Mental Health America of North Dakota and the Consumer and Family Network are members of the North Dakota Behavioral Health Planning Council and provide input into the planning of the behavioral health system of care.

DATA/INFRASTRUCTURE – MENTAL HEALTH BLOCK GRANT

Mental Health Block Grant Criterion 2

YOUTH: Over one in four (27.2%) ND high school students report feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past year. This percentage was highest among high school females (35.2% compared to 19.6% males).

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



According to the 2014-2015 National Survey on Drug Use and Health, approximately 10.5 percent of youth ages 12 to 17 reported a major depressive episode in the past year. At North Dakota Human Service Centers (statewide), an average of 1,556 youth are receiving mental health services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).

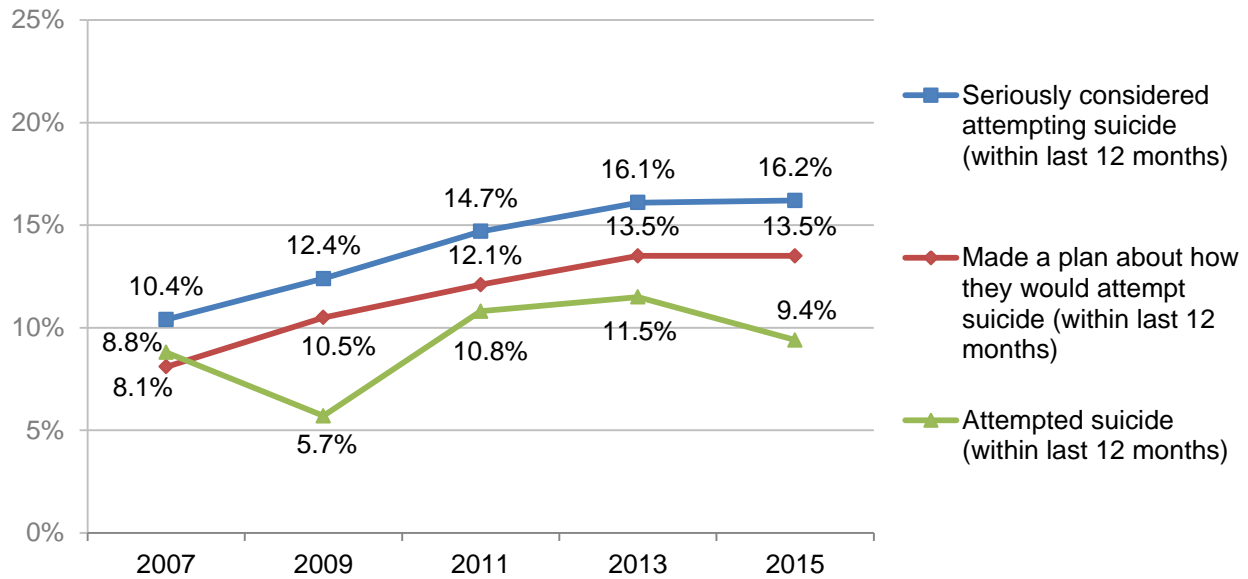
Good mental health often contributes to good physical health. Likewise, the presence of mental and/or substance use disorder is frequently associated with physical health disorders. 17.2% of ND high school students have a long-term health problem.²

Sixteen percent of ND high school students seriously considered attempting suicide at some point during the past year and 13.5% of made a plan about how they would attempt suicide. Again, these rates were higher among females than males (20.4% compared to 12.2% and

² North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

16.1% compared to 10.9% respectively). Almost one in ten (9.4%) ND high school students attempted suicide one or more times during the past year.³

ND High School Students - Suicide
YRBS



ADULTS: Approximately one in three (31.2%) ND adults report their mental health (including stress, depression, and problems with emotions) was not good on at least one day within the past 30 days. Similarly, one in three (33.9%) report poor physical or mental health kept them from doing their normal usual activities, such as self-care, work or recreation (within the past 30 days).⁴

Approximately 17% of ND adults report they have been told at some time in their life that they have a depressive disorder (including depression, major or minor depression and dysthymia).⁵ And, an estimated six percent of ND adults (ages 18 and older) have experienced a major depressive episode in the past year.⁶

³ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

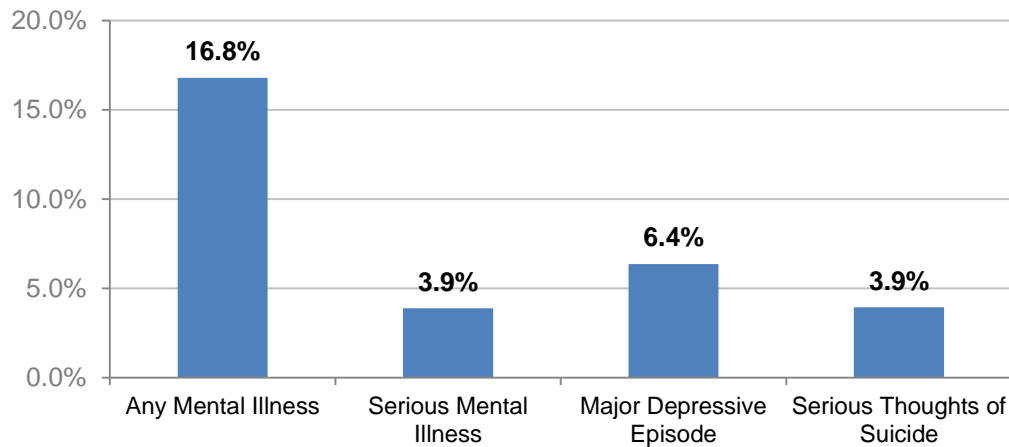
⁴ Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+

⁵ Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+

⁶ National Survey on Drug Use and Health, North Dakota, 2013-2014

**Reported Mental Illness within the Past Year among ND Adults
ages 18 and older**

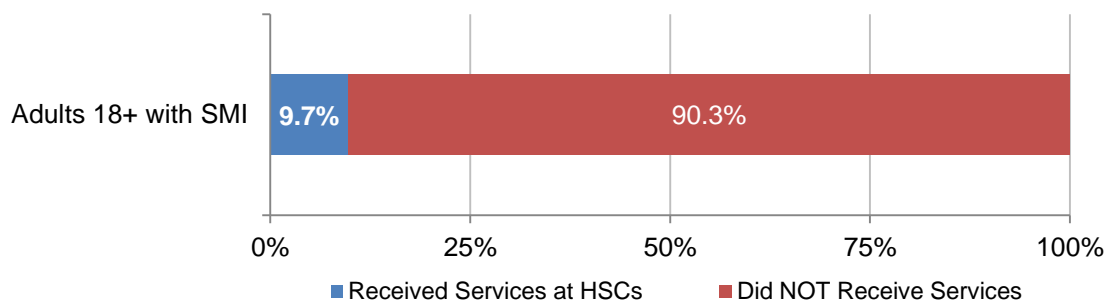
National Survey on Drug Use and Health, 2014-2015



The percentage of North Dakotans with any mental illness in the past year is 16.8 percent. While an estimated four percent have had a serious mental illness in the past year. Almost four percent of ND adults have had serious thoughts of suicide in the past year.⁷

At North Dakota Human Service Centers (statewide), an average of 6,102 adults are receiving any mental health services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).⁸ The National Survey on Drug Use and Health estimates four percent of ND adults to have a serious mental illness, which equals approximately 22,556 individuals age 18 and older in the state. In 2015, the Human Service Centers identified approximately 2,200 adults with serious mental illness as receiving services, which comes to 9.7% of the population needing services.

Percentage of Adults with Serious Mental Illness (SMI) Receiving Services at a Human Service Center, 2015



At times, it is appropriate and effective for inpatient treatment for individuals with mental illness. Conservative estimates suggest a need for 50-60 adult beds per 100,000 population. Based on this estimate, North Dakota total need would be an approximate 350-420 beds. The total beds currently available is right around 323.

⁷ National Survey on Drug Use and Health, North Dakota, 2013-2014

⁸ Unduplicated count of youth and adult mental health clients and addiction clients - Jan-March 2016

Mental Health Block Grant Criterion 5

In planning for allocation of the Mental Health Block Grant funding in North Dakota, the Behavioral Health Division took many considerations into account, including needs and gaps identified in the *Behavioral Health Assessment: Gaps and Recommendations* report and recommendations provided by the Behavioral Health Planning Council. Below are ten recommendations provided by the Behavioral Health Planning Council:

1. Fund a comprehensive approach to behavioral health with an implementation of the full continuum of care model.
2. Fund and implement the Medicaid 1915 (i) amendment to the state plan in the 2017-19 biennium budget.
 - a. Fund peer support services statewide with a goal to ensure that any individual receiving case management has access to peer support services.
 - b. Increase availability of long term employment supports for qualified individuals.
 - c. Expand crisis intervention services including mobile crisis units state-wide, peer supports within crisis intervention services, additional residential crisis beds, and less reliance on hospitals to perform those services.
 - d. Funding permanent supportive housing services for pre and post tenancy.
3. Fund Medicaid expansion and urge the legislature to reaffirm the expansion prior to sunset on July 2017.
4. Department of Human Services shall create opportunities to strengthen advocacy voices to assist in making system change as identified in the Behavioral Health Planning Report by Schulte Consulting July 22, 2014.
5. Follow EPSDT Medicaid mandates, filling existing service gaps for required services
6. Continued funding of the Housing Incentive Fund with a priority to support development of permanent supported housing.
7. Support the establishment of behavioral health courts with associated necessary public behavioral health provisions implemented, including services for veterans see.
8. Ensure Human service centers provide services in a manner so all individuals who are eligible for services are able to receive an unconditional care model of services (zero reject).
9. Ensure Evidence-Based or promising practices are provided with high fidelity quality assurances.
10. State agencies must be provided with state training to increase military cultural competency (how to communicate with veterans or those who have served). This training should also be made available to any providers of behavioral health services including private providers. ND Cares Network would be a good resource for the possible training materials.

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

- Partnerships Program (through the regional Human Service Centers): Mental Health Block Grant funding will support five Partnerships Programs located at the human service centers serving children with serious emotional disturbances.
- Peer Support: North Dakota is continuing to develop mental health peer support services throughout the state.
- First Episode Psychosis Treatment Program: The Division will continue work Prairie St. John's in Fargo to implement a Coordinated Specialty Care pilot program to provide evidence-based First Episode Psychosis (FEP) treatment services to individuals between 15 and 25 years of age.

- Consumer Family Network: The Division, through the Mental Health Block Grant, provides support for the Consumer Family Network, a consumer-run advocacy program.
- Mental Health Criminal Justice Reform: The Division intends to work with system stakeholders to decrease the criminalization of mental illness including development of diversion strategies within North Dakota.
- Aging and Mental Health: Through the Mental Health Block Grant, the Division plans to assist with training for long term care staff regarding mental illness and best practices in working with older adults experiencing mental illness.
- Workforce Training: In order to increase the utilization of best practices, the Division plans to utilize some of the Mental Health Block Grant to support the training of clinicians and other mental health stakeholders. One way of doing this is through the annual Behavioral Health Conference hosted by the Behavioral Health Division.
- Planning Council: The Division plans to utilize some of the Mental Health Block Grant to support the functioning of the state's Behavioral Health Planning Council, including administrative support services and travel reimbursement for the federally required North Dakota Behavioral Health Planning Council.

SPECIAL TOPICS/POPULATIONS

AMERICAN INDIAN POPULATIONS

The North Dakota Behavioral Health Division continues to partner and work with the American Indian Tribes in the state to ensure culturally-relevant behavioral health services are accessible. The Tribes in the state are represented on many state coalitions/task forces, which the Behavioral Health Division leads or participates in, including the State Epidemiological Outcomes Workgroup (SEOW), Prevention Expert Partners Workgroup (PEPW), the Governor's Prevention Advisory Council (GPAC), Problem Gambling Advisory Council, Mental Health and Substance Abuse Planning Council and Olmstead Commission.

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

The Division will also be taking over contracts for treatment/recovery services with the Native American reservations in the state, which were previously managed through the regional Human Service Centers. The Division is planning on furthering the development of partnerships between prevention and treatment efforts funded through the SAPT BG in order to align and leverage resources.

CRIMINAL JUSTICE POPULATIONS

In the 2017 North Dakota Legislative Session, Senate Bill 2015 established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. A primary goal of this effort is to improve healthcare outcomes and reduce recidivism by delivering high-quality community behavioral health services linked with effective community supervision. The Departments of Correction and Rehabilitation and Human Services are partnering with local agencies and governments to deliver coordinated and

comprehensive services to people in the program. Using a certified paraprofessional workforce and an integrated, multidisciplinary approach, community-based agencies will provide a range of services including comprehensive case planning, linking participants to services, peer recovery supports, and facilitating communication. The Department of Human Services has proposed four initial implementation sites for the community behavioral health program (Dickinson, Fargo, Devils Lake, and Bismarck areas).

Another goal of this effort is to cultivate a network of community behavioral health providers to help meet treatment needs of people in the criminal justice system. In particular, Care Coordination and Peer Support Specialists are two core support positions needing to be strengthened. The Behavioral Health Division is currently under contract with the University of North Dakota Center for Rural Health to create and initiate the implementation of a strategic plan to increase the availability of all types of behavioral health workforce in all regions of the state. The Center will develop deliverables for the project that will include outcome and strategic recommendation reports and fact sheets/policy briefs. Implementation of the strategic plan will begin with the development of a state approved Peer Support Specialist Certification. The Center will facilitate the creation certification standards, development of application and certification processes, and provide technical assistance to support the adoption of peer support services.

COLLABORATION WITH MILITARY SUPPORT ORGANIZATIONS

In January of 2015, Governor Jack Dalrymple established the North Dakota Cares Coalition. The North Dakota Cares (ND Cares) Coalition includes a broad spectrum of more than 45 service providers and partners whose work touches the lives of Service Members, Veterans, Families and Survivors. Members share a common interest in strengthening an accessible network of support across the state, even though each entity retains authority over its own programs and services. The ND Cares coalition is dedicated to the strengthening of an accessible, seamless system of support for service members, veterans, families and survivors in the state. The coalition's priority is behavioral health, defined as a state of mental and emotional being and/or choices and actions that affect wellness. The Behavioral Health Division staff is represented on this coalition as well as the executive committee. A military data booklet was developed through the assistance of Behavioral Health Division staff to enhance the sharing of data showing behavioral health needs of the military population.

In April 2017, the Behavioral Health Division and ND Cares Coalition coordinated a training to increase access to quality behavioral health treatment options, especially in rural areas, where service members may have fewer choices. The training focused on military culture and deployments, the challenges and difficulties often associated with military service that can affect service members and their families, and learn clinical skills that focus on specific evidence-based treatments to address some deployment-related behavioral health issues. These include post-traumatic stress disorder, traumatic brain injuries and suicide. Participating providers were selected based on their location, with priority given to providers serving rural areas, along with their credentials and ability to ensure access by being able to accept new clients. Participating behavioral health professionals have committed to providing the specialized evidence-based services for three years. The Behavioral Health Division developed a registry of ND Cares Behavioral Health Providers listing those providers who complete the training: <https://behavioralhealth.dhs.nd.gov/ndcaresprovider>

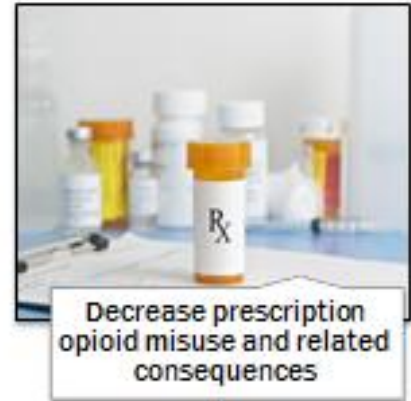
TREATMENT OF PROBLEM GAMBLING

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

Appendix A



North Dakota Behavioral Health Division
SUBSTANCE ABUSE PREVENTION
Strategic Plan 2016 – 2020



Goal 1: Increase implementation of effective prevention statewide

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

Outcome Measures: capacity is difficult to measure and will be evaluated within the objectives and strategies, including process measures

Goal 2: Decrease underage drinking

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

Outcome Measures: Decrease past month underage drinking by 7% and past month underage binge drinking by 5% as evidenced by the 2021 YRBS.

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

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

***links to BHD Opioid Strategic Plan*

Planning Steps

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

Narrative Question:

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

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

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

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

Through the [Healthy People Initiative](#)¹ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2: Identify Unmet Service Needs and Critical Gaps within the Current System

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NORTH DAKOTA'S STATE EPIDEMIOLOGICAL OUTCOMES

WORKGROUP

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

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

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

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

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

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

UNMET SERVICE NEEDS AND CRITICAL GAPS

The North Dakota Department of Human Services, Behavioral Health Division was tasked with reporting the outcome of this assessment by the 64th Legislative Interim Human Services Committee during the August 2015 committee meeting. The purpose of the North Dakota Behavioral Health Assessment is to identify priority recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting North Dakota's children, adults, families and communities in health and wellness, to reach their full potential.

In recent years, North Dakota's behavioral health system has received much attention and review, with stakeholders from multiple disciplines coming together initiating dialogue that would lead to effective change. Numerous suggestions, recommendations and priorities have previously been identified. This important work was considered through the development of this Behavioral Health Assessment. However, this Behavioral Health Assessment takes into consideration some important factors that have not been previously reviewed:

- Epidemiological data identifying the prevalence of behavioral health needs among children and adults in the state.
- A review of the full Continuum of Care (from promotion and prevention through recovery).
- Global systems infrastructure perspective.

In addition to the review of previously developed reports focused on the state's behavioral health system, this assessment sought perspectives from service providers, key stakeholders, and consumers and families in both the state's public and private behavioral health systems.

This assessment identifies global recommendations, which when implemented, will set the foundation to support further enhancements to the state's behavioral health system in a comprehensive, efficient and effective way. This assessment is one piece of the puzzle on the road to a comprehensive and effective behavioral health system. The goal of this document is to identify, as a foundation, where stakeholders can align to develop and support a comprehensive behavioral health system. See **Appendix A** for the summary of identified gaps.

The gaps identified were based on the review of the system with the SAPT BG and MHBG supporting service delivery and efforts throughout the state. Without the SAPT BG and MHBG the number and scope of identified gaps would be much larger.

It was acknowledged that the foundational recommendations in the assessment require the involvement and collaboration of a variety of stakeholders. No one system can address these issues. The identified gaps/needs and related recommendations that were made have been identified as vital foundational pieces on which further efforts can continue to be made and be sustained.

In general, throughout the behavioral health system of care, there are service shortages.

PREVENTION AND PROMOTION (INDIVIDUALS IN NEED OF PRIMARY SUBSTANCE ABUSE PREVENTION)

Gaps and needs identified in the 2016 North Dakota Behavioral Health Assessment: Gaps and Recommendations:

- Workforce and best practices are still being identified, as mental health promotion and mental illness prevention are new to the state.
- Limited resources supporting mental health promotion and mental illness prevention efforts.

- There is no credentialing process in the state for prevention professionals.
- Overall, promotion and prevention tends to not be valued as a priority.

EARLY INTERVENTION

Gaps and needs identified in the 2016 North Dakota Behavioral Health Assessment: Gaps and Recommendations:

- In general, gaps in collaboration and integration with the education system, including early childhood and childcare systems exist.
- There is a need to identify the primary workforce (including credentials) responsible for implementing evidence-based screening efforts.
- There is not a consistent, universal screening utilized in the state.
- At this time, it was identified that funding is a limitation in the widespread implementation of screenings and early intervention programs.
- Where screenings are occurring in the state, often there are issues with an efficient referral process to further assessment and/or treatment services.
- In general, the current process of conducting assessments is not efficient or effective and this often delays the provision of services.

TREATMENT

Gaps and needs identified in the 2016 North Dakota Behavioral Health Assessment: Gaps and Recommendations:

- There is a need to reduce the criminalization of behavioral health disorders. Also, reimbursement is not available for BH services for individuals in jails.
- As the field is moving to understand the chronic nature of behavioral health conditions, it has been identified that there are many limitations in the availability of community-based services (including housing, transportation, employment) to allow individuals choice of services in the least restrictive environment and to support individuals throughout their life.
- In general, behavioral health services in the state are not integrated in service provision. Also, limited collaboration or communication with community or health organizations, including the utilization and exchange of data. Also related to this integration, it was identified that when individuals change to a different level of care in service provision, the transition is often not fluid or seamless.
- Oftentimes the services available in a community are not widely known. Changes in services or processes are not always communicated widely to stakeholders and the general public.
- As has been identified in previous studies and assessments, there are gaps and needs in the behavioral health workforce. However, this limitation is not exclusively related to the number of providers. There are other considerations in this need, including the limitations in utilization of evidence-based practices among the current workforce. Also, there is a need for a single registry for mental health providers.
- Comprehensive care coordination is lacking across the system for individuals with a behavioral health condition. This includes a need for workforce capacity building about effective care coordination.
- There is a continued need for role clarification between the public and private behavioral health service systems to ensure the variety of treatment services are available to individuals.

RECOVERY

Gaps and needs identified in the 2016 North Dakota Behavioral Health Assessment: Gaps and Recommendations:

- Workforce limitations (number of trained providers in evidence-based recovery services)
- Limited evidence-based services, and the infrastructure to support these services, available in the state, including sober living environments and other community-based services and supports (including housing, transportation, employment)
- Limited payment to support evidence-based recovery services

PLANS TO MEET UNMET SERVICE NEEDS AND GAPS

To address the general gap of service shortages in the state, the SAPT BG and MHBG continue to support service delivery, workforce development and support to fill this gap.

PREVENTION AND PROMOTION (INDIVIDUALS IN NEED OF PRIMARY SUBSTANCE ABUSE PREVENTION)

Gap: *Workforce and best practices are still being identified, as mental health promotion and mental illness prevention are new to the state; **Gap:** Limited resources supporting mental health promotion and mental illness prevention efforts.*

Plan: Because Mental Health Block Grant dollars cannot be spent on primary prevention of mental illness, this remains a gap in the North Dakota behavioral health system. Through substance abuse prevention activities funded through both federal (including the Substance Abuse Prevention and Treatment Block Grant) and state sources, shared risk and protective factors are a focus in planning and implementing evidence-based activities.

Gap: *There is no credentialing process in the state for prevention professionals.*

Plan: The Division continues to work on increasing workforce development for prevention professionals in the state. In 2017, three staff at the Division participated in a train the trainer for the Substance Abuse Prevention Skills Training (SAPST) curriculum. Division staff will plan regular SAPST courses to increase the capacity of the workforce, while at the same time developing a plan to move to certification/credentialing.

Gap: *Overall, promotion and prevention tends to not be valued as a priority.*

Plan: The Division continues to develop partnerships and communicate the importance of prevention to stakeholders and the general community. In recent years, the Division developed and disseminated a video on prevention basics and a newspaper insert, among other activities. Ongoing funding of local communities to implement substance abuse prevention efforts is also a strategy that is being implemented to increase the understanding of and support for prevention.

EARLY INTERVENTION

Gap: *In general, gaps in collaboration and integration with the education system, including early childhood and childcare systems exist.*

Plan: Through the passage of House Bill 1040 in the 2017 ND Legislative Session, \$150,000 was appropriated to the Division for the purpose of establishing a children's prevention and early intervention behavioral health services pilot project in a school system of the department's choice. The Division is currently in the planning phase of this project.

Gap: *There is a need to identify the primary workforce (including credentials) responsible for implementing evidence-based screening efforts; **Gap:** There is not a consistent, universal screening utilized in the state; **Gap:** At this time, it was identified that funding is a limitation in*

*the widespread implementation of screenings and early intervention programs; **Gap:** Where screenings are occurring in the state, often there are issues with an efficient referral process to further assessment and/or treatment services; **Gap:** In general, the current process of conducting assessments is not efficient or effective and this often delays the provision of services.*

Plan: Through the passage of Senate Bill 2038 in the 2017 ND Legislative Session, a Task Force on Children's Behavioral Health was established. This task force will be looking at these gaps related to screening and early intervention specific to the children's behavioral health system. Through the SAPT BG, training and technical assistance is available to communities across the state on evidence-based problem identification and referral.

TREATMENT

Gap: *There is a need to reduce the criminalization of behavioral health disorders. Also, reimbursement is not available for BH services for individuals in jails.*

Plan: Senate Bill 2015 (passed in the 2017 ND Legislative Session) established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. The Departments of Correction and Rehabilitation and Human Services are partnering with local agencies and governments to deliver coordinated and comprehensive services to people in the program by increasing access to services and expanding the provider workforce. Through the MHBG, the Division also intends to work with system stakeholders to decrease the criminalization of mental illness including development of diversion strategies within North Dakota.

Gap: *As the field is moving to understand the chronic nature of behavioral health conditions, it has been identified that there are many limitations in the availability of community-based services (including housing, transportation, employment) to allow individuals choice of services in the least restrictive environment and to support individuals throughout their life.*

Plan: Senate Bill 2015 (passed in the 2017 ND Legislative Session) established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. One goal of this effort is to cultivate a network of community behavioral health providers to help meet treatment needs of people in the criminal justice system. In particular, Care Coordination and Peer Support Specialists are two core support positions needing to be strengthened. The Behavioral Health Division is currently under contract with the University of North Dakota Center for Rural Health to create and initiate the implementation of a strategic plan to increase the availability of all types of behavioral health workforce in all regions of the state. The work in this effort will increase access to community-based services for all individuals.

Through the MHBG, the Division continues to develop mental health peer support services throughout the state.

To increase effectiveness of services for pregnant women and women with dependent children, the Division is working with the public behavioral health service delivery system to post a Request for Proposal for specialty women's services. Evidence-based treatment and recovery services will be a requirement and there will be a focus on substance exposed newborns.

Gap: *In general, behavioral health services in the state are not integrated in service provision. Also, limited collaboration or communication with community or health organizations, including the utilization and exchange of data. Also related to this integration, it was identified that when*

individuals change to a different level of care in service provision, the transition is often not fluid or seamless.

Plan: The following recommendation was provided in the 2016 North Dakota Behavioral Health Assessment: Gaps and Recommendations: “Overall, it is recommended that a priority be placed on the utilization of comprehensive data to guide further work in the behavioral health field. Specifically, it is recommended that authority and resources be identified to require and/or incentivize data submission by programs, support the ongoing collection and analysis of the data, and communicate the data/results to stakeholders, decision-makers, and the general public.”

Gap: *Oftentimes the services available in a community are not widely known. Changes in services or processes are not always communicated widely to stakeholders and the general public; **Gap:** There is a continued need for role clarification between the public and private behavioral health service systems to ensure the variety of treatment services are available to individuals.*

Plan: The following recommendation was provided in the 2016 North Dakota Behavioral Health Assessment: Gaps and Recommendations: “In the effort to enhance services available to support an individual’s behavioral health, it is recommended to continue role clarification between the public and private behavioral health service delivery systems. The public service delivery system’s primary role as chronic disease management, regional intervention services and 24-hour crisis services has been identified. It is also recommended that the public service delivery system continue to enhance building awareness of these service changes. This may include increased communication to general public and stakeholders, holding regional meetings and providing information to consumers.”

Gap: *As has been identified in previous studies and assessments, there are gaps and needs in the behavioral health workforce. However, this limitation is not exclusively related to the number of providers. There are other considerations in this need, including the limitations in utilization of evidence-based practices among the current workforce. Also, there is a need for a single registry for mental health providers. **Gap:** Comprehensive care coordination is lacking across the system for individuals with a behavioral health condition. This includes a need for workforce capacity building about effective care coordination.*

Plan: Senate Bill 2015 (passed in the 2017 ND Legislative Session) established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. One goal of this effort is to cultivate a network of community behavioral health providers to help meet treatment needs of people in the criminal justice system. In particular, Care Coordination and Peer Support Specialists are two core support positions needing to be strengthened. The Behavioral Health Division is currently under contract with the University of North Dakota Center for Rural Health to create and initiate the implementation of a strategic plan to increase the availability of all types of behavioral health workforce in all regions of the state. The work in this effort will increase access to community-based services for all individuals.

In order to increase the utilization of best practices, the Division plans to utilize some of the MHBG to support the training of clinicians and other mental health stakeholders. One way of doing this is through the annual Behavioral Health Conference hosted by the Behavioral Health Division.

RECOVERY

Gap: *Workforce limitations (number of trained providers in evidence-based recovery services)*

Plan: Senate Bill 2015 (passed in the 2017 ND Legislative Session) established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. One goal of this effort is to cultivate a network of community behavioral health providers to help meet treatment needs of people in the criminal justice system. In particular, Care Coordination and Peer Support Specialists are two core support positions needing to be strengthened. The Behavioral Health Division is currently under contract with the University of North Dakota Center for Rural Health to create and initiate the implementation of a strategic plan to increase the availability of all types of behavioral health workforce in all regions of the state. The work in this effort will increase access to community-based services for all individuals.

The Division, through the MHBG, provides support for the Consumer Family Network, a consumer-run advocacy program. Also, through the MHBG, Through the MHBG, the Division continues to develop mental health peer support services throughout the state.

Through the state's Opioid STR grant, the Division funded five communities to implement a comprehensive set of strategies addressing opioid use disorder. Through this effort, many communities are working on increasing evidence-based recovery support services.

These efforts working in tandem will increase workforce supporting recovery services throughout the state.

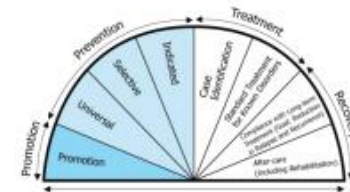
Gap: *Limited evidence-based services, and the infrastructure to support these services, available in the state, including sober living environments and other community-based services and supports (including housing, transportation, employment).* **Gap:** *Limited payment to support evidence-based recovery services*

Plan: The Division continues to collaborate with public and private entities to increase awareness of the need for evidence-based recovery services. Through the state's Opioid STR grant, the Division funded five communities to implement a comprehensive set of strategies addressing opioid use disorder. Through this effort, many communities are working on increasing evidence-based recovery support services.

Appendix A

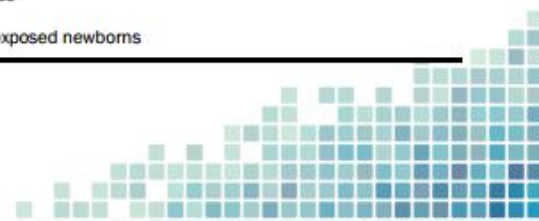


NORTH DAKOTA
Behavioral Health Assessment: Gaps and Recommendations
September 2016



IDENTIFIED GAPS

	PROMOTION/PREVENTION	EARLY INTERVENTION	TREATMENT	RECOVERY
All	<ul style="list-style-type: none"> Workforce credentialing Communicate value 	<ul style="list-style-type: none"> Workforce Funding/Reimbursement Services 	<ul style="list-style-type: none"> Stop criminalizing Jail funding/reimbursement Community-based services Transportation Integrated services Public awareness of services Crisis services (mobile crisis) Access Communicate chronic disease Outcome-based Care coordination Communicate role (public/private) 	<ul style="list-style-type: none"> Supported housing (sober living) Supported employment Transportation Peer-supports (recovery coaches) Best practices (chronic disease) Workforce Funding/reimbursement
Children's Behavioral Health	<ul style="list-style-type: none"> Mental Health best practice Mental Health workforce Mental Health funding 	<ul style="list-style-type: none"> Screening (at-risk or universal) School role First offender 		
Adult Mental Health	<ul style="list-style-type: none"> Best practice Workforce Funding 	<ul style="list-style-type: none"> Screening at-risk individuals 		
Substance Use Disorder		<ul style="list-style-type: none"> Screening Brief Intervention and Referral to Treatment (SBIRT) Jail First offender 	<ul style="list-style-type: none"> Medication Assisted Treatment (MAT) Best practices Women Substance exposed newborns 	



Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

Footnotes:

QUALITY AND DATA COLLECTION READINESS

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Treatment and Recovery Data Collection and Reporting Systems	3

NORTH DAKOTA'S APPROACH TO QUALITY AND DATA COLLECTION

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

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

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

SUBSTANCE ABUSE PREVENTION DATA COLLECTION AND REPORTING SYSTEMS

Process Measures

The Division's substance abuse prevention system has developed an Access reporting database, titled the Daily Reporting System (DRS) for internal use in order to record state-level prevention activities and the provision of training and technical assistance to communities across the state. It is designed to capture the process data (numbers served, resources created, technical assistance activities, etc.) needed for SAPT BG reporting and the evaluation of prevention programs and efforts. The Division also tracks statewide communication process measures including reach, frequency, web hits, etc.

All substance abuse prevention community grantees through the SAPT BG are required to submit reports on process data related to their work. These process measures include the following: number of materials disseminated, number of people served, number of media efforts (including reach), number of contacts with policy-makers, etc. The most recent contracts for the Tribal Community Prevention Programs have moved to be performance-based. Each month throughout their contract, they are required to submit a monthly report which summarizes process data on implemented strategies. Community grantees are encouraged to review their monthly reports to monitor implementation. A final report is also required which includes a summary of outcome measures, list of notable achievements and list of any barriers that impacted implementation effectiveness.

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

Outcome Measures

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

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

TREATMENT AND RECOVERY DATA COLLECTION AND REPORTING SYSTEMS

Process Measures

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

Outcome Measures

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

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

ROAP- All eight regional human services centers use this electronic record. The electronic record has one unique client identifier used across all centers so that whatever center provides services to a client will have access to their entire EHR. This system, which is a NetSmart product, captures client specific-level data for both mental health and substance use services.

The type, duration, and cost of services is captured. This is both a billing and a clinical record system. Services are captured by service area and service type. There is a ROAP code manual updated as needed. Data for the SUD program are captured on an episode of care, ASAM level, and National Outcome Measures basis. Mental health services are captured on a service specific and duration basis. For all behavioral health services, the system provides both claims data and encounter data. Each center has a national provider identifier and if a specific Medicaid service requires both the provider and the professional to be enrolled, both are completed. The system allows for unduplicated counts of clients within and across services. Services can be reported by clinician as well. Supervisory and clinician reports are generated routinely to provide administrative information. This system links with the state's Medicaid Management Information System.

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

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

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Primary Prevention
Priority Type: SAP
Population(s): PP

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Fund North Dakota communities to follow the Strategic Prevention Framework model and implement evidence-based strategies.
Provide support for North Dakota communities to follow the Strategic Prevention Framework model and implement evidence-based strategies.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Decreased past month binge drinking rates among adults.
Baseline Measurement: Ages 18-25: 53.75%. Ages 26+: 27.94% (2012-2013 NSDUH)
First-year target/outcome measurement: Implementation of evidence-based adult binge drinking strategies.
Second-year target/outcome measurement: 2% decrease for Ages 18-25, 1% decrease for Ages 26+

Data Source:

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

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

None identified at this time

Indicator #: 2
Indicator: Decreased past month alcohol use among ND high school students.
Baseline Measurement: 35.3% ND High School students reported alcohol use in the past 30 days
First-year target/outcome measurement: Continued implementation of evidence-based strategies targeting underage drinking
Second-year target/outcome measurement: A 2% decrease in past 30 days alcohol usage among ND high school students.

Data Source:

North Dakota Youth Risk Behavior Survey (YRBS)

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

None identified at this time.

Indicator #: 3

Indicator: Decreased prescription drug abuse among ND high school students

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

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

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

Data Source:

North Dakota Youth Risk Behavior Survey (YRBS)

Description of Data:

Quantitative

Data issues/caveats that affect outcome measures::

None identified at this time

Priority #: 2

Priority Area: Substance Abuse Treatment - Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increase number of substance abusing pregnant women and women with dependent children in need of treatment who receive evidence-based treatment and recovery services.

Objective:

Increase access to evidence-based treatment services for substance abusing pregnant women and women with dependent children in need of treatment.

Strategies to attain the objective:

The BHD will post a new RFP seeking behavioral health services for substance abusing pregnant women and women with dependent children, ensuring services are best practice and integrating with medical services.
Provide training and technical assistance to increase the implementation of best practice.
Continue collaborations with healthcare systems to identify areas of integration.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: Qualitative information from current providers illustrating limited evidence-based practice implementation

First-year target/outcome measurement: Number of training/technical assistance efforts implemented

Second-year target/outcome measurement: Providers are implementing evidence-based practices

Data Source:

Internal tracking of training and technical assistance provision; contract management/reporting; qualitative feedback; possibly quantitative survey of providers

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

data sources are not currently existing

Priority #: 3
Priority Area: Substance Abuse Treatment - Medication Assisted Treatment
Priority Type: SAT
Population(s): Other

Goal of the priority area:

Increase infrastructure and capacity to provide effective treatment and recovery services for individuals with a substance use disorder with a focus on individuals with an opioid use disorder.

Objective:

Increase access to Medication-Assisted Treatment (MAT) as a clinically appropriate evidence-based practice for Opioid Use Disorder (OUD) treatment.

Strategies to attain the objective:

Communicate, train and support professionals in utilizing MAT for the treatment of OUD.
Train and support professionals and systems serving individuals at high risk of opioid overdose.
Provide training and technical assistance to potential Opioid Treatment Programs (OTPs)
Provide training and technical assistance to communities and professionals on the efficacy of MAT.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increased number of MAT providers in the state
Baseline Measurement: ND has 3 OTPs and 23 buprenorphine prescribers (August 2017)
First-year target/outcome measurement: Number of training/technical assistance efforts implemented
Second-year target/outcome measurement: Increase the number of OTPs to 4 and buprenorphine prescribers to 50

Data Source:

Internal tracking of training and technical assistance provision; contract management/reporting; possibly quantitative survey of providers; SAMHSA MAT provider locator; ND Opioid Treatment Program licensing records.

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

some data sources are not currently existing

Priority #: 4
Priority Area: Substance Abuse Treatment - Withdrawal Management
Priority Type: SAT
Population(s): Other

Goal of the priority area:

Expand appropriate utilization of intoxication and withdrawal management based on the updated ASAM criteria.

Objective:

Increase access to appropriate intoxication and withdrawal management services.

Strategies to attain the objective:

Update and enhance intoxication & withdrawal management within administrative rules
 Provide training and technical assistance - Training on withdrawal management and the use of the Clinical Institute of Withdrawal from Alcohol Scale (CIWAS) and Clinical Opiate Withdrawal Scale (COWS) will be conducted in one location in each of the eight regions of the state.
 Policies & Procedures for Withdrawal Management and MAT integration completed for Department of Corrections and Rehabilitation (DOCR) and interested correctional facility partners
 Support for Withdrawal Management and MAT integration for interested correctional facility partners to include:

1. On-call phone support
2. Drug Court liaison

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Increased implementation of appropriate intoxication and withdrawal management practices.
 Baseline Measurement: unknown
 First-year target/outcome measurement: Number of training/technical assistance efforts implemented
 Second-year target/outcome measurement: Number of ND communities who develop and implement a collaborative plan related to appropriate intoxication and withdrawal management (to include law enforcement, jail, EMS, ER, BH providers, other crisis response, etc.)

Data Source:

Internal tracking of training and technical assistance provision; contract management/reporting; qualitative feedback; possibly quantitative survey

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

data sources are not currently existing

Priority #: 5
 Priority Area: Substance Abuse Treatment - Collaboration with Tribal Nations
 Priority Type: SAT
 Population(s): Other (Underserved Racial and Ethnic Minorities)

Goal of the priority area:

In collaboration with the state's Tribal nations, work to address the health disparities related to substance use disorders.

Objective:

Increase the provision of culturally relevant treatment and recovery services in collaboration with the state's Tribal nations.

Strategies to attain the objective:

Fund Tribal nations to implement evidence-based culturally relevant treatment and recovery services

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Increase number of culturally-relevant, evidence-based treatment and recovery services provided on tribal nations

Baseline Measurement: 50% of tribes in the state have implemented some treatment services.

First-year target/outcome measurement: 75% of tribes in the state have implemented culturally-relevant, evidence-based treatment and recovery services

Second-year target/outcome measurement: 100% of tribes in the state have implemented culturally-relevant, evidence-based treatment and recovery services

Data Source:

Internal tracking; contract management/reporting; qualitative feedback

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

data sources are not currently existing

Priority #: 6

Priority Area: Mental Health - Peer Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase utilization of peer support specialists and mental health technician certification.

Objective:

Develop a peer certification process for ND.

Strategies to attain the objective:

Define peer support services, define certified peer support specialist and their qualifications.
 Partner with ND DHS Medicaid to determine the utilization review process and reimbursement methodologies.
 Obtain ND DHS Medicaid approval and assist with submission to CMS for approval.
 Develop the infrastructure for certification process.
 Provide technical assistance and support for the adoption on peer support services.
 Develop data tracking on implementation of peer support program.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Peer Certification process developed

Baseline Measurement: no certification is present in North Dakota

First-year target/outcome measurement: Provide technical assistance and support for the adoption on peer support services.

Second-year target/outcome measurement: Peer Certification process is developed

Data Source:

Internal tracking; contract management/reporting; qualitative feedback

Description of Data:

quantitative and qualitative

Data issues/caveats that affect outcome measures::

data sources are not currently existing

Priority #: 7
Priority Area: Mental Health - Coordination and collaboration across system of care
Priority Type: MHS
Population(s): SED, ESMI, Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Increase integration of children's behavioral health services across the continuum of care.

Objective:

Increase coordination and collaboration across systems related to children's behavioral health

Strategies to attain the objective:

Implementation of a children's behavioral health task force
Development of plan and implementation of strategies to increase integration of services.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Development of plan and implementation of strategies to increase integration of services.
Baseline Measurement: Current plan does not exist
First-year target/outcome measurement: Implementation of a children's behavioral health task force
Second-year target/outcome measurement: Development of plan and implementation of strategies to increase integration of services.

Data Source:

internal tracking, qualitative feedback, finalized report

Description of Data:

qualitative

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$9,237,331		\$1,507,108	\$3,040,000	\$18,427,184	\$0	\$20,691,401
a. Pregnant Women and Women with Dependent Children**	\$985,800		\$0	\$0	\$0	\$0	\$0
b. All Other	\$8,251,531		\$1,507,108	\$3,040,000	\$18,427,184	\$0	\$20,691,401
2. Primary Prevention	\$3,259,138		\$0	\$3,911,920	\$151,240	\$0	\$75,000
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	\$545,707		\$0	\$344,456	\$42,965	\$0	\$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	\$13,042,176	\$0	\$1,507,108	\$7,296,376	\$18,621,389	\$0	\$20,766,401

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			\$0	\$698,880	\$3,059,878	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$1,093,162	\$19,258,421	\$10,885,691	\$61,767,777	\$0	\$11,385,175
8. Mental Health Primary *		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$128,574	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$64,000	\$0	\$10,000	\$317,123	\$0	\$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	\$0	\$1,285,736	\$19,258,421	\$11,594,571	\$65,144,778	\$0	\$11,385,175

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

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	0	73
Women with Dependent Children	0	0
Individuals with a co-occurring M/SUD	0	3356
Persons who inject drugs	0	723
Persons experiencing homelessness	0	300

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

Data is not available for the data cells with "0". The Behavioral Health Division is working to hire a research analyst to assist with the data/evaluation needs.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$9,237,331
2 . Primary Substance Abuse Prevention	\$3,259,138
3 . Tuberculosis Services	\$0
4 . Early Intervention Services for HIV*	\$0
5 . Administration (SSA Level Only)	\$545,707
6. Total	\$13,042,176

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy		IOM Target	FY 2018
		SA Block Grant Award	
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		\$778,721
	Total		\$778,721
Education	Universal		
	Selective		
	Indicated		
	Unspecified		\$93,446
	Total		\$93,446
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		\$62,298
	Total		\$62,298
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		\$155,744
	Total		\$155,744

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	\$1,090,209
	Total	\$1,090,209
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	\$934,465
	Total	\$934,465
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	\$40,000
	Total	\$40,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$3,154,883
Total SABG Award*		\$13,042,176
Planned Primary Prevention Percentage		24.19 %

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	\$0
Total SABG Award*	\$13,042,176
Planned Primary Prevention Percentage	0.00 %

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

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

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems			\$12,672	
2. Infrastructure Support			\$18,432	
3. Partnerships, community outreach, and needs assessment			\$41,472	
4. Planning Council Activities (MHBG required, SABG optional)	\$28,197		\$0	
5. Quality Assurance and Improvement			\$7,488	
6. Research and Evaluation			\$6,144	
7. Training and Education			\$18,048	
8. Total	\$28,197	\$0	\$104,256	\$0

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³³ Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁹ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴³ SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴⁴ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:1027123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52777

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nlm.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

³⁶ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁷ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁸ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁰ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴¹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

⁴² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁴³ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

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

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

North Dakota does not have adequate integration of mental health and primary health care. There is some practice of providing specialty care services in primary care settings and some primary care services in the community mental health clinics. There is some telehealth behavioral health services for primary care and given to critical access hospitals. Federally qualified health clinics have specialty services on site. The community mental health centers partner with public health and certain primary care clinics for medical services to the vulnerable and needy.
2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The community mental health centers have applied an objective tool measuring the integration of services for co-occurring disorders with demonstrated average capacity and an identified set of goals for improvement. 75% of clients served in the community mental health centers have co-occurring disorders and thus treatment models and care delivery have adapted to meet this need.
3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? j n Yes j n No

and Medicaid? j n Yes j n No
4. Who is responsible for monitoring access to M/SUD services by the QHP?
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? j n Yes j n No

6. Do the behavioral health providers screen and refer for:
- a) Prevention and wellness education j n Yes j n No
 - b) Health risks such as
 - i) heart disease j n Yes j n No
 - ii) hypertension j n Yes j n No
 - viii) high cholesterol j n Yes j n No
 - ix) diabetes j n Yes j n No
 - c) Recovery supports j n Yes j n No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? j n Yes j n No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? j n Yes j n No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)⁴⁸.

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁹

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵⁰. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁵¹. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵¹ http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

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

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵⁶ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵⁸ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

⁵² United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵³ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵⁴ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? j n Yes j n No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- a) Leadership support, including investment of human and financial resources.
- b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- c) Use of financial and non-financial incentives for providers or consumers.
- d) Provider involvement in planning value-based purchasing.
- e) Use of accurate and reliable measures of quality in payment arrangements.
- f) Quality measures focus on consumer outcomes rather than care processes.
- g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- h) The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? Yes No

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

Through a contract with Prairie St. Johns (a private behavioral health provider located in Fargo, ND) has developed an action plan and initiated implementation of the Navigate Model of evidence-based first episode psychosis treatment services.

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

The state utilizes many forms of communication to promote the use of evidence-based practices for individuals with a ESMI, including: presentations at the annual statewide Behavioral Health Conference, community presentations, information dissemination via email, meetings, website and social media.

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

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

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

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

Through a contract with Prairie St. Johns (a private behavioral health provider located in Fargo, ND) has developed an action plan and initiated implementation of the Navigate Model of evidence-based first episode psychosis treatment services.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

By October of 2018, the current contractor is required to submit a comprehensive final report summarizing the program, cumulative data, data trends, and lessons learned. Based on this information efforts will be made to further enhance efforts through Prairie St. Johns and expand services to other parts of the state.

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

The state's contract with Prairie St. Johns requires the collection and reporting of data. By October of 2018, the program is required to submit a comprehensive final report summarizing the program, cumulative data, data trends, and lessons learned.

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

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

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

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP 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, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? j n Yes j n No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
Person-centered planning is a value of the Department of Human Services. All state employees are required to complete a training on how to be person-centered through all work. All contracts for behavioral health services through the Behavioral Health Division require vendors to be person-centered.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
State encourages consumers and caregivers in making 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.
4. Describe the person-centered planning process in your state.
All contracts for behavioral health services through the Behavioral Health Division require vendors to be person-centered. How the person-centered planning process is implemented may vary by behavioral health provider.
Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? Yes No
2. Are there any concretely planned initiatives in our state specific to self-direction? Yes No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health 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 programs requirements, including quality and safety standard? Yes No

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

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?

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

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

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

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

The Division will also be taking over contracts for treatment/recovery services with the Native American reservations in the state, which were previously managed through the regional Human Service Centers. The Division is planning on furthering the development of partnerships between prevention and treatment efforts funded through the SAPT BG in order to align and

leverage resources.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

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

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

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

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No

- Data on consequences of substance using behaviors
- Substance-using behaviors
- Intervening variables (including risk and protective factors)
- Others (please list)

Community Readiness

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

- Children (under age 12)
- Youth (ages 12-17)
- Young adults/college age (ages 18-26)
- Adults (ages 27-54)
- Older adults (age 55 and above)
- Cultural/ethnic minorities
- Sexual/gender minorities
- Rural communities

Others (please list)

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

Archival indicators (Please list)

National survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavioral Surveillance System (YRBS)

Monitoring the Future

Communities that Care

State - developed survey instrument

Others (please list)

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

If yes, (please explain)

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

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

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

The state's SEOW developed products which are available here: www.prevention.nd.gov/data. The SEOW also recently launched the "Substance Use North Dakota" website: www.sund.nd.gov.

Please indicate areas of technical assistance needed related to this section

Narrative Question

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

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

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

Capacity Building

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

If yes, please describe

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

If yes, please describe mechanism used

Through the state's Prevention Resource and Media Center, the Division provides training and technical assistance to the prevention workforce across the state via two pathways: proactive and reactive. The proactive approach includes in-person and phone trainings, compilation and dissemination of technical assistance resources, etc. The reactive approach includes the availability of training and technical assistance staff for community-specific needs and requests. Training and technical assistance can be requested and is free to anyone in the state through the prevention website: www.prevention.nd.gov. In 2017, three Division staff participated in a train the trainer for the Substance Abuse Prevention Specialist Skills Training (SAPST) curriculum and will be planning at least annual trainings available to the prevention workforce.

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

If yes, please describe mechanism used

Through the SPF SIG and SPF-PFS SEOW funding, the state (through contract with the Wyoming Survey and Analysis Center) funded the implementation of a statewide community readiness survey. This survey was completed in 2015, 2017 and will be again in 2019.

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

The Community Readiness Survey reports are available at www.prevention.nd.gov/data.

Please indicate areas of technical assistance needed related to this section

Narrative Question

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

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- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
Plan is attached.
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) Timelines
 - c) Roles and responsibilities
 - d) Process indicators
 - e) Outcome indicators
 - f) Cultural competence component
 - g) Sustainability component
 - h) Other (please list):
 - i) Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No
If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based
Through SPF SIG (and utilized in the SPF-PFS), the Evidence-Based Workgroup utilized SAMHSA's definition of evidence-based strategies and developed a "menu" of pre-approved strategies for SPF SIG and PFS community grantees to select from.
Does the state have any activities related to this section that you would like to highlight?

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.

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

Narrative Question

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

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

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) SSA staff directly implements primary prevention programs and strategies.
 - b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) The SSA funds regional entities that provide training and technical assistance.
 - e) The SSA funds regional entities to provide prevention services.
 - f) The SSA funds county, city, or tribal governments to provide prevention services.
 - g) The SSA funds community coalitions to provide prevention services.
 - h) The SSA funds individual programs that are not part of a larger community effort.
 - i) The SSA directly funds other state agency prevention programs.
 - j) Other (please describe)
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:

The Behavioral Health Division operates the Prevention Resource and Media Center which actively disseminates information to communities and stakeholders.

The Behavioral Health Division implements evidence-based mass media/communication efforts targeting priorities set by the state's SEOW:

 - Parents Lead
 - Lock. Monitor. Take Back.
 - Stop Overdose

Information dissemination strategies are funded through community and tribal contracts.
 - b) Education:

Education strategies are funded through community and tribal contracts.

Training and technical assistance is provided to communities and tribes on evidence-based education efforts.

- c) Alternatives:
Alternative strategies are funded through community and tribal contracts.
Training and technical assistance is provided to communities and tribes on evidence-based alternatives.
- d) Problem Identification and Referral:
Problem Identification and Referral strategies are funded through community and tribal contracts.
Training and technical assistance is provided to communities and tribes on evidence-based problem identification and referral.
The Behavioral Health Division certifies providers for DUI education courses.
- e) Community-Based Processes:
Community-Based process strategies are funded through community and tribal contracts.
Training and technical assistance is provided to communities and tribes on evidence-based community-based processes.
- f) Environmental:
Environmental strategies are funded through community and tribal contracts.
Training and technical assistance is provided to communities and tribes on evidence-based environmental strategies.

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

If yes, please describe

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

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

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

Narrative Question

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

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

Evaluation

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

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

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

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

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

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

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

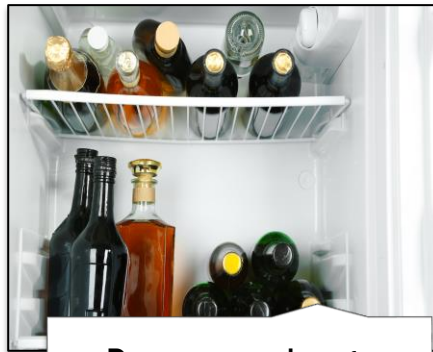
- a) 30-day use of alcohol, tobacco, prescription drugs, etc

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

Footnotes:



**Increase implementation
of effective prevention
statewide**



**Decrease underage
drinking**



**Decrease adult binge
drinking and related
consequences**



**Decrease prescription
opioid misuse and related
consequences**

Goal 1: Increase implementation of effective prevention statewide

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

Outcome Measures: capacity is difficult to measure and will be evaluated within the objectives and strategies, including process measures

Goal 2: Decrease underage drinking

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

Outcome Measures: Decrease past month underage drinking by 7% and past month underage binge drinking by 5% as evidenced by the 2021 YRBS.

Goal 3: Decrease adult binge drinking and related consequences

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

Goal 4: Decrease prescription opioid misuse and related consequences

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

**links to BHD Opioid Strategic Plan

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

Through the public behavioral health service delivery system, individuals diagnosed with a serious mental illness, in most cases, are provided service through the Extended Care Treatment Units in each regional human service center. The core services offered through the Extended Care Treatment Units, either directly or through public/private provider partnership or contracting include: case management, Supported Employment and Extended Service, and other services such as group, individual, and family therapy, psychological services, and medication monitoring.

Working with the family, formal and natural supports (the child and family team) are wrapped around the family to provide them with the services/supports required to meet their needs. The wraparound process includes a set of core elements: 1) individualized plans of care, 2) culturally competent and tailored to the unique needs of families, 3) parental involvement, 4) strength-based, 5) least restrictive setting. The array of services provided through the Partnerships Program within the children's mental health system of care include: care coordination, case aide, flexible funding, crisis residential services, substance abuse/dual diagnosis services.

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

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

Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

All individuals presenting for services at the regional human service centers are screened during the intake or multidisciplinary case staffing to determine if they have a serious mental illness and meet criteria for case management services. Clients meeting the diagnostic and additional criteria are offered case management services. If consumers are interested in receiving such services, a case manager is assigned to work with them. The case manager begins the process of completing the Daily Living Activities (DLA-

20): Adult Mental Health, a functional assessment with the client. The assessment focuses on 20 daily living activities. The completion of this assessment determines what areas of daily living the client needs assistance with, level of case management service, assists with determining which services and supports the client wants and needs, and assists with the development of the person-centered treatment plan.

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

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health 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	22556	16917
2. Children with SED	6740	5055

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.

included average incidence, not those seeking treatment. Of those currently seeking care we have only 600 children identified as SED and using accurate definition for SMI (not SPMI receiving targeted case management) then of the 21,000 individuals enrolled for care a total of 15,000 qualify as SMI – qualifying diagnoses many of whom with co-occurring SUD and a second or third mental illness, and with severe functional deficit.

Narrative Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

- | | |
|---|---|
| a) Social Services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| b) Educational services, including services provided under IDE | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Juvenile justice services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| d) Substance misuse preventiion and SUD treatment services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| e) Health and mental health services | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| f) Establishes defined geographic area for the provision of services of such system | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

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

Describe your state's targeted services to rural and homeless populations and to older adults

Homelessness continues to be an issue in North Dakota. The state lacks sufficient affordable housing, especially for low and extremely low-income brackets. There is a severe shortage of homeless shelter options available in at least five of North Dakota's eight regions. The availability of housing options that serve people with differing levels of need is also very limited – transitional units, low demand housing, and supported permanent housing are in very short supply. Housing subsidy funds are limited and waiting periods of 6 months to more than 1 year are common. Some zoning laws in the state contain provisions that make it difficult to construct group living facilities, which is the category most permanent supportive housing projects fall into.

The specific regulatory language often involves definition of "non-household" living, rules regarding the number of unrelated individuals per unit, and the requirement for public hearings associated with conditional use permits process. Rental and credit history requirements create significant barriers for people to transition out of homelessness. Regions report that minimum credit scores of 600 are common for people to access housing. There continues to be barriers, particularly with HUD subsidized housing, for people with criminal histories and finding housing for individuals with a history of sexual offenses is particularly problematic. In addition, the employment opportunities are decreasing in the areas of the state impacted by the oil industry, due to the decline in activity, but the housing costs have not shown a similar decline. This has resulted in less potential for people who are homeless to enter the job market while the lack of affordable housing has maintained. The ND Housing Finance Administration Director reports that there is a continued shortage of affordable housing.

Even with some decrease in the oil industry activity, North Dakota's estimated population on December 21, 2016 was 757,952. This estimate makes North Dakota the state with the highest percentage growth rate in the nation since the 2010 census. According to North Dakota's Housing Finance Agency's Executive Director, affordable housing continues to be a concern statewide in which homelessness is often a result. According to Reuters (2015), though the fall in oil prices has led to a decline in housing demand and rental costs, the demand for housing still outpaces the supply in western North Dakota. There are no homeless shelters in the two major western North Dakota communities and the slowdown in the oil industry has led to an increase in unemployment.

The most recent Point-In-Time (PIT) Survey conducted in January 2016 found 923 people were experiencing homelessness on that night in North Dakota, including 769 adults and 154 children. Of these, 535 people were in emergency shelters, 172 were in transitional settings, and 216 (23%) were unsheltered. However, due to the limitations with the survey, it is believed this data underrepresents the true picture of homeless in North Dakota.

Eight regionally-based coordinators funded under the Projects for Assistance in Transition from Homelessness (PATH) Grant provide persons who are homeless or at risk of homelessness and are mentally ill or have a co-occurring mental illness and substance use disorder with intensive case management services including therapy, skills training, supportive residential services and coordinate obtaining other community mental health and addiction services from staff of the human service centers. Persons who are homeless and mentally ill are provided outreach services, screening for treatment services, housing services, and referral for health, education, and entitlements.

Criterion 5: Management Systems

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

Criterion 5

Describe your state's management systems.

In planning for allocation of the Mental Health Block Grant funding in North Dakota, the Behavioral Health Division took many considerations into account, including needs and gaps identified in the Behavioral Health Assessment: Gaps and Recommendations report and recommendations provided by the Behavioral Health Planning Council. Below are ten recommendations provided by the Behavioral Health Planning Council:

1. Fund a comprehensive approach to behavioral health with an implementation of the full continuum of care model.
2. Fund and implement the Medicaid 1915 (i) amendment to the state plan in the 2017-19 biennium budget.
 - a. Fund peer support services statewide with a goal to ensure that any individual receiving case management has access to peer support services.
 - b. Increase availability of long term employment supports for qualified individuals.
 - c. Expand crisis intervention services including mobile crisis units state-wide, peer supports within crisis intervention services, additional residential crisis beds, and less reliance on hospitals to perform those services.
 - d. Funding permanent supportive housing services for pre and post tenancy.
3. Fund Medicaid expansion and urge the legislature to reaffirm the expansion prior to sunset on July 2017.
4. Department of Human Services shall create opportunities to strengthen advocacy voices to assist in making system change as identified in the Behavioral Health Planning Report by Schulte Consulting July 22, 2014.
5. Follow EPSDT Medicaid mandates, filling existing service gaps for required services
6. Continued funding of the Housing Incentive Fund with a priority to support development of permanent supported housing.
7. Support the establishment of behavioral health courts with associated necessary public behavioral health provisions implemented, including services for veterans see.
8. Ensure Human service centers provide services in a manner so all individuals who are eligible for services are able to receive an unconditional care model of services (zero reject).
9. Ensure Evidence-Based or promising practices are provided with high fidelity quality assurances.
10. State agencies must be provided with state training to increase military cultural competency (how to communicate with veterans or those who have served). This training should also be made available to any providers of behavioral health services including private providers. ND Cares Network would be a good resource for the possible training materials.

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

- Partnerships Program (through the regional Human Service Centers): Mental Health Block Grant funding will support five Partnerships Programs located at the human service centers serving children with serious emotional disturbances.
- Peer Support: North Dakota is continuing to develop mental health peer support services throughout the state.
- First Episode Psychosis Treatment Program: The Division will continue work Prairie St. John's in Fargo to implement a Coordinated Specialty Care pilot program to provide evidence-based First Episode Psychosis (FEP) treatment services to individuals between 15 and 25 years of age.
- Consumer Family Network: The Division, through the Mental Health Block Grant, provides support for the Consumer Family Network, a consumer-run advocacy program.
- Mental Health Criminal Justice Reform: The Division intends to work with system stakeholders to decrease the criminalization of mental illness including development of diversion strategies within North Dakota.
- Aging and Mental Health: Through the Mental Health Block Grant, the Division plans to assist with training for long term care staff regarding mental illness and best practices in working with older adults experiencing mental illness.
- Workforce Training: In order to increase the utilization of best practices, the Division plans to utilize some of the Mental Health Block Grant to support the training of clinicians and other mental health stakeholders. One way of doing this is through the annual Behavioral Health Conference hosted by the Behavioral Health Division.
- Planning Council: The Division plans to utilize some of the Mental Health Block Grant to support the functioning of the state's Behavioral Health Planning Council, including administrative support services and travel reimbursement for the federally required North Dakota Behavioral Health Planning Council.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- | | |
|---------------------------------|--|
| i) Screening | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ii) Education | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| iii) Brief Intervention | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| iv) Assessment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| v) Detox (inpatient/social) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| vi) Outpatient | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| vii) Intensive Outpatient | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| viii) Inpatient/Residential | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ix) Aftercare: Recovery support | <input type="checkbox"/> Yes <input type="checkbox"/> No |

b) Are you considering any of the following:

- | | |
|---|--|
| Targeted services for veterans | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Expansion of services for: | |
| (1) Adolescents | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (2) Other Adults | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (3) Medication-Assisted Treatment (MAT) | <input type="checkbox"/> Yes <input type="checkbox"/> 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. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Are you considering 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, custody issue Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

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

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

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

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

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

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

Regional human service centers publicize priority status is provided to pregnant woman. This is found within their brochure and on the department's web page at the following link: <http://www.nd.gov/dhs/services/mentalhealth/index.html>

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

To ensure that interim services are provided to pregnant women in the event a human service center is has insufficient capacity to provide treatment services, a plan is in place. The eight regional human service centers are required and responsible to comply with all requirements of the SAPT Block Grant including capacity management and waiting list systems. The BHD worked with regional human service centers to create a signed Assurance of Compliance with Rules and Regulations outlining all activities required for receipt of SAPT Block Grant funds. Items included in this assurance include:

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

A Substance Abuse Prevention and Treatment Block Grant Monitoring Checklist has been distributed. The Division maintains a toll -free number ((800) 755-2719). Providers are also instructed to call 1-800-755-2719 or e-mail immediately if they are unable to admit and/or provide interim services for intravenous drug users and pregnant women.

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

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

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

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

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement j n Yes j n No
 - b) 14-120 day performance requirement with provision of interim services j n Yes j n No
 - c) Outreach activities j n Yes j n No
 - d) Syringe services programs j n Yes j n No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation j n Yes j n No

2. Are you considering any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached j n Yes j n No
 - b) Automatic reminder system associated with 14-120 day performance requirement j n Yes j n No
 - c) Use of peer recovery supports to maintain contact and support j n Yes j n No
 - d) Service expansion to specific populations (military families, veterans, adolescents, older adults) j n Yes j n No

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

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

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

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

To ensure that interim services are provided to pregnant women in the event a human service center is has insufficient capacity to provide treatment services, a plan is in place. The eight regional human service centers are required and responsible to comply with all requirements of the SAPT Block Grant including capacity management and waiting list systems. The BHD worked with regional human service centers to create a signed Assurance of Compliance with Rules and Regulations outlining all activities required for receipt of SAPT Block Grant funds. Items included in this assurance include:

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

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

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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. Are you considering any of the following:
 - a) Business agreement/MOU with primary healthcare providers Yes No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No
 - c) Established co-located SUD professionals within FQHCs Yes No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

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

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

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? j n Yes j n No
2. Are you considering any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas j n Yes j n No
 - b) Establishment or expansion of tele-health and social media support services j n Yes j n No
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS j n Yes j n No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C.A§ 300x-31(a)(1)F)? j n Yes j n No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? j n Yes j n No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

Yes No

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

Criterion 8,9&10

Syringe 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. Are you considering any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of service for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Are you considering 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, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? Yes No
2. Are you considering any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) Develop an organized referral system to identify alternative providers Yes No
 - a) Develop 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. Are you considering 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 j n Yes j n No
- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background j n Yes j n No

Patient Records

- 1. Does your state have an agreement to ensure the protection of client records? j n Yes j n No
- 2. Are you considering any of the following:
 - a) Training staff and community partners on confidentiality requirements j n Yes j n No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients j n Yes j n No
 - c) Updating written procedures which regulate and control access to records j n Yes j n No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure j n Yes j n 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? j n Yes j n No
- 2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

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

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

- 3. Are you considering any of the following:
 - a) Development of a quality improvement plan j n Yes j n No
 - b) Establishment of policies and procedures related to independent peer review j n Yes j n No
 - c) Develop long-term planning for service revision and expansion to meet the needs of specific populations j n Yes j n No
- 4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? j n Yes j n 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. Are you considering any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Are you considering 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

Waivers

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

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

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

North Dakota Century Code 50-06: <http://www.legis.nd.gov/cencode/t50c06.pdf>

Administrative Rule: <http://www.legis.nd.gov/information/acdata/html/Title75.html>

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

Yes No

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

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

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶¹ paper.

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

61 *Ibid*

Please respond to the following items

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

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

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁶²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶³

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

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁶² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csqjusticecenter.org/mental-health/>

Please respond to the following items

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

In the 2017 North Dakota Legislative Session, Senate Bill 2015 established a \$7.5M investment in behavioral health services for people in the criminal justice system to improve public safety and public health outcomes. A primary goal of this effort is to improve healthcare outcomes and reduce recidivism by delivering high-quality community behavioral health services linked with effective community supervision. The Departments of Correction and Rehabilitation and Human Services are partnering with local agencies and governments to deliver coordinated and comprehensive services to people in the program. Using a certified paraprofessional workforce and an integrated, multidisciplinary approach, community-based agencies will provide a range of services including comprehensive case planning, linking participants to services, peer recovery supports, and facilitating communication. The Department of Human Services has proposed four initial implementation sites for the community behavioral health program (Dickinson, Fargo, Devils Lake, and Bismarck areas).

Another goal of this effort is to cultivate a network of community behavioral health providers to help meet treatment needs of people in the criminal justice system. In particular, Care Coordination and Peer Support Specialists are two core support positions needing to be strengthened. The Behavioral Health Division is currently under contract with the University of North Dakota Center

for Rural Health to create and initiate the implementation of a strategic plan to increase the availability of all types of behavioral health workforce in all regions of the state. The Center will develop deliverables for the project that will include outcome and strategic recommendation reports and fact sheets/policy briefs. Implementation of the strategic plan will begin with the development of a state approved Peer Support Specialist Certification. The Center will facilitate the creation certification standards, development of application and certification processes, and provide technical assistance to support the adoption of peer support services.

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

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

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

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

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

North Dakota was one of the last two states in the nation to provide Opioid Treatment Programs (OTP). On August 10, 2016, Community Medical Services began serving patients at the first OTP in Minot, North Dakota. As of May 1, 2017, they were serving 70 patients. Client demographics show an age range from 19 to 62. The state's second OTP opened in Bismarck, North Dakota, on March 8, 2017, and as of May 1, 2017, they were serving 20 patients. On April 18, 2017, North Dakota's third OTP opened in Fargo, North Dakota, and is currently serving 17 patients.

Please indicate areas of technical assistance needed to this section.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

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

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

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please respond to the following items:

1. Crisis Prevention and Early Intervention

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

2. Crisis Intervention/Stabilization

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

3. Post Crisis Intervention/Support

- a) WRAP Post-Crisis
- b) Peer Support/Peer Bridges

- c) € Follow-up Outreach and Support
- d) € Family to Family Engagement
- e) € Connection to care coordination and follow-up clinical care for individuals in crisis
- f) € Follow-up crisis engagement with families and involved community members
- g) € Recovery community coaches/peer recovery coaches
- h) € Recovery community organization

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

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

Please respond to the following:

1. Does the state support recovery through any of the following:
 - a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
 - b) Required peer accreditation or certification? Yes No
 - c) Block grant funding of recovery support services. Yes No
 - d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
Through the Behavioral Health Planning Council (which has more than 51% membership of consumers and family members). Yes No
2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
Recovery and recovery support services for SMI and SED include targeted case management and care coordination, skills training and other rehabilitative services, supported employment, peer support, residential services, supported housing, medication management, Recovery Centers for socialization activities.
4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
Recovery and recovery supports services for SUD services provided in the public behavioral health system include the following: recovery management, supported employment, medication management, individual and group psychotherapy, supported housing, residential services, withdrawal management, case management
5. Does the state have any activities that it would like to highlight?

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

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

Please respond to the following items

- Does the state's Olmstead plan include :
 - housing services provided. Yes No
 - home and community based services. Yes No
 - peer support services. Yes No
 - employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community⁶⁶. 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 24⁶⁷. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death⁶⁸.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21⁶⁹. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ on systems of care, services:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

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

⁶⁶Centers for Disease Control and Prevention. (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, 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.

⁶⁸Centers 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.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? j n Yes j n No
 - The recovery and resilience of children and youth with SUD? j n Yes j n No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - Child welfare? j n Yes j n No
 - Juvenile justice? j n Yes j n No
 - Education? j n Yes j n No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? j n Yes j n No
 - Costs? j n Yes j n No
 - Outcomes for children and youth services? j n Yes j n No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? j n Yes j n No
 - Mental health treatment and recovery services for children/adolescents and their families? j n Yes j n No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult behavioral health system? j n Yes j n No
 - for youth in foster care? j n Yes j n No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)
North Dakota intends to apply for the System of Care grant, but continues efforts to connect services.
- Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

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

Please respond to the following items:

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

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

Implementation of Sources of Strength, upstream suicide and substance use prevention program, across ND through a statewide contract. Any school in ND can implement Sources of Strength for free as funded through state general funding. (Implemented in 30 districts last semester)

Implementation of Zero Suicide in major healthcare systems across ND. NDDoH and NDDHS Applied for two SAMHSA Grants to implement Zero Suicide in Critical Access Hospitals and across major systems of care in ND.

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? Yes No

If so, please describe the population targeted.

ND has implemented a statewide rollout of the evidence-based Sources of Strength program. Any ND middle or high school can receive this comprehensive upstream program for free. This rollout has included two Master Train the Trainer events.

PATH Inc. Therapeutic Foster Homes, their clinics and providers are implementing Zero Suicide across all of their Foster Homes and clinics, reinventing the model to fit the system of care.

Valley Community Health Clinics (Federally Qualified Clinic) has adopted the Rural Toolkit for Suicide Prevention, found on the Suicide Prevention Resource center. They have implemented EBP screening and protocols and have developed and assessed the PHQ9 and best practice protocols for their Somali and LGBTQ+ populations.

The ND Suicide Prevention Program, the ND Suicide Prevention Coalition, ND's Chapter of the American Foundation for Suicide Prevention and ND Cares Coalition have worked together to host webinars and presentations on Zero Suicide to gain support for Zero Suicide, ND. In recent Zero Suicide efforts, ND has received over 25 letters of commitment from key state departments like the ND Department of Corrections and federal entities like ND Veteran Administration as well as from major health and behavioral healthcare providers.

ND has held Master Train the Trainer (T4T) events across ND in Counseling on Access to Lethal Means, and EBP gatekeeper training which trains the gatekeeper to talk to those at-risk and their family about reducing access to lethal means, such as firearms and medication.

In the 2017 legislative session, Teachers require 8 hours of professional development in school-district determined areas related to behavioral health including but not excluded to suicide, resiliency, trauma and bullying. The ND Department of Public Instruction, Regional Education Associations, the ND Department of Health and the ND DHS have partnered to provide the EBP Sources of Strength gatekeeper trainings to schools upon request to fulfill this need.

Implementing Zero Suicide in PATH Therapeutic Foster homes (ND's most vulnerable youth statewide) and working to implement Zero Suicide across ND Family Planning clinics, ND's vulnerable residents without healthcare coverage or those who are on their parents' insurance and are sexually active.

SoS and EBP trainings target Middle and High School students, with priority on Tribal lands, the Counseling on Access to Lethal Means training targeted military/veteran, law enforcement, and first responders.

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

Sources of Strength statewide rollout for any middle or high school, with priority to Tribal communities. PATH Inc. Therapeutic Foster Homes, their clinics and providers are implementing Zero Suicide across all of their Foster Homes and clinics, reinventing the model to fit the system of care. Valley Community Health Clinics (Federally Qualified Clinic) has adopted the Rural Toolkit for Suicide Prevention, found on the Suicide Prevention Resource center. They have implemented EBP screening and protocols and have developed and assessed the PHQ9 and best practice protocols for their Somali and LGBTQ+ populations.

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

Footnotes:

North Dakota

Suicide Prevention Plan 2017-2020





North Dakota

Suicide Prevention Plan

2017-2020

Governor Doug Burgum

State Health Officer Mylynn Tufte



Division of Injury Prevention and Control

600 E. Boulevard Ave., Dept. 301

Bismarck, N.D. 58505-0200

701.328.4536

www.ndhealth.gov/injury

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Acknowledgements for the North Dakota Suicide Prevention Plan 2017-2020

ND Suicide Prevention Coalition Leadership:

Jared Klempel, Chair-Elect
Claudette McLeod, Co-Chair

Authors:

Trish Arnold, North Dakota Department of Public Instruction, Safe and Healthy Schools
Samantha Bruers, American Foundation for Suicide Prevention – North Dakota Chapter
Darcy Corbitt-Hall, Dakota OutRight
Darcie Handt, ND Cares
Brad Hawk, North Dakota Indian Affairs Commission
Jennifer Illich, FirstLink, Fargo
Jared Klempel, Chair-Elect
Cindy Miller, FirstLink, Fargo
Alison Traynor, North Dakota Department of Health
Yvonn Weigel-Frank, Roughrider Education Services Program
Mary Weiler, American Foundation for Suicide Prevention – North Dakota Chapter

Contributing Members:

Cynthia Jelleberg, North Central Education Cooperative
Claudette McLeod, Co-Chair, Turtle Mountain Outreach
Jessica Rudnick, Department of Human Services Behavioral Health Division
Cody Sletten, Sources of Strength

Special thanks to all members of the coalition and to all who work to prevent suicides.

State Suicide Prevention Plan Process


This plan has been developed to focus and coordinate suicide prevention efforts in North Dakota. The North Dakota Department of Health Suicide Prevention Program will guide the implementation of activities in collaboration with national and local partners invested in suicide prevention efforts. This plan is based on the best and promising practices for suicide prevention and the 2012 National Strategy for Suicide Prevention Goals and Objectives.

The state plan will be reviewed each biennium to ensure that it continues to serve the needs of North Dakotans, as well as reflect the suicide prevention work that is being done in North Dakota. The review will also ensure that state practices reflect national priorities in suicide prevention and education.

This plan provides a brief history of the priority populations in need of suicide prevention help, a recap of suicide prevention work that has been completed by partners across North Dakota and action steps for 2017 through 2020.

Unless otherwise noted, the data and graphs in this document are based on occurrent data, which takes into consideration the number of suicides that occur in North Dakota regardless of resident status at the time of death. Occurrent data was used for a variety of reasons. First, individuals may not claim North Dakota residency because they are temporarily living in the state for school, work, relocation, among other reasons. Second, there is no set length of time required to be considered a resident of North Dakota.

In the past, resident-only data was used for charts and graphs. It is important to note that the occurrent data may not match resident-only data from previous years. When reporting rates, the number of suicides that occurred within a particular population or community is used as the numerator (unless otherwise noted). The denominator used is based on the census populations. This was done for consistency between the resident and occurrent trends, as well as using a verified census count rather than population estimates.

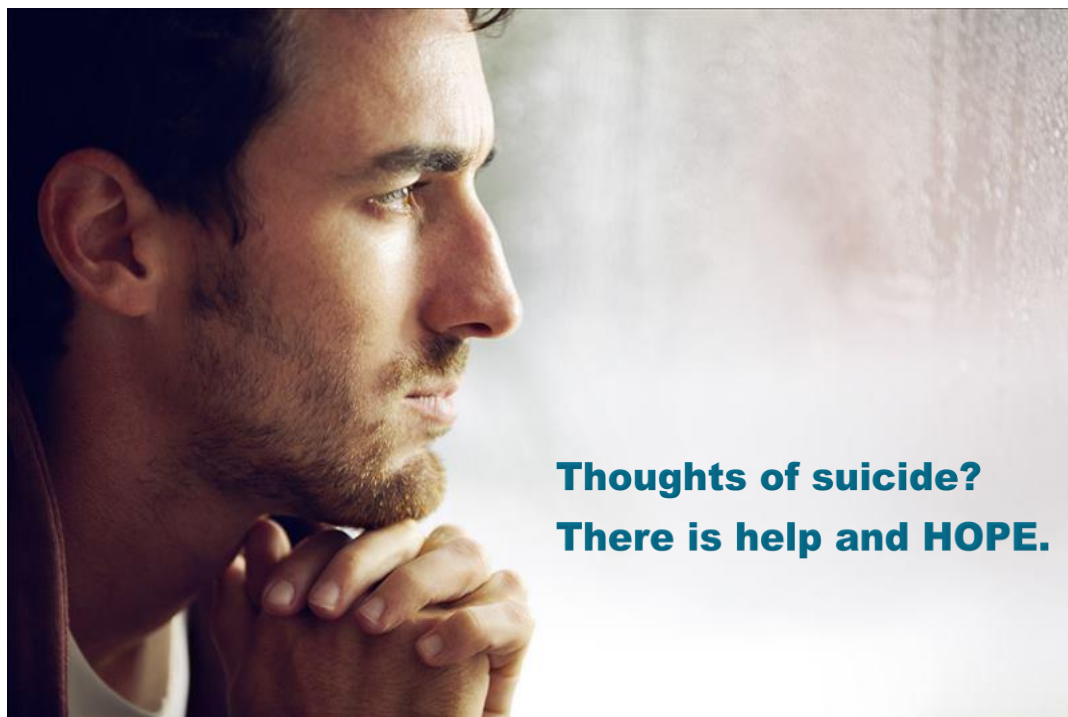


*Suicide is a preventable
public health issue in
North Dakota*



Burden of Suicide in the United States

Approximately 117 Americans die by suicide daily. A total of 42,773 suicides were documented in 2014, which translates to an average of one person dying by suicide every 12.3 minutes. This is the highest rate of suicide in the last 15 years. In 2014, suicide was the tenth leading cause of death overall and the third leading cause of death for those ages 15 to 24. The U.S. Centers for Disease Control and Prevention (CDC) estimates that one million people attempt suicide annually and two million experience suicidal thoughts each year. These statistics translate to one attempt every 34 seconds (American Association of Suicidology).



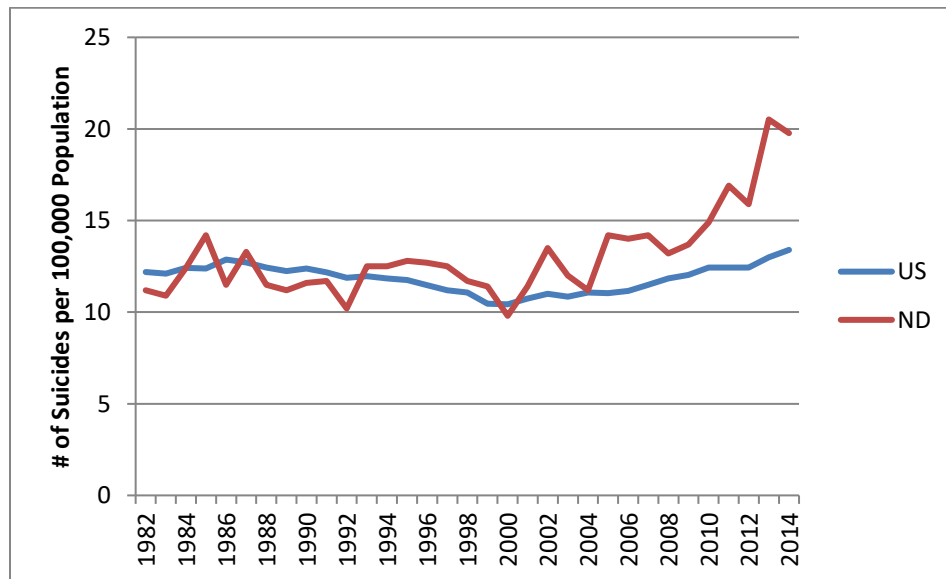
Burden of Suicide in North Dakota

In 2015, 117 North Dakota residents died by suicide. Suicide is the ninth leading cause of death in North Dakota overall, and the second leading cause of death for those between the ages of 15 and 24.

While many more North Dakotans attempt suicide than die by suicide, North Dakota does not yet have a system to track how many North Dakotans receive medical treatment for injuries resulting from suicide attempts. The American Association of Suicidology estimates for every completed suicide, there are as many as 25 more people who attempt suicide but do not die (2008).

In 2015, 1,870 North Dakota residents called the National Suicide Prevention Lifeline requesting support for suicidal thoughts or actions (reported by North Dakota's crisis-line service provider, Firstlink Fargo).

The following graph compares the suicide rate (per 100,000 people) in the United States and North Dakota.



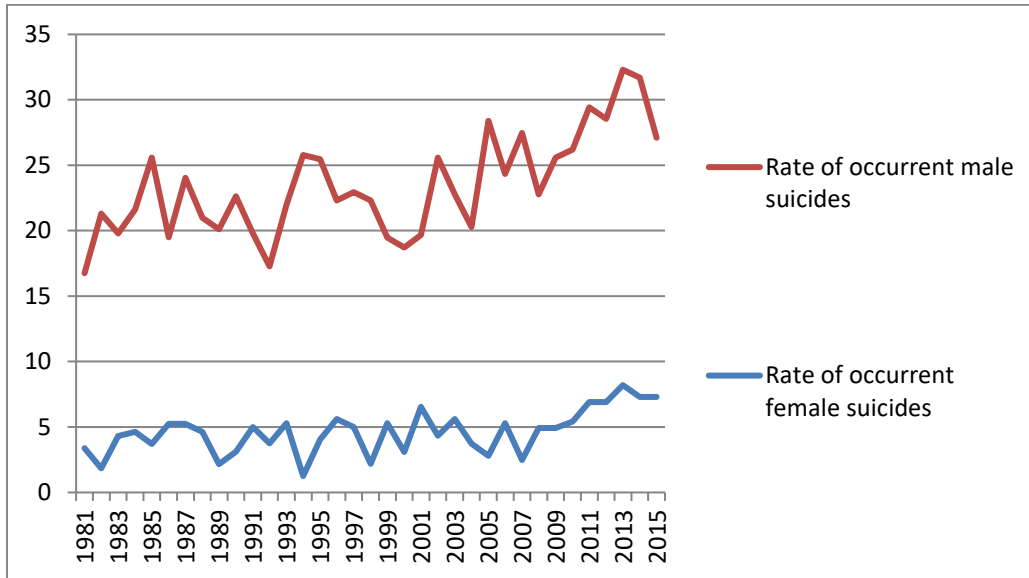
Suicide Rates per 100,000 in North Dakota and the U.S.A. from 1980-2014

Source: North Dakota Department of Health, Vital Records

Suicide has devastating consequences for not only family and relationships, but also society in general. CDC estimates that the average suicide costs the decedent's family and community \$1,164,499 (updated June 2015 based on 2010 figures). Based on this estimate, the 117 suicides that took place in North Dakota in 2015 cost \$136,246,380 due to combined medical and work loss costs.

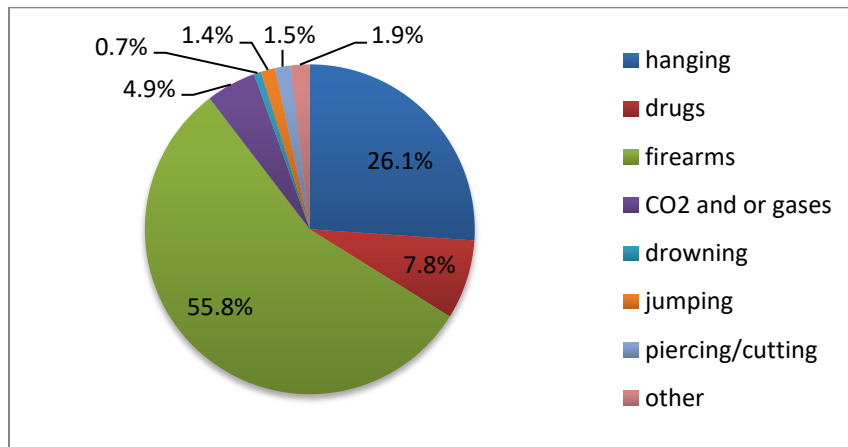


Males typically complete suicide four times more frequently than females. The graph below depicts the suicide rate of males and females in North Dakota from 1980 to 2015.



ND Suicide Rate for Men and Women as measured per 100,000 from 1980-2015
Source: North Dakota Department of Health, Vital Records

Firearms are the leading means of suicide in the U.S. and North Dakota. According to the Harvard C.H. Chan School of Public Health, access to firearms is a risk factor for suicides. While firearm owners are not more suicidal than non-owners, their suicide attempts are more likely to be fatal. Many suicide attempts are made with little planning during a short-term crisis period. If highly lethal means are made less available to impulsive attempters, and they substitute less lethal means or temporarily postpone their attempt, survival odds increase.



Lethal Means Used in North Dakota Suicide Deaths from 1980 to 2015
Source: North Dakota Department of Health, Vital Records

Suicide Survivors

There are two types of people referred to as suicide survivors:

1. People who attempt suicide and survive.
2. People who have lost a loved one to suicide.

The loss of a loved one by suicide is often traumatic, and perhaps one of the most difficult things a person will face in their lifetime. They may feel as if they cannot survive the death of their loved one. The individual may need support and community resources to assist with the grieving and healing process.

In the U.S., it is estimated that between 6 and 32 survivors exist for each suicide, depending on the definition used (Berman, A. L. Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior* 2011. 41(1), 110–116). There are approximately 5 million survivors in the U.S.

In North Dakota, using the most conservative estimate (Berman, A.L.,2011), it is calculated that 702 North Dakotans became new suicide survivors in 2015, in addition to the thousands of survivors already living in the state. In North Dakota, we recognize that survivors bear a significant emotional weight over the loss of their loved one. There are several ways survivors can connect with each other, such as support groups, community walks or recognition of International Survivors of Suicide Loss Day.

Being a suicide survivor is considered a risk factor for attempting suicide. According to the American Association of Suicidology, the increased risk of suicide in the survivor population is an area that needs further research.

Some advice for survivors

- ☞ Feelings of shock, guilt, blame, anger, relief, depression and isolation are common. These feelings are often overwhelming, but normal.
- ☞ Seek people who are able and willing to listen; this may include friends and family, clergy or professionals.
- ☞ Survivors need to take care of themselves physically, mentally, emotionally and spiritually. They should seek professional help if needed.

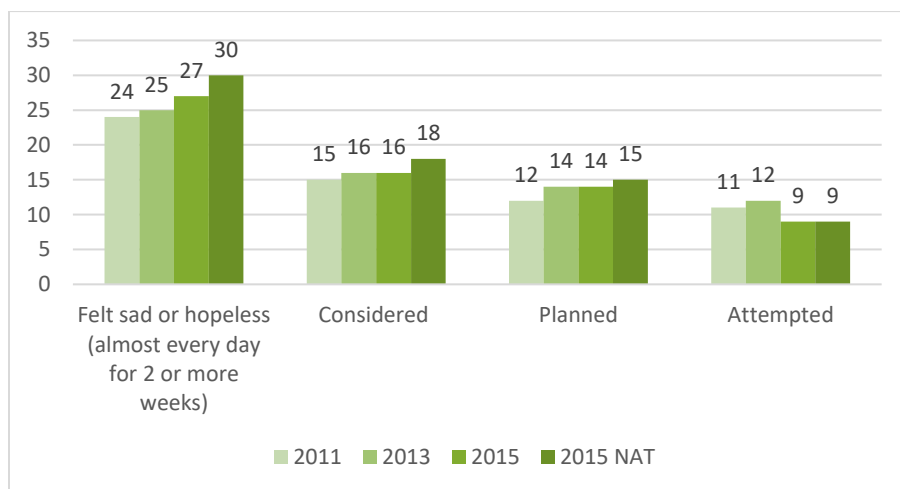


Suicide in Adolescents and Young Adults

Teenagers and young adults go through a period of development and self-identity that can also be a time of loneliness and confusion. According to CDC national vital records, about 5,000 young people between the ages of 10 and 24 die by suicide each year. Youth suicide rates in the U.S. have tripled since the 1950s.

Nationally, suicide is the third leading cause of death for those between the ages of 15 and 24. In North Dakota, suicide is the second leading cause of death for this age group.

The Youth Risk Behavior Survey (YRBS) is a biennial survey that monitors health risks and behaviors of youth in grades 7 through 12.



Suicide-Related Behaviors (Grades 9-12)

Source: North Dakota Department of Public Instruction, YRBS 2011, 2013, 2015, and National 2015 data

Young people consistently say that having caring adults in their lives such as teachers, coaches, ministers and other trusted adults, is a valuable resource during times of suicidal thoughts (Jason Foundation).

In addition to general population risk factors for suicide, specific risk factors occur in the adolescent and young adult population. These include:

- 🌀 **Worsening school performance**
- 🌀 **Unhealthy peer relationships**
- 🌀 **Participating in risky behaviors**
- 🌀 **Bullying**
- 🌀 **Fixation on violence and death**
- 🌀 **Unrealistic academic pressures**
- 🌀 **Unrealistic social or family expectations that may create a sense of rejection**



Suicide in Middle Adulthood

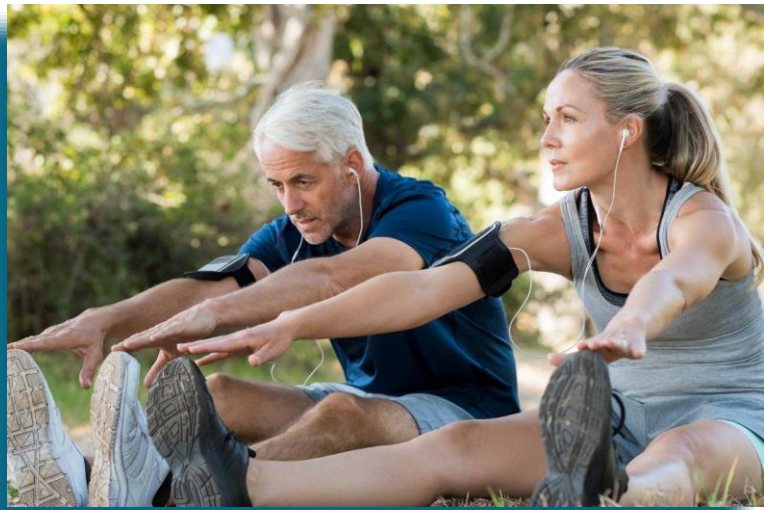
For many people, middle adulthood (ages 35-64) is the prime of their lives. Those in middle adulthood can also face many stressful life events. This has contributed to a steadily increasing number of completed suicides in the U.S. and North Dakota over the past several years. In fact, they show the largest increases in any age group.

In 2011 (most recent national data), middle-aged adults accounted for the most significant proportion of suicides (56%), and from 1999-2010, the suicide rate among this group increased by almost 30% (CDC Suicide Facts at a Glance, 2015). In recent years, North Dakota has experienced a significant increase in suicide among Caucasian men in middle adulthood. This increase roughly reflects the population changes that began with what has been called North Dakota's oil boom. However, it is also important to note that suicide rates peak for women in midlife.

Risk factors for suicide in middle adulthood include:

- ☞ Loss of youthful dreams can result in the realization that the perfect ideal life will not be a reality.
- ☞ Depression is most common in midlife and a major factor in midlife suicides. Depression is more than just sadness and can be effectively treated.
- ☞ High-risk behaviors such as substance use, unsafe sexual behavior, reckless spending or self-injury often pose as escapes from depression or loneliness; however, these behaviors frequently magnify the feelings that the person is trying to avoid.
- ☞ Decreased social support resulting from divorce, job loss or empty nest syndrome may contribute to loneliness, depression and substance use.

*With help,
there is hope.*



Suicide in the Older Adult Population

Depression and suicidal ideation is not a normal part of aging. For some older adults, physical or emotional pain prevents them from finding fulfillment. If their pain is not addressed, they may attempt suicide.

Suicide and suicide attempts in the older adult population tend to occur more often in rural areas than urban. Older Caucasians are more likely to die by suicide than other races. Older adults are less likely to act on suicidal thoughts impulsively; therefore, there may be more time to notice warning signs of suicide and intervene.

Risk factors for suicide in the older adult population include:

- ☞ Loss of self-esteem can be a contributor to thoughts of suicide. Feelings of uselessness, hopelessness or anger because of the aging process can lead to thoughts of suicide.
- ☞ Depression is more than just “sadness.” Depression is a major risk factor in suicide attempts and completed suicides in older adults. It is important to know there are effective treatments for depression.
- ☞ Substance use is sometimes used to cope with feelings of depression or loneliness; however, substance use often magnifies the feeling that the person is trying to escape.
- ☞ Chronic illness can affect some older adults with severe and painful results. Physical pain, in addition to feelings of hopelessness and depression, can lead to suicidal thoughts or actions.
- ☞ Isolation from family and friends may make an older person more susceptible to loneliness, depression and substance use.

*Talk to someone, or
call the National
Suicide Prevention
Lifeline at
1.800.273.TALK (8255)*



Suicide Among Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and Others (LGBTQ+)

LGBTQ+ include individuals who have a sexual orientation (i.e., enduring a set of physical and emotional attractions) toward members of the same-sex (e.g., lesbian, gay, bisexual) and individuals with a gender identity (i.e., enduring internal sense of being a man, a woman, or neither) which is different than their sex assigned at birth (American Psychological Association, 2008). The term LGBTQ+ also encompasses identities which transcend traditional binary views of romantic attraction (e.g., asexual, polyamorous, pansexual, etc.) and gender (e.g., gender-queer, bigender, agender, etc.), and identities represented by the queer plus (i.e., Q+) portion of the acronym (Bornstein, 1998; Wilchins, 2002).

LGBTQ+ individuals account for an estimated four percent of the U.S. population and two percent of North Dakota's population (Gates, 2011). Despite medical and psychological research demonstrating the normalcy of these identities and expression (American Psychological Association et al., 2015; Swaab & Garcia-Falgueras, 2009), the LGBTQ+ community experiences higher rates of discrimination than the general public.

Rates of Suicide in the LGBTQ+ Population

The LGBTQ+ population experiences higher rates of suicide than most other populations. Existing empirical literature indicates that LGBTQ+ youth are 3.4 times more likely to attempt suicide than their non-LGBTQ+ peers. Transgender individuals are ten times more likely to attempt suicide than the general population (Clements-Nolle, Marx, & Katz, 2006; Grossman & D'augelli, 2006; Haas, Rodgers, & Herman, 2014). Homeless LGBTQ+ youth make up 40 percent of the homeless population. Sixty-two percent of members of LGBTQ+ adults report attempting suicide, while 29 percent of their straight peers report attempting suicide (Haas et al., 2010).



The 2013 National School Climate Survey issued by the Gay, Lesbian and Straight Education Network (GLSEN) found that most LGBTQ+ high school students had been verbally or electronically harassed because of sexual identity or gender expression. Students who were harassed were more likely to skip school, drop out, and experience low self-esteem and depression.



Risk Factors for Suicide in the LGBTQ+ Population

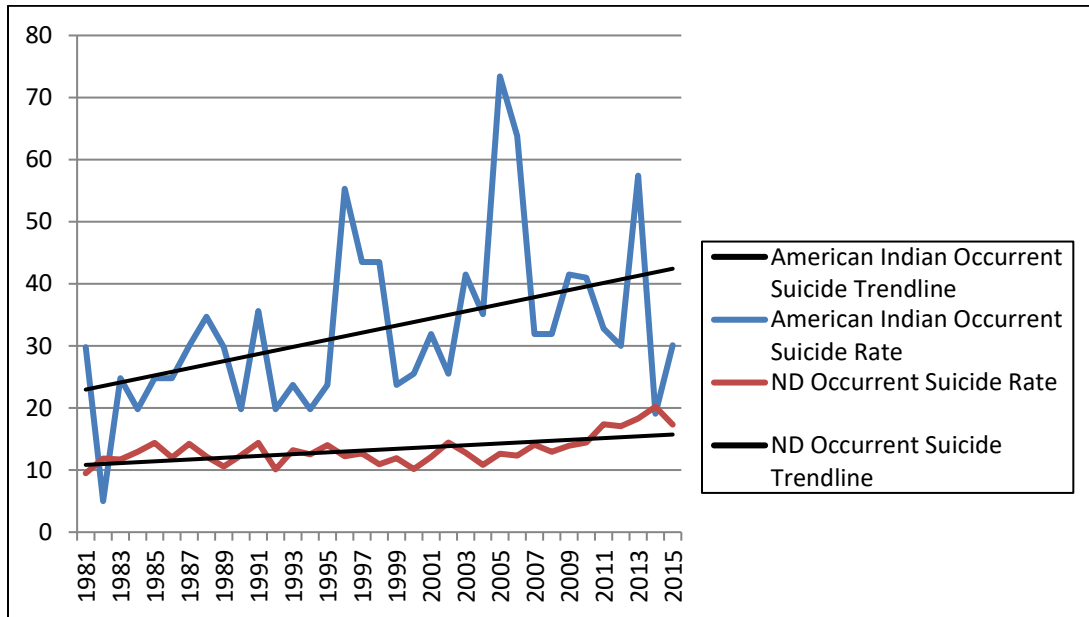
- ☞ **Harassment** is a major suicide risk factor for LGBTQ+ people. Nearly 8 out of 10 students have experienced harassment at school in the past year (Centers for Disease Control and Prevention), <http://www.cdc.gov/lgbthealth/youth.htm>). Sixty percent reported they felt unsafe while at school.
- ☞ **Coming Out** or disclosing oneself as homosexual can be a critical and dangerous time. Research indicates that the first year after disclosure of sexual orientation to one's parents is a prime period for suicide attempts. Teens who are rejected by their families are at more than eight times the risk for a suicide attempt (Centers for Disease Control and Prevention, <http://www.cdc.gov/lgbthealth/youth.htm>). Lack of familial support has been established to be a significant factor in poor mental health, poor physical health, lower socio-economic status, poor academic performance, criminality and the current rate of LGBTQ+ youth homelessness (40% of the homeless population (Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion, 2016).
- ☞ **Increased Risk for Mental Illness.** Due to lack of acceptance, LGBTQ+ individuals experience higher rates of mental illness and suicide than any other population (Goldstein, 2013), and are three times more likely to experience mental illness than the general population (National Alliance on Mental Illness, 2016).
- ☞ **Greater Likelihood of Victimization.** A larger proportion of LGBTQ+ individuals report physical assault (25-55%), sexual harassment (84%), parental abuse (34-46%), and bullying (49%) by both peers and teachers than the general population (Kosciw, Greytak, Palmer, & Boesen, 2014).
- ☞ **Lack of Access to Affirming Healthcare.** Current data indicate that existing healthcare providers are woefully unprepared to treat LGBTQ+ people (Shipherd, Green, & Abramovitz, 2010). As such, this population is less likely to seek mental health care services out of fear of being mistreated or emotionally abused by mental health professionals (Blumer, Green, Knowles, & Williams, 2012).
- ☞ **Substance Use and Abuse.** The LGBTQ+ population has higher rates of usage and abuse of controlled and illicit substances including alcohol (twice as likely), marijuana (three times as likely) and cocaine (eight times as likely) (Ward et al., 2014).
- ☞ **HIV/AIDS Status.** The LGBTQ+ population has a disproportionately high rate of HIV/AIDS. As a result, nearly half of transgender individuals who are HIV-positive are likely to make a suicide attempt (Haas et al., 2014). However, the rate of LGBTQ+ persons who are HIV-positive and make a suicide attempt is decreasing due to increased access to antiretroviral treatments (Haas et al., 2011).



Suicide in the American Indian Population

The term American Indian/Alaska Natives (AI/AN) encompasses many ethnic and cultural groups, tribes and traditions. The reasons why suicide rates are high among the AI/AN population are complex, but some include the prevalence of serious mental health disorders which are related to suicide, such as anxiety, substance use and depression.

The graph below depicts the occurrence of the total suicide rate in North Dakota (per 100,000) compared to the American Indian suicide rate in North Dakota.



American Indian and All Other Populations in North Dakota From 1980-2015
North Dakota Department of Health, Vital Records

The American Indian suicide rate appears to fluctuate dramatically because the number of American Indian North Dakota residents is small compared to other populations. The blue line rises substantially with each suicide within the AI/AN community. The black trend lines are added to the graph to more accurately illustrate the larger suicide trends in both populations over the years.



Risk Factors for Suicide in the North Dakota American Indian Population

- ☞ Contagion is used to describe when multiple people within the same social or geographic community die by suicide within a short time frame. Proximity and relationship to suicide may put individuals at greater risk of suicide. American Indians may be at higher risk of suicide because AI/AN have much exposure to suicide.
- ☞ Discrimination is as important a predictor of suicide ideation as poor self-esteem or depression.
- ☞ Mental health services are difficult to access for many American Indians in North Dakota. Barriers to care include a lack of quality service providers and funding on reservations, personal transportation and payment barriers, as well as stigma.
- ☞ Stressful environments result from few economic resources or social supports for many American Indian families on and off reservations in North Dakota.
- ☞ Trauma from adverse or violent experiences increases suicide risk. American Indians are at higher risk of physical assault.
- ☞ Historical Trauma is the trauma resulting from past efforts to eliminate American Indian cultures throughout the United States with such means as the sending of children to boarding schools and prohibiting their language and cultural activities. The fallout from reported boarding school child abuse and other historical traumas contribute to suicide risk today.
- ☞ Family breakdown may result from historical trauma, economic struggles, discrimination, or family histories of substance use disorders.
- ☞ Alienation or feeling emotionally disconnected from his or her family of origin or culture may cause a loss of well-being or lead to depression. Alcohol and drug use is an ongoing risk factor. In 2005-2006, 37.1 percent of AI/AN in the U.S. who died from suicide and had tested positive for alcohol were legally intoxicated (Morbidity and Mortality Weekly Review, June 19, 2009; 58(23):637-4).
- ☞ Acculturation is the changing of a culture as it mixes with other cultures. In some national studies, AI/AN with greater acculturation reported increased psychosocial stress, less happiness and increased use of drugs to cope with stress.



Suicide in the Military

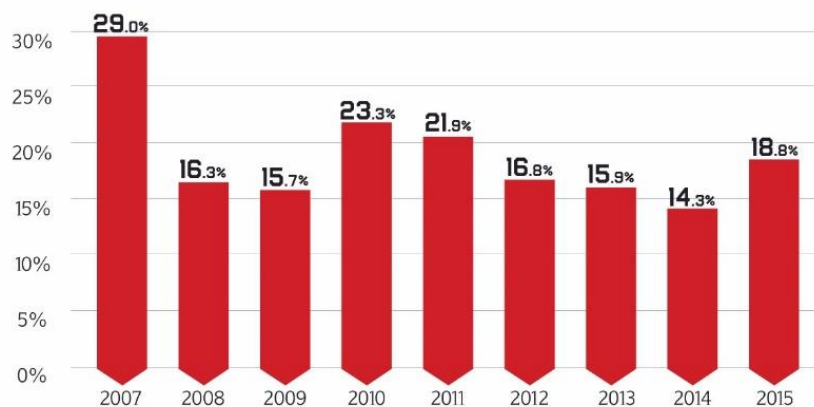
In the United States, veterans are at higher risk of suicide than those that have not served in the military. In 2014, 7,400 veterans died by suicide, making up 18 percent of all suicides in America that year, while Veterans only make up nine percent of the U.S. population. According to new data revealed by the Department of Veterans Affairs, roughly 20 veterans die by suicide every day nationwide. Veteran suicides increased 50 percent from 2001 to 2008 (The War Within: Preventing Suicide in the U.S. military, Rand Cooperation. 2011).

Military veterans are twice as likely to die from suicide as people who have never served in the military. Research about suicide by members of the armed forces indicated that risk factors include: male, depression, substance abuse and relationship issues (James LC, Kowalski TJ) (Mil Med 1996; 161:97-101). More than of 90 percent of Army suicides involve substance abuse, primarily alcohol.

A study of suicide mortality of veterans being treated for depression in the Veterans Affairs Health System reported that “unlike the general population, older and younger veterans are more prone to suicide than are middle-aged veterans” (Zivin K, Kim HM, McCarthy JF, Austin KIL, Hoggatt KJ, Walters H, Valenstein M.; American Journal of Public Health. 2007; 97:12).

In North Dakota, suicide rates for those who have served in the military at some point in their lives are consistently around 15 to 20 percent of the total yearly suicide deaths. The national average is 20 percent.

ND INDIVIDUALS WHO LOST THEIR LIVES TO SUICIDE WHO WERE OF VETERAN STATUS



Percent of Total Annual Suicide Deaths That Were Veteran or Service Member Suicides

Source: North Dakota Department of Human Services, Behavioral Health Division in collaboration with ND Cares Coalition. Data Source: North Dakota Department of Health, Vital Records



Suicide and Substance Use

There is a link between suicide and substance use, which can include prescription drugs, alcohol or illegal substances. The National Institute on Drug Abuse states that teens who engage in high-risk behaviors such as using drugs, alcohol and tobacco, report significantly higher rates of depression, suicidal thoughts and suicide attempts. Additionally, binge drinking among teens has been identified as a predictive factor for suicidal thoughts.

A study concerning alcohol and suicide found that in the suicide deaths studied, 33.3 percent tested positive for alcohol. Of those, more than 56 percent had blood alcohol content over .08, which is legally intoxicated (Morbidity and Mortality Weekly Report, 2009).

The rise in drug abuse over the past 30 years and the more recent epidemic of opioid use is believed to be a contributing factor in the increase in youth suicides, specifically among adolescent males.

According to the Youth Risk Behavior Survey (YRBS) that was conducted in 2013 in North Dakota, six percent of students in middle school and 21 percent of students in high school reported that they had consumed five or more drinks of alcohol in a row, that is, within a couple of hours, in one or more of the past 30 days, which constitutes binge drinking.

Suicide and Mental Health

People with a mental illness may have a heightened risk of suicidal thoughts. When coupled with substance use, the risk increases. While 95 percent of individuals with a mental illness and/or substance use disorder will never complete suicide, several decades worth of data from numerous studies found evidence suggesting that as many as 90 percent of individuals who complete suicide experience a mental or substance use disorder, or both (Center for Substance Abuse Treatment, 2008).

Violence, Trauma, Adverse Childhood Experiences and Suicide

Research shows that there is a relationship between violence and suicide among victims of domestic and sexual abuse, as well as other forms of violence. Like suicide, domestic violence is often stigmatized and hidden; the exact link between domestic violence and suicide is not known. Richard McKeon, Ph.D., chief of the suicide prevention branch at the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), states that survivors of intimate partner violence are twice as likely to attempt suicide multiple times.

Adverse Childhood Experiences (ACEs), negative and traumatic childhood experiences such as child abuse have been linked to mental illness, substance use disorder and many other suicide risk factors and disorders in adulthood. It is, therefore, no surprise that ACEs are also linked to



suicide attempts. One study published by the Journal of Preventive Medicine (Felitti, VJ. et al. May 1998. Volume 14, Issue 4, Pages 245–258) found that persons who had experienced four or more ACEs had a 4- to 12-fold increase in health risks for alcoholism, drug abuse, depression and suicide attempts. The study concluded that there is a strong, graded relationship between exposure to abuse during childhood and multiple risk factors including suicide.

Underlying Principles of the North Dakota Suicide Prevention Plan

Suicide is Largely Preventable

Suicide is preventable and always has contributing factors. No single event causes suicide to occur. The majority of people who die by suicide show signs of suicidality long before they attempt suicide. Early identification of warning signs, effective intervention and treatment drastically reduces the risk of someone dying by suicide. Learning about suicide and suicide prevention will assist North Dakotans in recognizing the warning signs. Perhaps this knowledge could help someone prevent the loss of a loved one or friend who is in crisis.

Everyone Can Help Prevent Suicide

Just as suicide affects everyone, all North Dakotans can help prevent suicides. Suicide prevention requires vision, will and a commitment from the state, communities and individuals within North Dakota. While treatment must be provided by a qualified professional, everyone can learn to recognize suicide warning signs. People who are in contact with those at risk of suicide are often the first line of defense for suicide prevention. These “gatekeepers” can be family members, social acquaintances or those in more formal relationships, such as physicians, teachers and hairdressers. It is important for people to feel empowered to intervene when they perceive someone to be at risk for suicide.

Professionals can play an influential role in suicide prevention and education. Partners in behavioral health, education and other disciplines help identify clients or students at risk of suicide and offer effective intervention services. Professionals can also provide suicide prevention training to their communities to spread the word that suicide is preventable.

The Stigmas Associated With Suicide Should Be Eliminated

Social stigma continues to challenge suicide prevention efforts. Stigma and shame often plague those experiencing suicidal thoughts as well as those who have survived a suicide attempt or loss. Suicide risk factors like substance use, mental illness and depression also carry a social stigma. Stigma prevents many at risk of suicide from reaching out for help from professionals, friends or family. If we eliminate the stigma around suicide, more people will get help and more lives will be saved.



Highlights of Suicide Prevention Efforts from 2013-2016



The North Dakota Suicide Prevention Coalition (NDSPC) and the North Dakota Department of Health (NDDoH) Suicide Prevention Program have implemented many suicide prevention programs to help prevent suicides across North Dakota. Progress has been made through partnerships and collaborative efforts.

- ☞ NDDoH Suicide Prevention Program received state general funding to support over 30 regional and local community suicide prevention projects and a full-time suicide prevention director.
- ☞ NDSPC established infrastructure and regular meetings for the coalition.
- ☞ NDSPC and NDDoH expanded suicide prevention community partners.
- ☞ North Dakota passed legislation requiring all middle and high school educators to receive two hours of suicide prevention training annually and eight hours of behavioral health training every two years.
- ☞ American Foundation for Suicide Prevention, North Dakota Chapter (AFSP ND Chapter), Department of Public Instruction (DPI) and other NDSPC partner organizations created multiple documents, including evidence-based suicide prevention training fact sheets for use in professional settings such as schools, medical facilities and social service offices.
- ☞ NDDoH and NDSPC partners have provided evidence-based gatekeeper training, including Question, Persuade, Refer (QPR) for Suicide Prevention; More than Sad; Sources of Strength; and Applied Suicide Intervention Skills Training (ASIST) to communities statewide.
- ☞ NDDoH provided training opportunities to community members including medical professionals, social workers, teachers, journalists, law enforcement and emergency medical providers.
- ☞ FirstLink expanded the Follow-Up Program, a program to provide free follow-up phone service to those at risk of suicide to include phone calls and service to clinics and emergency rooms across ND.
- ☞ AFSP ND Chapter and NDDoH and other coalition partners incorporated wellness and resiliency messages into training and programs to encourage help-seeking behavior.
- ☞ NDSPC and NDDoH provided statewide Public Service Announcements and print material for the highest risk groups of youth, working-age males, veterans and American Indians.
- ☞ Regional Education Associations (REAs) and DPI held Trauma Sensitive School training in schools across North Dakota.
- ☞ DPI, NDDoH and several REAs started the evidence-based comprehensive peer mentoring program, Sources of Strength, in over eleven districts across North Dakota.
- ☞ NDDoH provided a suicide prevention track at the 2016 Injury Prevention Conference.
- ☞ NDDoH provided grants to local organizations for suicide prevention activities.
- ☞ AFSP ND Chapter coordinated International Survivors of Suicide Day activities.
- ☞ AFSP ND Chapter coordinated statewide Out of the Darkness walks, expanding to several new communities.
- ☞ North Dakota Center for Persons with Disabilities (NDCPD) completed a Suicide Prevention Community Needs Assessment for the western, energy-impacted regions of North Dakota and made recommendations.
- ☞ NDDoH, AFSP, and other NDSPC organizations worked to increase data collection through partnerships with state agency data workgroups and local partners.



Goals and Strategies

Goal I. Develop and implement effective programs that promote wellness and prevent suicide-related behaviors.

Strategy I.A. Promote evidence-based programs.

Action Step A.1: The North Dakota Suicide Prevention Coalition (NDSPC) will update the interagency on-line suicide prevention training calendar and trainer list by January of 2017. The list will be maintained on an ongoing basis.

Action Step A.2: The NDSPC members responsible for suicide prevention training will enhance existing evidence-based programs such as: Applied Suicide Intervention Skills and Training Workshop (ASIST), More than Sad, Signs of Suicide (SOS), Sources of Strength and other programs listed on SAMHSA's Suicide Prevention Resource Center (SPRC) Evidence-Based Registry (EBR) on an ongoing basis.

Action Step A.3: The NDSPC and the North Dakota Department of Health (NDDoH) will support Regional Education Associations (REAs) and the American Foundation for Suicide Prevention North Dakota Chapter (AFSPND) to provide evidence-based training to area schools on an ongoing basis.

Outcome Measure I.A. By 2020, 75 percent of North Dakota middle and high schools will provide Substance Abuse and Mental Health Services Administration (SAMHSA) certified evidence-based suicide prevention training to educational staff. *(Estimated baseline is less than 50 percent; exact baseline is being determined.)*

Strategy I.B. Promote the National Suicide Lifeline and FirstLink's Follow-up Program throughout the state of North Dakota as community-wide suicide prevention resources.

Action Step B.1: The North Dakota Department of Health (NDDoH) will use media contracts to promote the National Suicide Lifeline and FirstLink's Follow-Up Program on an ongoing basis.

Action Step B.2: FirstLink will complete a one-page fact sheet for professionals about the National Suicide Lifeline and FirstLink's Follow-up Program for easy distribution in a wide array of settings (human service centers, medical facilities, schools, faith-based organizations, etc.) by February 2017.

Action Step B.3: FirstLink will guide the development of consistent media messaging for the National Suicide Lifeline and FirstLink's Follow-up Program by January 2018.

Action Step B.4: The NDSPC and suicide prevention partners will use multimedia and social media for promotion of the Suicide Lifeline and FirstLink's Follow-up Program.

Action Step B.5: FirstLink and NDSPC Health Liaisons will meet with health system administrators and medical professionals to increase the number of medical professionals screening for suicidal ideation and referring to FirstLink's Follow-Up Program by May 2018.

Outcome Measure I.B. By 2020, FirstLink will increase partnering healthcare settings by 30 percent. Study results will show 80 percent of respondents received care which they perceived as beneficial as indicated via self-report in SAMHSA's Follow-Up Program Study report. *(2017 baseline is 5 sites.)*



Strategy I.C. Develop strong stakeholder relationships and promote wellness activities in all communities across North Dakota.

Action Step C.1: The NDSPC members will utilize FirstLink’s database to present accurate local resource information to legislators and community leaders on wellness programs that assist in reducing barriers to help-seeking behaviors across all ages and populations by January 2017.

Action Step C.2: The NDSPC will maintain and expand partnerships with each Tribal Suicide Prevention coordinator and other stakeholders by March 2017 and on an ongoing basis.

Action Step C.3: The NDSPC and partners will promote effective protective factors for suicide prevention such as resiliency, communication skills, mental wellness, connectedness and positive self-esteem to middle and high school students (i.e., Sources of Strength, Trauma-Sensitive Schools, Resiliency, Imagine Thriving and other preventive programs) on an ongoing basis.

Action Step C.4: The NDSPC will collaborate with North Dakota Department of Human Services, Division of Substance Abuse, to distribute educational materials, created by Parents LEAD, to providers and community partners by September 2017.

Action Step C.5: The NDSPC will research and promote preventive resources for North Dakota’s highest risk groups of adult males such as Mantherapy.org by January 2018.

Action Step C.6: The NDSPC will develop and distribute suicide prevention materials describing the association between bullying and suicide for all partners’ use by May 2018.

Action Step C.7: The NDSPC members will research and share information on policies, materials and programs shown to decrease suicide risk. NDSPC members will support prevention efforts in their communities and workplaces on an ongoing basis.

Outcome Measure I.C: By 2020, increase evidence-based upstream/primary suicide prevention programs like Sources of Strength from 10 schools to 60 schools. Qualitative and quantitative assessment results will show the impact on risk and protective factors amongst 30 percent of students attending schools where Sources of Strength will be implemented. *(2017 baseline is 10 schools.)*



Goal II. Integrate and coordinate activities across multiple sectors and settings, including training for community and clinical service providers on suicide prevention and awareness of suicide-related behaviors.

Strategy II.A. Offer suicide prevention sessions at annual conferences across the state.

1. Behavioral Health Conference, 2018
2. Educational conferences, August 2019
3. Mental Health Summits (VA Affairs, United Tribes), September 2019

Outcome Measure II.A. By 2020, two partner conferences will include a full suicide prevention track for clinicians, public health professionals and/or other community members. (2017 baseline is zero.)

Strategy II.B. Research and implement effective training and program activities for the following higher risk populations:

1. Adolescents and Young Adults

Action Step 1.a: The NDSPC training members will continue to increase awareness that suicide is preventable through best practice training programs that teach adults how to identify warning signs of suicide and to make appropriate referrals.

Action Step 1.b: The NDSPC members will distribute suicide prevention materials such as American Foundation for Suicide Prevention's (AFSP) Model School Policy to education partners.

Action Step 1.c: The NDSPC school trainers will incorporate postvention resources, such as AFSP's After a Suicide: A Toolkit for Schools, within suicide prevention training.

Action Step 1.d: The NDSPC will collaborate with local advocacy groups to provide culturally competent programs and services for high-risk groups such as LGBTQ+ youth and culturally isolated youth by August 2017.

Action Step 1.e: The NDSPC members will communicate the importance of behavioral wellness and coping skills through education within their area schools on an ongoing basis.

Action Step 1.f: The NDSPC Health Liaisons will connect with the North Dakota University System, the North Dakota Board of Higher Education and each university to advocate for suicide prevention training in psychology 101. NDSPC members will connect with nursing, social work, medical, and teacher preparation departments at ND higher education institutions.

Action Step 1.g: The NDDoH will support ND colleges and universities in applying for federal grants to enhance psychosocial supports for college students such as mentoring programs and screening and referral projects by November 2019.

Outcome Measure II.B.1 (Adolescents and Young Adults). By 2020, YRBS results will show a two percent reduction among youth reporting a suicide attempt within the last twelve months. (2013 baseline is 12 percent.)

2. Middle Adulthood

Action Step 2.a: The NDDoH will determine how many primary healthcare systems use a suicide prevention screening tool for adult patients and make appropriate referrals by March 2017.

Action Step 2.b: FirstLink and NDSPC Health Liaisons will meet with healthcare administrators and clinics to increase screening, brief intervention and referral practices by November 2017.

Action Step 2.c: The NDDoH will work with Suicide Prevention Fund clinical grantees to be in compliance with the Suicide Prevention Depression Screening Grant Protocol as verified through the Ahlers reporting system and other electronic records by January 2018.



Action Step 2.d: The NDSPC Health Liaison will connect with peace officer training academies and institutions to embed suicide prevention training like QPR by January 2019.

Action Step 2.e: The NDSPC will identify local partners to advance suicide prevention education and campaigns on lethal means and bystander interventions amongst local partners by January 2018.

Action Step 2.f: The NDSPC and the NDDoH will connect with worksite wellness to explore programming options for behavioral health and suicide prevention such as depression and suicidal ideation screening and referral programs by November 2017.

Action Step 2.g: The NDDoH will continue support of Optimal Pregnancy Outcomes Program and the Family Planning clinics across North Dakota to administer depression and suicidal ideation screening. The NDDoH will partner with the University of North Dakota Master of Public Health program to assess project outcomes by January 2018.

Action Step 2.h: The NDSPC will connect with all medical system contacts, including obstetricians and gynecologists to advocate for a Zero Suicide Academy to train on depression and suicidal ideation screening, brief intervention, and referral by January 2018.

Action Step 2.i: The NDSPC, the NDDoH and the NDAFSP will hold a Zero Suicide Academy in collaboration with one healthcare system or organization by January 2019.

Action Step 2.j: The NDSPC members will promote Parents Lead materials to stakeholders and local partners. Website analytics will show an increase in Parents Lead materials by January 2019.

Action Step 2.k: The NDDoH will support the implementation of the Zero Suicide comprehensive model across all public health and medical settings by promoting on-going conference calls and mentoring between the Zero Suicide Academy trainers and healthcare administrations' implementation teams by March 2019.

Outcome Measure II.B.2 (Middle Adulthood). By 2020, incorporate Zero Suicide's comprehensive model within North Dakota's public health and/or healthcare systems. Increase universal screening, brief intervention, referral and follow-up practices by ten percent as evidenced by a 0.5 percent decrease in deaths by suicide among middle adulthood residents. *(2015 baseline rates per 100,000 – ages 25-34: 34.4; ages 35-44: 35.9; ages 45-54: 20.7.)*

3. Older Adults

Action Step 3.a: The NDSPC will disseminate suicide prevention education to non-traditional partners (e.g. realtors, lawyers, landlords) each quarter to encourage help-seeking behaviors beginning in September 2017.

Action Step 3.b: The NDSPC will research, compile, and develop suicide prevention resources of different forms (print, multimedia, face-to-face) for statewide distribution on an ongoing basis.

Action Step 3.c: The NDSPC, North Dakota Center for Persons with Disabilities (NDCPD), and the NDDoH will provide SafeTALK and other evidence-based suicide prevention training to community partners like the Long Term Care Association, county social service Quality Service Provider (QSP) training agencies, nursing homes, and other groups that support older adults by February 2018.

Action Step 3.d: The NDDoH will support suicide prevention training for clergy members and will develop a list and functional referral system to connect certified chaplains to rural residents in crisis by January 2018.

Outcome Measure II.B.3 (Older Adults). By 2020, increase universal screening practices in primary care settings, brief intervention, referral, and follow-up practices by 10 percent. Decrease deaths by suicide among adults ages 55 and older by five percent. *(2015 baseline rates per 100,000 – ages 55-65: 15.9; ages 65+: 12.3.)*



4. LGBTQ+

Action Step 4.a: Dakota OutRight, a North Dakota LGBTQ+ Service Advocacy organization, will appoint a liaison to participate in NDSPC meetings, planning and other activities by January 2017 and on an ongoing basis.

Action Step 4.b: Dakota OutRight will perform a cultural competency audit of all NDSPC and NDDoH Suicide Prevention materials by September 2017.

Action Step 4.c: The NDSPC will work with an LGBTQ+ Liaison to create culturally competent LGBTQ+ materials by March 2018.

Action Step 4.d: The NDSPC and the NDDoH will coordinate and support a three-tiered competency training for crisis workers as well as to emergency response professionals providing suicide prevention interventions state-wide. The first tier will be completed by September 2017.

Action Step 4.e: The NDSPC will support the inclusion of culturally competent questions regarding gender identity and sexual orientation within surveys and other study models to inform North Dakota's future targeted LGBTQ+ prevention interventions.

Outcome Measure II.B.4 (LGBTQ+). By 2020, 75 percent of crisis workers providing telephone suicide crisis counseling will complete a cultural sensitivity training which meets the standards of North Dakota's LGBTQ+ Service Advocacy organization, Dakota OutRight. One hundred percent of all NDSPC materials will be culturally sensitive as determined by Dakota OutRight. *(2017 baseline is zero.)*

5. American Indians

Action Step 5.a: The NDSPC Board will initiate communication with each tribal designee by February 2017 and on a quarterly basis after that to identify new tribal stakeholders as well as to assess changing needs.

Action Step 5.b: The NDSPC Health Liaison will update the NDSPC list serve to include new tribal participant information by March 2017 and on an ongoing basis.

Action Step 5.c: Tribal NDSPC members will inform efforts to make suicide prevention materials available in a wide-variety of settings (print, multimedia, face-to-face) using culturally competent pictures and language.

Action Step 5.d: The NDSPC members will provide evidence-based suicide prevention programs and training within Bureau of Indian Education (BIE) schools. Training like Sources of Strength, SafeTALK or other gatekeeper training will be provided to each BIE school district on an annual basis.

Action Step 5.e: The NDSPC will continuously support efforts by the North Dakota Indian Affairs Commission to increase employment and service opportunities for American Indians on reservations and across North Dakota.

Outcome Measure II.B.4 (American Indian Communities). By 2020, 60 percent of educators working on tribal lands in North Dakota will have training in evidence-based suicide prevention practices. *(Estimated baseline is less than 50 percent; exact baseline is being determined.)*



6. Service Members, Veterans, Family Members, and Survivors

Action Step 5.a: The North Dakota National Guard will continue suicide prevention training throughout North Dakota Communities.

Action Step 5.b: The North Dakota National Guard will continue to participate in community sponsored suicide prevention events.

Action Step 5.c: The NDSPC will work in collaboration with the National Guard and North Dakota Cares coalition to ensure suicide prevention messaging is culturally competent for service members, veterans, family members, and survivors.

Action Step 5.d: The NDSPC and the National Guard will develop a listing of suicide prevention training, facilitated by the North Dakota National Guard, and disseminate to statewide partners by January 2018.

Action Step 5.e: The Department of Human Services in collaboration with North Dakota Cares Coalition will develop and implement a statewide Star Behavioral Health Program (SBHP), a tier-based continuing education program that develops cultural competency for behavioral health professionals by January 2018.

Outcome Measure II.B.5 (Service Members, Veterans, Family Members, and Survivors): By 2020, the number of North Dakota Army National Guard Service Members trained in Applied Suicide Intervention Skills and Training (ASIST) will increase by 50 percent. *(2017 baseline is being established.)*

Strategy II.C: Support the integration of suicide prevention strategies within behavioral health professional settings.

Action Step C.1: The NDDoH will continue competitive funding opportunities for all health based systems, focusing on suicide risk factor screening, best practice brief intervention, referral and follow-up service projects.

Action Step C.2: The NDSPC, the AFSP and other key partners will disseminate suicide prevention education through various professional communications throughout the state by January 2018.

Action Step C.3: The NDSPC will support parish, nurse and clergy community with suicide prevention education as it relates to behavioral health intervention.

Action Step C.4: The NDSPC and the NDDoH will meet with university administration, licensure boards and educators to promote curriculum expansion in medical and helping professions that include suicide prevention strategies.

Outcome Measure II.C: By 2020, increase the number of higher education school programs with a suicide prevention theory and practice requirement within the North Dakota University System by 25 percent. *(2017 baseline is two.)*



Risk factors for suicide

There are many risk factors for suicide. Some risk factors are genetic and cannot be changed; others are short lived and situational. Because risk factors are present does not mean that someone will attempt or complete suicide; however, any warning signs that are associated with a change in behavior should be carefully monitored.

Chronic Risk Factors

Risk factors that are permanent and cannot be changed:

- ☞ Demographics: Caucasian, American Indian, male, older age, separation or divorce, early widowhood
- ☞ History of suicide attempts (especially if more than one attempt)
- ☞ Prior suicidal ideation
- ☞ History of self-harming behavior
- ☞ History of suicide or suicidal behavior in the family
- ☞ Parental history of violence, substance abuse, divorce or hospitalization for major psychotic disorders
- ☞ History of trauma, or physical or sexual abuse
- ☞ History of psychiatric hospitalization
- ☞ History of violent behaviors
- ☞ History of impulsive and reckless behaviors

Other Chronic Risk Factors

- ☞ Major Axis I psychiatric disorder, especially:
 - Mood disorder
 - Anxiety disorder
 - Schizophrenia
 - Substance use disorders (drug and alcohol abuse or dependence)
 - Eating disorders
 - Body dysmorphic disorder
 - Conduct disorder
- ☞ Axis II personality disorder, especially cluster B
- ☞ Axis III medical disorder, especially if it involves functional impairment and/or chronic pain
 - Traumatic brain injury
- ☞ Comorbidity of Axis I disorders (especially depression and alcohol use, or dependence)
- ☞ Low self-esteem
- ☞ Attitude of acceptance toward suicide
- ☞ Exposure to another's death by suicide
- ☞ Lack of self- or familial acceptance of sexual orientation
- ☞ Smoking
- ☞ Perfectionism





Acute Risk Factors

(If these are present, they increase the risk of a potential suicide attempt or death in the near future.)

- ⊕ Recently divorced or separated, with feelings of victimization or rage
- ⊕ Suicide ideation (threatened, communicated, planned or prepared for suicide)
- ⊕ Current self-harming behavior
- ⊕ Recent suicide attempt
- ⊕ Excessive or increased use of drugs or alcohol
- ⊕ Acute distress due to perceived loss, defeat, rejection, etc.
- ⊕ Recent discharge from a psychiatric hospital
- ⊕ Anger, rage, revenge-seeking or other aggressive behavior
- ⊕ Isolation and withdrawal from usual activities, friends, interests, school or work
- ⊕ Anhedonia – the inability to experience pleasure
- ⊕ Anxiety or panic
- ⊕ Agitation
- ⊕ Insomnia
- ⊕ Persistent nightmares
- ⊕ Suspiciousness, paranoia, ideas of persecution
- ⊕ Severe feelings of confusion or disorganization
- ⊕ Command hallucinations, especially ones urging harm to self or others
- ⊕ Intense affect states (desperation, intolerable aloneness, self-hate, etc.)
- ⊕ Dramatic mood changes
- ⊕ Hopelessness
- ⊕ Poor problem solving
- ⊕ Cognitive constriction (thinking in black and white terms and not able to see shades of gray)
- ⊕ Rumination (continuously focusing on distress)
- ⊕ Inability to see reasons for living
- ⊕ Inability to imagine possible positive future events
- ⊕ Feeling like a burden
- ⊕ Recent diagnosis of chronic or terminal condition
- ⊕ Feeling trapped, like there is no way out other than death
- ⊕ Loss of purpose or loss of meaning
- ⊕ Negative or mixed attitude toward receiving help
- ⊕ Recklessness or excessive risk-taking behavior, especially any that is out of character
- ⊕ Any real or perceived events causing shame, guilt, despair, humiliation, unacceptable loss of face or status, legal problems, financial problems, and feelings of rejection and abandonment

(Information adapted from the U.S. Centers for Disease Control and Prevention.)



If You Are Thinking About Suicide

If you are experiencing thoughts of suicide, know that you are not alone. As many as one in six people will think about suicide at some point in their lives.

Please know that there is help available

The most important thing you can do is talk to someone you trust. If there is no one you feel you can talk to, call the National Suicide Prevention Lifeline at **1.800.273.8255** or **1.800.273.TALK**.

Please remember:

- ☞ Suicidal thinking is usually associated with problems that can be treated. Several tries at treatment are sometimes necessary before the right combination is found.
- ☞ If you are unable to think of solutions other than suicide, it is not that solutions don't exist, only that they are not apparent to you. Therapists and friends can often help you see possible solutions.
- ☞ Suicidal crises are almost always temporary. Although it might seem as if your unhappiness will never end, it is important to realize that crises are usually time-limited. Don't let suicide rob you of better times that will come your way.
- ☞ Problems are seldom as great as they appear at first glance. Stressful events can seem catastrophic at the time they are happening. Months or years later, they usually look smaller and more manageable.
- ☞ Reasons for living can help sustain a person in pain. You might be able to strengthen your connection with life when you remember what has gotten you through hard times in the past.

(Information adapted from the American Association of Suicidology.)



*Please, reach out to someone.
Don't keep suicidal thoughts
to yourself.*



REMEMBER,





For more information, contact:

Suicide Prevention Program

Division of Injury Prevention and Control

North Dakota Department of Health

600 E. Boulevard Ave., Dept. 301

Bismarck, N.D. 58505-0200

www.ndhealth.gov/suicideprevention

1.701.328.4580



Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

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

If yes, with whom?

- The Behavioral Health Division works closely with a number of entities to ensure that quality, efficient, and effective behavioral health services are available statewide. These include (but not limited to) the Behavioral Health Planning Council, Brain Injury Advisory Group, and the Problem Gambling Advisory Council. The ND Substance Abuse Prevention System leads and is a participant in many state-level partnerships in an effort to eliminate duplication of services and streamline goals. These partnerships include all levels, from department directors (Governor's Prevention Advisory Council), to program administrators (Prevention Expert Partners Workgroup), to data analysts (State Epidemiological Outcomes Workgroup). Other partners include the ND Cares Coalition, the Non-Medical Use of Pharmaceuticals Task Force, Healthy ND, ND Board of Realtors, Indian Affairs Commission, Injury Prevention coalition, and the State Suicide Taskforce.
3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The North Dakota Mental Health and Substance Abuse Planning Council's membership includes representatives from Medicaid, the North Dakota Housing Finance Agency, social services, behavioral health, the North Dakota Department of Correction and Rehabilitation, Vocational Rehabilitation, the North Dakota Indian Affairs Commission, Aging Services, and the North Dakota Department of Public Instruction. They are highly involved with the planning for the community-based public behavioral health system and actively participate in the quarterly meetings of the Council.

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

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁷²

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

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

Under the mandate outlined in Public Law 102-321 (42 U.S.C 300X-4), thirty member board -- the North Dakota Mental Health and Substance Abuse Planning Council -- was created with members appointed by the Governor of North Dakota. The Council's objective is to monitor, review, and evaluate the allocation and adequacy of mental health services in the state. Each board member is appointed to a three-year term and not less than 50% of the board is composed of individuals other than state employees and providers of mental health services.

The Council meets quarterly to discuss community-based public behavioral health services and works closely to plan for the system of care and monitor its implementation. The agenda of each meeting involves review and discussion of the priority areas found in the block grant and discussion of the system of care. The Council's input is woven into the block grant plan. The Council developed recommendations which drove the decisions regarding the Mental Health Block Grant budget allocations. The Council also has provided recommendations to both the Department of Human Services and the Governor's Office.
 - b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i Yes No
2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No
3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

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

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

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

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

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

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

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

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

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

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Key Recommendations for Governor and Legislature (Updated 11/10/16)

1. Fund a comprehensive approach to behavioral health with an implementation of the full continuum of care model. *See Attachment A*
2. Fund and implement the Medicaid 1915 (i) amendment to the state plan in the 2017-19 biennium budget.
 - a. Fund peer support services statewide with a goal to ensure that any individual receiving case management has access to peer support services.
 - b. Increase availability of long term employment supports for qualified individuals.
 - c. Expand crisis intervention services including mobile crisis units statewide, peer supports within crisis intervention services, additional residential crisis beds, and less reliance on hospitals to perform these services.
 - d. Fund permanent supportive housing services for pre and post tenancy.
3. Fund Medicaid expansion and urge the legislature to reaffirm the expansion prior to sunset on July 2017
4. Follow EPSDT Medicaid mandates, filling existing service gaps for required services *See Attachment B*
5. Continued funding of the Housing Incentive Fund with a priority to support development of permanent supported housing
6. Establish and fund behavioral health courts and implement necessary public behavioral health provisions, including services for veterans see *Attachment C*
7. Ensure Human service centers provide services in a manner so all individuals who are eligible for services are able to receive an unconditional care model of services (zero reject)
8. State agencies must be provided with state training to increase military cultural competency (how to communicate with veterans or those who have served). This training should also be made available to any providers of behavioral health services including private providers. ND Cares Network would be a good resource for the training materials.

Key Recommendations for the Department of Human Services

1. Fund a comprehensive approach to behavioral health with an implementation of the full continuum of care model. *See Attachment A*
2. Fund and implement the Medicaid 1915 (i) amendment to the state plan in the 2017-19 biennium budget.
 - a. Fund peer support services statewide with a goal to ensure that any individual receiving case management has access to peer support services.
 - b. Increase availability of long term employment supports for qualified individuals.
 - c. Expand crisis intervention services including mobile crisis units state-wide, peer supports within crisis intervention services, additional residential crisis beds, and less reliance on hospitals to perform those services.
 - d. Funding permanent supportive housing services for pre and post tenancy.
3. Fund Medicaid expansion and urge the legislature to reaffirm the expansion prior to sunset on July 2017
4. Department of Human Services shall create opportunities to strengthen advocacy voices to assist in making system change as identified in the Behavioral Health Planning Report by Schulte Consulting July 22, 2014.
5. Follow EPSDT Medicaid mandates, filling existing service gaps for required services See *Attachment B*.
6. Continued funding of the Housing Incentive Fund with a priority to support development of permanent supported housing
7. Support the establishment of behavioral health courts with associated necessary public behavioral health provisions implemented, including services for veterans see *Attachment C*
8. Ensure Human service centers provide services in a manner so all individuals who are eligible for services are able to receive an unconditional care model of services (zero reject)
9. Ensure Evidence-Based or promising practices are provided with high fidelity quality assurances.
10. State agencies must be provided with state training to increase military cultural competency (how to communicate with veterans or those who have served). This training should also be made available to any providers of behavioral health services including private providers. ND Cares Network would be a good resource for the possible training materials.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2017 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Darrin Albert	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5619 20th Street Circle South Fargo ND, 58104 PH: 701-235-8315	darrin.albert@yahoo.com
Nicole Amsbaugh	Others (Not State employees or providers)		2701 S 36th St Grand Forks ND, 58201	nlamsbaugh@gmail.com
Cheryl Anderson	State Employees		1237 W Divide Ave Ste 18 Bismarck ND, 58505	chess@nd.gov
Debbie Baier	State Employees	North Dakota Department of Human Services	600 E. Boulevard Avenue Bismarck ND, 58505 PH: 701-328-4864 FX: 701-328-1544	dabaier@nd.gov
Lorraine Davis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		513 E Bismarck Expressway, Ste.22 Bismarck ND, 58504	lorrainedvs@nativecenter.org
Shiobahn Deppa	Others (Not State employees or providers)	Consumer Family Network ND	2130 s. 12th Street Bismarck ND, 58504 PH: 701-223-8535	siobhandeppa@gmail.com
Rosalie Etherington	State Employees	North Dakota State Hospital	2605 Circle Drive Jamestown ND, 58401 PH: 701-253-3694 FX: 701-253-3999	retherinton@nd.gov
Michelle Gayette	State Employees	North Dakota Department of Human Services	1237 W. Divide Avenue Bismarck ND, 58501 PH: 701-328-4613 FX: 701-328-8744	mgayette@nd.gov
Brad Hawk	State Employees	North Dakota Indian Affairs Commission	600 E. Boulevard Avenue Bismarck ND, 58505 PH: 701-328-2428 FX: 701-328-1537	bhawk@nd.gov
Jennifer Henderson	State Employees	North Dakota Housing Finance Agency	PO Box 1535 Bismarck ND, 58502 PH: 701-328-8055 FX: 701-328-8090	jhenaderson@nd.gov
Jeff Herman	Providers	Prairie St. John's	510 4th Street South Fargo ND, 58103 PH: 701-476-7221	Jeff.Herman@uhsinc.com
Deb Jendro	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2709 Elm Street Fargo ND, 58102 PH: 701-235-9923	debjefederation@yahoo.com

	services)		FX: 701-235-9923	
Teresa Larsen	Others (Not State employees or providers)	Protection and Advocacy Project of North Dakota	400 East Broadway Bismarck ND, 58501 PH: (701) 328-2950 FX: (701) 328-3934	tlarsen@nd.gov
Carlotta McCleary	Others (Not State employees or providers)	ND Federation of Families for Children's Mental Health	PO Box 3310 Bismarck ND, 58502-3310 PH: 701-222-3310	cmccleary@ndffcmh.com
Jeffrey Olson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 473 Wilton ND, 58579 PH: 701-426-6308	jro.ptf@hotmail.com
Kim Osadchuk	State Employees	Burleigh County Social Services	415 E. Rosser Avenue Bismarck ND, 58501 PH: 701-222-6670	kosadchuk@nd.gov
Lisa Peterson	State Employees	North Dakota Department of Corrections and Rehabilitation	PO Box 1898 Bismarck ND, 58502 PH: 701-328-6790 FX: 701-328-6651	lapeterson@nd.gov
Tom Regan	Others (Not State employees or providers)	Mental Health America of North Dakota	PO Box 4106 Bismarck ND, 58501 PH: 701-255-3692	tom@heartview.org
Pamela Sagness	State Employees	North Dakota Department of Human Services	1237 W. Divide Avenue Bismarck ND, 58501 PH: 701-328-8824 FX: 701-328-8969	psagness@nd.gov
Kurt Snyder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		101 East Broadway Avenue Bismarck ND, 58501 PH: 701-222-0386	kurt@heartview.org
Derek Solberg	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1006 N. 29th Street Bismarck ND, 58501 PH: 701-530-2420	dacksolberg@hotmail.com
Jodi Stittsworth	Parents of children with SED		739 Great Plains Ct Grand Forks ND, 58201 PH: 701-610-1724	jodi1510@hotmail.com
Timothy Wicks	Others (Not State employees or providers)		Bismarck Military Service Center Bismarck ND, 58506 PH: 701-333-4828	timothy.j.wicks.nfg@mail.mil
Carl Young	Parents of children with SED		206 2nd Street SE Garrison ND, 58540 PH: 701-463-7804	carl@clientfactor.com

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2017 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	24	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)	6	
Total Individuals in Recovery, Family Members & Others	14	
State Employees	9	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies		
Total State Employees & Providers	10	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

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

If yes, provide URL:

An email was sent to all Behavioral Health Planning Council members with the plan narrative to review and make comment. Once the final plan is submitted, it will be posted on the web for additional public comment.

Footnotes:

NORTH DAKOTA

Behavioral Health Assessment

Gaps and Recommendations

The purpose of the North Dakota Behavioral Health Assessment is to identify priority recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting North Dakota's children, adults, families and communities in health and wellness, to reach their full potential.

The North Dakota Department of Human Services, Behavioral Health Division was tasked with reporting the outcome of this assessment by the 64th Legislative Interim Human Services Committee during the August 2015 committee meeting.



North Dakota Department of Human Services
Behavioral Health Division
1237 W Divide Avenue, Suite 1C
Bismarck ND 58501

September 2016

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Executive Summary



The purpose of this ND Behavioral Health Assessment is to identify priority recommendations to enhance the foundation of the state’s behavioral health system, with the goal of supporting North Dakota’s children, adults, families and communities in health and wellness, to reach their full potential. We can prevent and reduce chronic disease and promote wellness by treating behavioral health needs on an equal footing with other health conditions.

APPROACH

To ensure a comprehensive approach, a variety of sources were utilized in the development of this assessment, including stakeholder feedback and existing reports. Also, this Behavioral Health Assessment takes into consideration some important factors that have not been previously reviewed, including:

- **Epidemiological data** identifying the prevalence of behavioral health needs among children and adults in the state is included. Basing decisions on epidemiological data ensures that efforts are selected appropriately and implemented effectively. Sample of Data Sources reviewed: Youth Risk Behavior Survey; Behavioral Risk Surveillance System; National Survey on Drug Use and Health
- The proposed vision for the North Dakota Behavioral Health System is grounded on the Institute of Medicine’s **Continuum of Care** model, this assessment provided a review of the full Continuum of Care (from promotion and prevention through recovery).
- In order to see sustained effective behavioral health system changes we need to have a strong, developed infrastructure. Therefore, the discussion and initial recommendations are based on this **global systems and infrastructure perspective**.

Approach

This **Behavioral Health Assessment** takes into consideration some important factors that have not been previously reviewed:

- **Epidemiological data** identifying the prevalence of behavioral health needs among children and adults in the state
- **A review of the full Continuum of Care** (from promotion and prevention through recovery)
- **Global systems/ infrastructure perspective**

CONSIDERATIONS

In the review of the full Continuum of Care, **funding and reimbursement, infrastructure** (including agency-level, workforce, oversight) and **best practice** were considerations. Below is a summary of gaps and needs identified within the Continuum of Care model.

Considerations

In each area of the Continuum of Care, the following are considerations:

Funding/ Reimbursement	Infrastructure <small>(Agency, workforce, oversight, etc.)</small>	Best Practices
---------------------------	---	----------------

Continuum of Care	Gaps/Needs
Promotion/ Prevention	<ul style="list-style-type: none"> Limited resources for mental health promotion and mental illness prevention efforts The field of mental health promotion and mental illness prevention is fairly new. Workforce and best practices are still being identified No credentialing for prevention professionals Overall, promotion and prevention tends to not be valued as a priority

Continuum of Care	Gaps/Needs
Intervention	<ul style="list-style-type: none"> • Gaps in collaboration/integration with the education system, including early childhood and childcare systems. • Workforce limitations (credentials needed to conduct screenings and assessments, utilization of evidence-based practices) • A consistent, universal screening is not utilized • Funding can be limited for screenings • When screenings are occurring, often there are issues with an efficient referral process to further assessment and/or treatment services • In general, the current process of conducting assessments is not efficient or effective
Treatment	<ul style="list-style-type: none"> • Criminalization of behavioral health disorders <ul style="list-style-type: none"> – There is no payment for services for individuals in jail – Limited community-based services (including housing, transportation, employment) available to allow individuals choice of services in the least restrictive environment • Current services are not integrated with each other or other community organizations; this includes the utilization and exchange of data. Changes in level of care are often not fluid. • Communication/promotion of services available is limited. • Workforce limitations <ul style="list-style-type: none"> – Limitations in utilization of evidence-based practices – No single registry of mental health providers • Role clarification needed between public and private service systems
Recovery	<ul style="list-style-type: none"> • Workforce limitations (number of trained providers in evidence-based recovery services) • Limited evidence-based services, and the infrastructure to support these services, available in the state, including sober living environments and other community-based services and supports (including housing, transportation, employment) • Limited payment to support evidence-based recovery services

ND BEHAVIORAL HEALTH SYSTEM RECOMMENDATIONS



It is the hope that this assessment lays the foundation to support an effective, efficient and sustainable behavioral health system in North Dakota. This is not the end, but the beginning.

Purpose

The purpose of the North Dakota Behavioral Health Assessment is to identify recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting North Dakota's children, adults, families and communities in health and wellness, to reach their full potential. The recommendations identified through this assessment are not "magic bullets" and are not the lone answers to filling the gaps in the state's behavioral health system. True, sustainable change takes time and investment needs to be made in the foundation. When these recommendations are implemented, the foundation will be laid where additional work can be done to ensure the individuals, families and communities in North Dakota have access to quality behavioral health services and that this work is able to be sustained.

The North Dakota Department of Human Services, Behavioral Health Division was tasked with reporting the outcome of this assessment by the 64th Legislative Interim Human Services Committee at the August 2015 committee meeting.¹

The mission of the Department of Human Services is to provide quality, efficient and effective human services, which improve the lives of people. The Behavioral Health Division provides leadership for the planning, development and oversight of the state's behavioral health system. The Behavioral Health Division does not provide direct services, rather the role of the Division is to ensure health and safety and access to a wide-range of quality behavioral health services across the state.

¹ www.legis.nd.gov/assembly/64-2015/committees/interim/human-services-committee

Introduction and Approach

In recent years, the state'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. This important work was considered through the development of this Behavioral Health Assessment. However, this Behavioral Health Assessment takes into consideration some important factors that have not been previously reviewed:

- Epidemiological data identifying the prevalence of behavioral health needs among children and adults in the state.
- A review of the full Continuum of Care (from promotion and prevention through recovery).
- Global systems infrastructure perspective.

This assessment identifies global recommendations, which when implemented, will set the foundation to support further enhancements to the state's behavioral health system in a comprehensive, efficient and effective way. This assessment is one piece of the puzzle on the road to a comprehensive and effective behavioral health system. The goal of this document is to identify, as a foundation, where stakeholders can align to develop and support a comprehensive behavioral health system.

The following provides some additional background on how this assessment was approached:

- It is acknowledged there are **regional and community-level differences** in need and available services across the state. However, in order to provide a comprehensive look at the state's behavioral health system and infrastructure, this assessment takes a statewide and global perspective. Communities are encouraged to take the information from this assessment and overlay with any local-specific information to ensure efforts are relevant.
- It is important to identify the structure and readiness of the current system when assessing and making recommendations. Matching strategies to a community/**system's level of readiness** is absolutely essential for success. Efforts that are too ambitious are likely to fail because community members or stakeholders will not be ready or able to respond.
- The current structure of the behavioral health system in the state is **not fully integrated**. Most often, substance use disorder and mental health services are delivered in separate systems, or at best co-located. It is recognized that true integration is a key objective in order to be most effective. Because of this lack of integration, this assessment is broken up into the following topic areas: children's behavioral health; adult mental health; and adult substance use. Also, efforts are continuing to further integrate behavioral health and primary care.
- It is acknowledged that **multiple efforts are occurring**, each impacting the state's behavioral health system. These efforts include the recently finalized brain injury needs assessment, the substance exposed newborns task force recommendations, seclusion and restraint task force recommendations, problem gambling needs assessment, justice reinvestment efforts, opioid addiction efforts and other local/regional work. It is important to note this assessment does not include any specific information or recommendations from these efforts. Instead, it is encouraged to use the recommendations of this assessment as the foundation for moving these efforts forward.

- Through the process of developing this assessment and the many conversations with stakeholders, it was identified that people want change and are working toward change at the community and regional-level. There are **good examples** of efforts to integrate and deliver services effectively in areas throughout the state. It will be important to garner these successes and consider the ability to scale these efforts statewide.

In addition to the review of previously developed reports focused on the state’s behavioral health system, this assessment sought perspectives from service providers, key stakeholders, and consumers and families in both the state’s public and private behavioral health systems. The following table summarizes the information utilized in the development of this assessment to ensure a well-rounded approach:

STAKEHOLDER FEEDBACK	REPORTS	DATA
<ul style="list-style-type: none"> • Tribal Behavioral Health meeting • Medicaid Waiver Stakeholder meetings • Behavioral Health Conference breakout sessions • County Social Services Directors • Education System (ND Regional Education Association and School Administration representatives) • Early Childhood system representatives (Child Care Aware) • Juvenile Court • Division of Juvenile Services • Residential Child Care Facility (RCCF) representatives • Psychiatric Residential Treatment Facility (PRTF) representatives • Foster Care (PATH and families) • Substance Use Disorder Leadership meetings • Mental Health advocates • behavioral health public and private providers • behavioral health consumers and family members 	<ul style="list-style-type: none"> • Interim Human Services Committee testimony • Schulte Consulting, LLC Behavioral Health Planning Final Report July 22, 2014 • North Dakota Behavioral Health Stakeholders Group Reports <ul style="list-style-type: none"> - Building Stronger Behavioral Health Services in North Dakota: Framing Key Issues and Answers – 7/18/2014 - November 17, 2015 Summary Reports - Behavioral Health Stakeholder Survey, June 2016 	<ul style="list-style-type: none"> • National Survey on Drug Use and Health • Crime in North Dakota. North Dakota Office of Attorney General, Bureau of Criminal Investigation • North Dakota Crash Summary, North Dakota Department of Transportation • Behavioral Risk Factor Surveillance System Survey • Youth Risk Behavior Survey • ND Community Readiness Survey • North Dakota epidemiological profile: Alcohol, tobacco and illicit drug prevalence, root causes, and consequences in North Dakota.

See Appendix A for links to reports and data.

Overview of Behavioral Health

What is Behavioral Health?

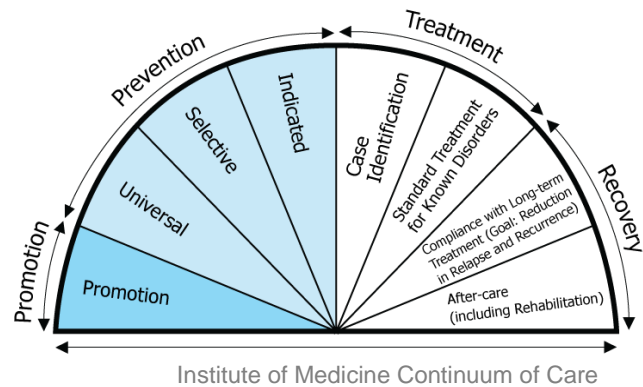
Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health conditions affect people from all walks of life and all age groups. These illnesses are common, recurrent, and often serious, but they are treatable and people recover.² Such conditions are far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society.

Behavioral health is an essential part of health service systems and effective community-wide strategies. Behavioral health and physical health are also connected. Good behavioral health often contributes to good physical health. Likewise, the presence of behavioral health disorders is frequently associated with physical health disorders.

Vision for an Effective Behavioral Health System

Behavioral health is an essential part of overall health in which prevention works, treatment is effective and people recover. The North Dakota behavioral health system is built to support people – at both the individual and community levels.

The proposed vision for the North Dakota Behavioral Health System is grounded on the Institute of Medicine’s Continuum of Care model. The goal of this model is to ensure there is **access to a full range of high quality services** to meet the various needs of North Dakotans. The services available throughout this continuum should **reflect current knowledge and technology** and be **grounded in evidence-based practice**.



Throughout all levels of the continuum, there should be a **continuous promotion of healthy behaviors and lifestyles**, a primary driver of health outcomes.

In summary, the goal of the state’s behavioral health system is to ensure there is access to quality services across the continuum of care supporting the behavioral health of North Dakotans across the lifespan. See Appendix B for some excerpts from the “*Description of a Good and Modern Addictions and Mental Health Service System*”, which describes some key components of an effective behavioral health system in more detail.

² SAMHSA

Behavioral Health Data Review

Basing decisions on epidemiological data ensures that efforts are selected appropriately and implemented effectively. By understanding the true scope of the problem, decision-makers are able to identify priority areas and reach the populations of greatest need.

The North Dakota Department of Human Services' Behavioral Health Division initiated the State Epidemiological Outcomes Workgroup (SEOW) in 2006, though funding received from the Substance Abuse and Mental Health Services Administration (SAMHSA). Initially created with the purpose of bringing data on substance abuse to the forefront of the prevention planning process, the SEOW broadened its scope in 2014 to include broader behavioral health issues. The mission of the North Dakota SEOW is to identify, analyze and communicate key substance abuse and related behavioral health data to guide programs, policies and practices. The SEOW has built a broad representation of diverse partners and continues to provide leadership in identifying data needs. For more information on the SEOW and data products, visit: www.prevention.nd.gov/data.

This section presents a set of behavioral health indicators as found through existing statewide and national datasets, much of which through the state's SEOW. This array of indicators provides an overview of the state's behavioral health at a point in time. The data presented in this assessment is a sampling and does not intend to be exhaustive. The purpose of this brief review is to identify some key data available to guide decision-making, and simultaneously identify gaps in available data. It will be important to continue this data collection, analysis and review, with specific considerations for health disparities. This information is vital in the state's efforts to reduce the impact of behavioral health conditions on North Dakota individuals, families and communities.



Overview/General

Behavioral health conditions can have a powerful effect on the health of individuals, their families, and communities. These conditions are among the top conditions that cause disability and carry a high burden of disease in the United States, resulting in significant costs to families, employers, and publicly funded health systems. By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.³

According to SAMHSA's 2013-2014 National Survey on Drug Use and Health (NSDUH) an estimated 91,912 (16.1%) North Dakotans ages 18 and up experienced some form of mental illness. In the past year, 51,950 adults (9.1%) had a substance use disorder. Of these, 18,839 people had both a mental disorder and substance use disorder, also known as co-occurring mental and substance use disorders.

Persons with mental illness and/or substance use disorders die, on average, about 5 years earlier than persons without these conditions.⁴ And, persons with serious mental illness (SMI) are now dying 25 years earlier than the general population.⁵ In addition, behavioral health conditions can lead to other chronic diseases such as diabetes and heart disease. Individuals with a mental illness may develop cancer at a 2.6 times higher rate on account of late stage diagnosis and inadequate treatment and screenings.⁶ Addressing the impact of substance use alone is estimated to cost Americans more than \$600 billion each year.⁷

F-M Ambulance Service (FMA) is the largest ambulance operator in North Dakota responding to more than 26,000 calls for service annually. Of those calls, one-third are behavioral health related. Common calls include substance abuse, depression, suicidal ideation, anxiety and depression. Too often psychological maladies are often accompanied by chronic physical illnesses.⁸

Children's Behavioral Health

MENTAL HEALTH

Over one in four (27.2%) ND high school students report feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past year. This percentage was highest among high school females (35.2% compared to 19.6% males). At North Dakota Human Service Centers (statewide), an average of 1,556 youth are receiving mental health services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).

³ SAMHSA: <http://www.samhsa.gov/prevention>

⁴ Druss BG, et al. Understanding Excess Mortality in Persons With Mental Illness: 17-Year Follow Up of a Nationally Representative US Survey. *Medical Care* 2011; 49(6), 599–604.

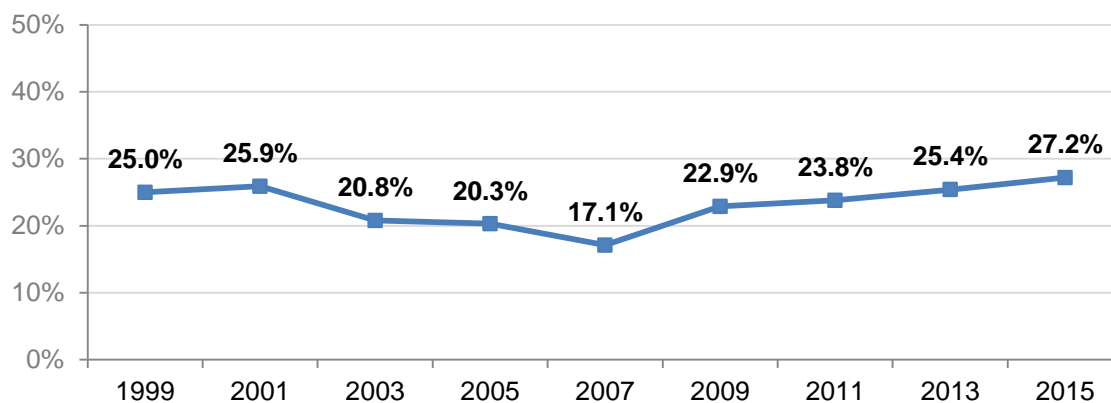
⁵ <http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf>

⁶ McGinty EE, et al. (2012). Cancer incidence in a sample of Maryland residents with serious mental illness. *Psychiatric Services*, 63(7), 714-717.

⁷ SAMHSA: <http://www.samhsa.gov/prevention>

⁸ 3-8-16 Interim Human Services Committee Testimony

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



From July through December 2015, Child Care Aware of ND provided technical assistance to 89 child care providers regarding 204 children. Fifty-five percent of the needs for these children were developmental, which includes autism, ADHD and prenatal drug exposure. Thirty-nine percent of needs were behavioral needs (screaming, biting, kicking, etc.).⁹

Good mental health often contributes to good physical health. Likewise, the presence of mental and/or substance use disorder is frequently associated with physical health disorders. 17.2% of ND high school students have a long-term health problem.¹⁰

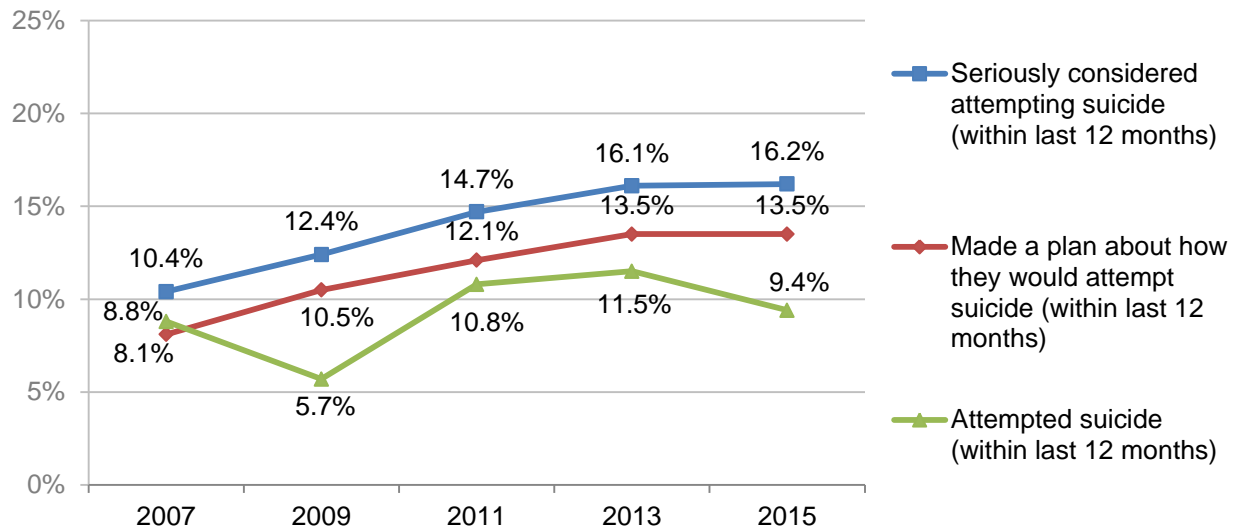
Suicide: Sixteen percent of ND high school students seriously considered attempting suicide at some point during the past year and 13.5% of made a plan about how they would attempt suicide. Again, these rates were higher among females than males (20.4% compared to 12.2% and 16.1% compared to 10.9% respectively). Almost one in ten (9.4%) ND high school students attempted suicide one or more times during the past year.¹¹

⁹ Child Care Providers Caring for Children with Special Needs; Child Care Aware® of North Dakota Data; July-December 2015

¹⁰ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

¹¹ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

ND High School Students - Suicide
YRBS



Gambling: Almost one third (29.4%) of ND high school students have gambled on a sports team, gambled when playing cards or a dice game, played one of their state’s lottery games, gambled on the Internet, or bet on a game of personal skill such as pool or a video game at least once in the past year.¹² Nationally, approximately 4-5% of youth, ages 12-17, meet one or more criteria of having a gambling problem. Another 10-14% are at risk of developing an addiction, which means that they already show signs of losing control over their gambling behavior.¹³

Substance Use and Abuse: Even with great declines in the past decade, alcohol and tobacco are still the most currently used substances among youth in the state. The percentage of North Dakota high school students who reported having one or more drinks of alcohol during the past 30 days, decreased from 60.5% in 1999, to 30.8% in 2015. Just over 17% report binge drinking on at least one day during the past 30 days.¹⁴

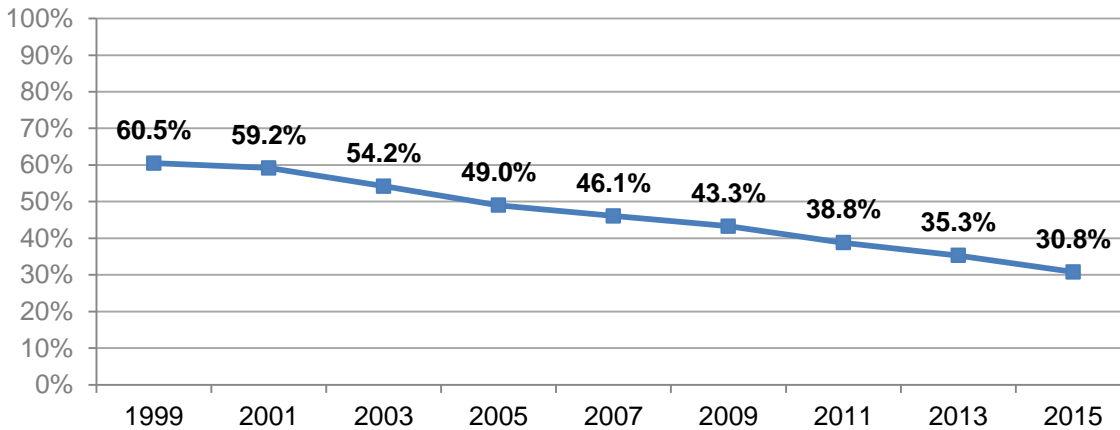
51.3% of ND adults are concerned about whether their community has sufficient alcohol and other drug abuse prevention programs
2015 ND Community Readiness Survey

¹² North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

¹³ National Council on Problem Gambling; http://www.ncpgambling.org/files/HS_Fact_Sheet.pdf

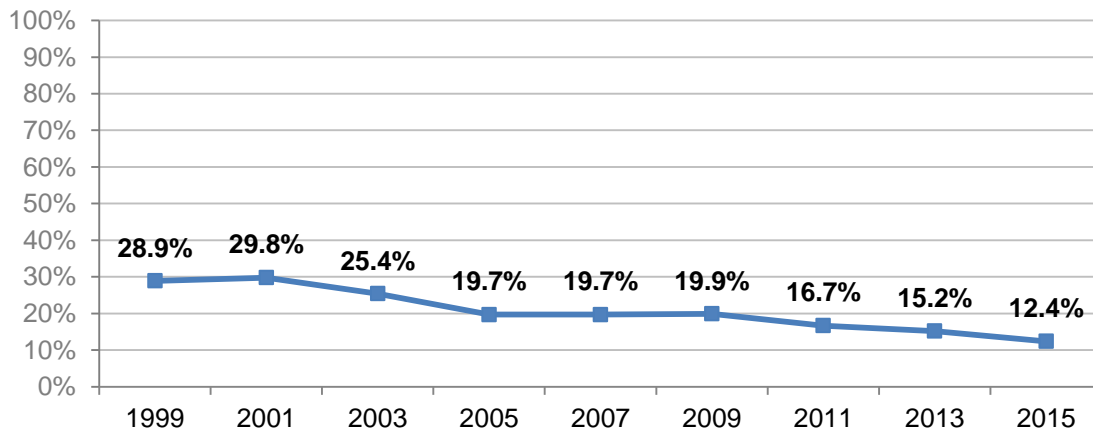
¹⁴ drinking five or more drinks of alcohol in a row (within a couple of hours); North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

Current Alcohol Use (past 30 days) among ND High School Students
YRBS



Just over one in ten (12.4%) ND high school students report having their first drink of alcohol before age 13.¹⁵ Research has shown that individuals who begin drinking before age 15 are four times more likely to become addicted than those who wait until they are 21.¹⁶

ND High School Students reported first drink of alcohol before age 13
YRBS



Approximately one third (31.1%) of ND high school students report current use (within the past 30 days) of a tobacco product. Cigarettes remain the most commonly used tobacco product by North Dakota youth.¹⁷ Fifteen percent report current use of marijuana (a decrease from 18.8% in 1999) and 14.5% report taking a prescription drug without a doctor's prescriptions at least one time in their life. Among ND high school students, almost four percent report ever using cocaine,

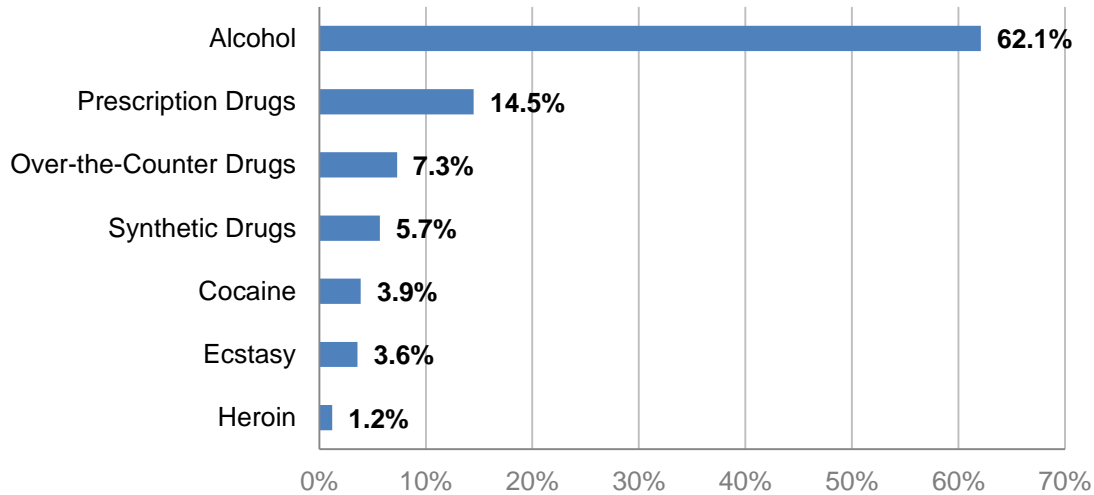
¹⁵ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

¹⁶ Center for Adolescent Health

¹⁷ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>; National Survey on Drug Use and Health, North Dakota, 2013-2014

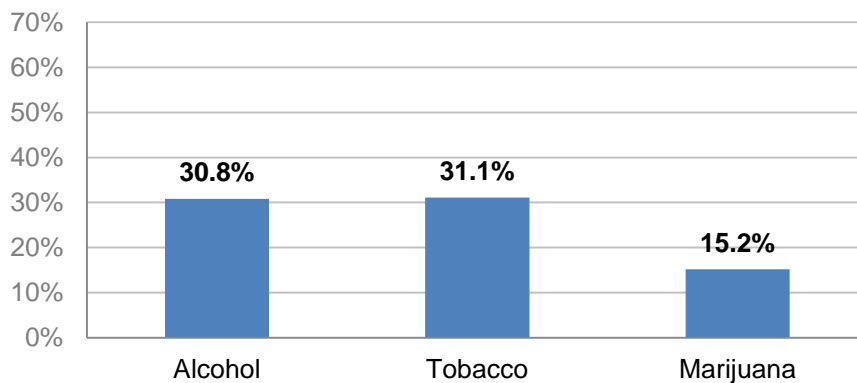
one percent report ever using ecstasy, and almost six percent report ever using synthetic drugs.¹⁸

ND High School Student Reported *Lifetime* Substance Use*
YRBS, 2015



*In 2009 (the last time the question was asked), lifetime use of marijuana among ND high school students was 30.7%.

ND High School Student Reported *Current* (past 30-days) Substance Use
YRBS, 2015



The percentage of North Dakota high school students who reported driving a vehicle after consuming alcohol one or more times during the past 30 days, decreased from 31.4%, in 1999 to 7.8% in 2015.¹⁹ In the 2013-2014 school year, 58 students were suspended or expelled for alcohol-related incidents in the public school system and 189 students were suspended or expelled for drug incidents.²⁰ The percentage of North Dakota high school students that were

¹⁸ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

¹⁹ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

²⁰ ND Department of Public Instruction

offered, sold, or given an illegal drug on school property during the past year, increased from 14.1% in 2013 to 18.2% in 2015.²¹

Approximately three percent of North Dakotans aged 12 through 17 reported alcohol abuse or dependence in the previous year. Similarly, three percent report illicit drug abuse or dependence.²² At North Dakota Human Service Centers (statewide), an average of 712 youth are receiving addiction services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).²³

At a point in time (May 2, 2016), 22% of youth on the state’s Juvenile Court caseload were identified as having substance abuse needs; 31% had mental health needs; and 14% had needs in both substance abuse and mental health.

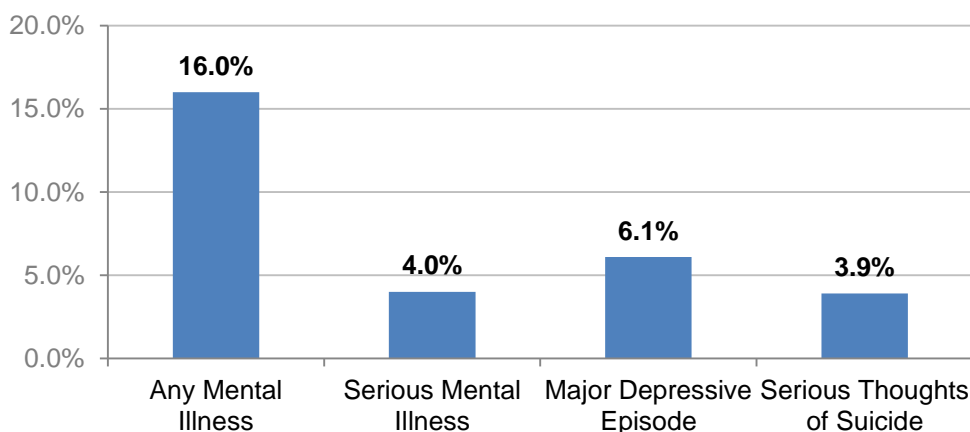
Adult Mental Health

Approximately one in three (31.2%) ND adults report their mental health (including stress, depression, and problems with emotions) was not good on at least one day within the past 30 days. Similarly, one in three (33.9%) report poor physical or mental health kept them from doing their normal usual activities, such as self-care, work or recreation (within the past 30 days).²⁴

Approximately 17% of ND adults report they have been told at some time in their life that they have a depressive disorder (including depression, major or minor depression and dysthymia).²⁵ And, an estimated six percent of ND adults (ages 18 and older) have experienced a major depressive episode in the past year.²⁶

Reported Mental Illness within the Past Year among ND Adults ages 18 and older

National Survey on Drug Use and Health, 2013 and 2014



²¹ North Dakota Youth Risk Behavior Survey, 2015 <https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/>

²² National Survey on Drug Use and Health, North Dakota, 2013-2014

²³ Unduplicated count of youth and adult mental health clients and addiction clients - Jan-March 2016

²⁴ Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+

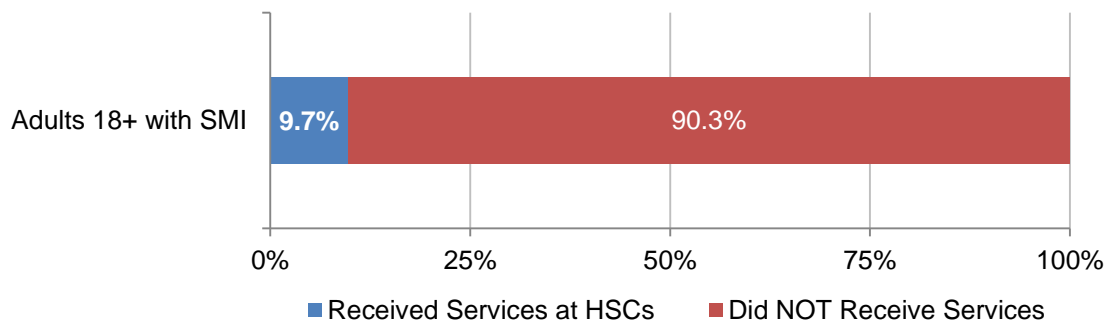
²⁵ Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+

²⁶ National Survey on Drug Use and Health, North Dakota, 2013-2014

The percentage of North Dakotans with any mental illness in the past year is 16%. While an estimated four percent have had a serious mental illness in the past year. Almost four percent of ND adults have had serious thoughts of suicide in the past year.²⁷

At North Dakota Human Service Centers (statewide), an average of 6,102 adults are receiving any mental health services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).²⁸ The National Survey on Drug Use and Health estimates four percent of ND adults to have a serious mental illness, which equals approximately 22,556 individuals age 18 and older in the state. In 2015, the Human Service Centers identified approximately 2,200 adults with serious mental illness as receiving services, which comes to 9.7% of the population needing services.

Percentage of Adults with Serious Mental Illness (SMI) Receiving Services at a Human Service Center, 2015



At times, it is appropriate and effective for inpatient treatment for individuals with mental illness. Conservative estimates suggest a need for 50-60 adult beds per 100,000 population. Based on this estimate, North Dakota total need would be an approximate 350-420 beds. The total beds currently available is right around 323.

Adult Substance Use

Alcohol is the most commonly abused substance among adults in North Dakota. Among North Dakotans aged 18 or older, 63.2% reported having at least one drink of alcohol in the past 30 days and 30% reported having five or more drinks on the same occasion on at least one day in the past 30 days. North Dakota ranks third in the nation for binge drinking rates among those ages 18 or older (30% in ND compared to 24.7% in U.S.).²⁹

Approximately four percent of ND adults ages 18 or older report nonmedical use of pain relievers in the past year. Just under three percent report current illicit drug use, other than marijuana (within the past 30 days) and five percent report current marijuana use.³⁰ Just about

²⁷ National Survey on Drug Use and Health, North Dakota, 2013-2014

²⁸ Unduplicated count of youth and adult mental health clients and addiction clients - Jan-March 2016

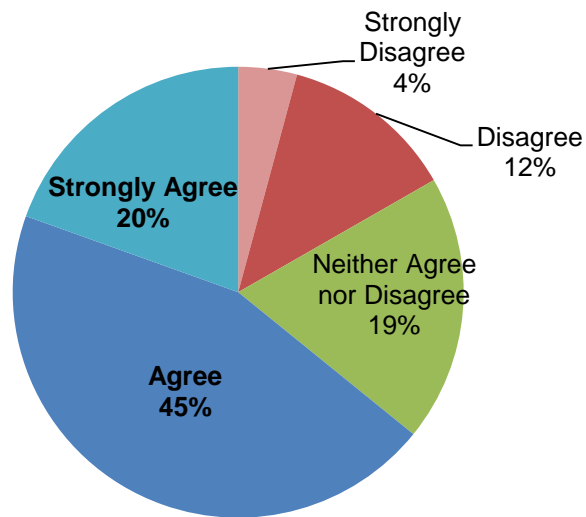
²⁹ National Survey on Drug Use and Health, North Dakota, 2013-2014

³⁰ National Survey on Drug Use and Health, North Dakota, 2013-2014

one in six (15.6%) North Dakotans aged 18 or older report using tobacco products every day.³¹ Cigarettes remained the most commonly used tobacco product.³²

About half of all fatal crashes on North Dakota roads are alcohol-related (nationally, alcohol is typically involved in 30% of fatal crashes).³³ One in three (33.7%) arrests in the state are for driving under the influence and liquor law violations (nationally this rate is 12.8%).³⁴ In 2014, 56 drivers involved in traffic crashes (fatal and injury) were cited for driving under the influence of drugs.³⁵ The number of arrests made for drug-related offenses increased from 1,106 in 1996 to 3,431 in 2013.³⁶ Assessment of new arrivals to prison over the past three years indicates that approximately 72% are recommended to complete substance abuse treatment.³⁷

"I know who to go to if I need help for myself or family member(s) who are abusing alcohol or other drugs" - ND Adults
North Dakota Community Readiness Survey, 2015



Approximately eight percent of North Dakotans aged 18 or older report alcohol abuse or dependence. Two percent report illicit drug abuse or dependence.³⁸ About 2 in 3 (65%) ND adults know who to go to if they need help for themselves or a family member who is abusing alcohol or other drugs.³⁹ Almost eight percent of ND adults ages 18 or older who need treatment for alcohol did not receive the treatment.⁴⁰ At North Dakota Human Service Centers (statewide), an average of 2,082 adults are receiving addiction services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).⁴¹

³¹ Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+

³² National Survey on Drug Use and Health, North Dakota, 2013-2014

³³ ND Department of Transportation Crash Summary 2014

³⁴ ND Uniform Crime Report, 2014

³⁵ ND Department of Transportation Crash Summary 2014

³⁶ North Dakota Bureau of Criminal Investigation (NDBCI), 2014

³⁷ ND Department of Corrections and Rehabilitation, 2014

³⁸ National Survey on Drug Use and Health, North Dakota, 2013-2014

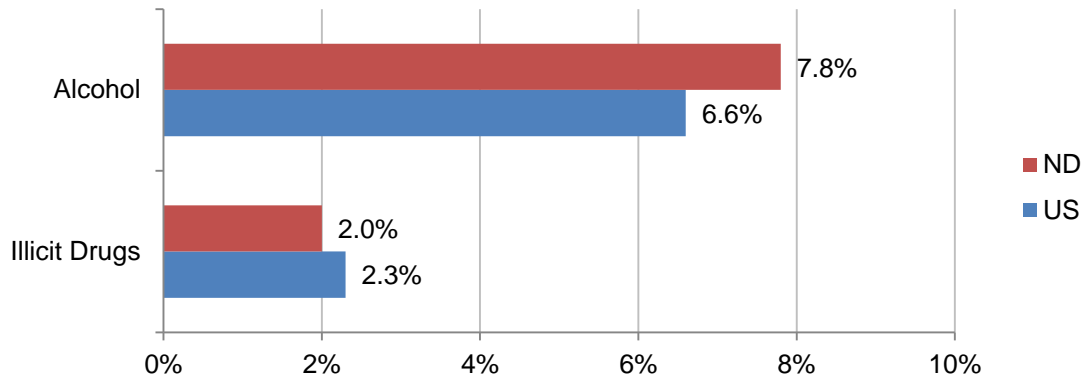
³⁹ ND Community Readiness Survey, 2015

⁴⁰ National Survey on Drug Use and Health, North Dakota, 2013-2014

⁴¹ Unduplicated count of youth and adult mental health clients and addiction clients - Jan-March 2016

Adults (ages 18+) Needing But Not Receiving Treatment for Alcohol or Illicit Drugs

National Survey on Drug Use and Health, 2013 and 2014



North Dakota Behavioral Health System Review

By defining and reviewing resources across the Institute of Medicine's Continuum of Care model, the state is beginning to develop and ensure the full continuum of services are available in the state. When components of the system are missing, individuals with behavioral health needs are either under-treated or over-treated, which limits positive outcomes for the individual, family and larger community. It is vital that an individual's behavioral health need is identified early, assessed accurately, and the best-possible, least-restrictive services (directly matching the need) are available and provided. Simplistically, an individual with a behavioral health need should receive the right services at the right time in the right dose.

Another vital component of ensuring a full continuum of care is partnership and collaboration. Movement throughout the continuum should be seamless and fluid. Because an individual's behavioral health needs cannot be disconnected, services and stakeholders should not be disconnected. Supportive, healthy communities are needed to support overall health. This includes involvement and collaboration among a variety of sectors: primary care, education, criminal justice, behavioral health services (public & private), medical services, social services, etc.

When reviewing services and systems in place across the continuum of care, there are a few additional considerations that were taken into account in this assessment. In order to create sustainable and effective change, it is not sufficient to merely identify that a particular service is or is not available. It is vital to look deeper into why services are not available and if they are available, whether they are effective.

- **Funding or reimbursement:** If there is not funding or resources to support a service, or there is no reimbursement for the service, the service will likely not exist.
- **Infrastructure, including agencies/organizations, workforce, and oversight bodies:** In order for a service to be available and sustainable, there are several layers of infrastructure that are needed. There needs to be an agency or organization through which the service is provided, a workforce to provide the service, and an oversight body to ensure quality, health and safety.
- **Best practices:** Best practices exist and should be utilized in the provision of all behavioral health services across the state. Services must continuously evaluate effectiveness.

Promotion/Prevention

The field of prevention science, well known for advancing the health of people at risk for illnesses such as cancer, diabetes, and heart disease, has also produced effective strategies for the behavioral health fields. Prevention is a cost-effective and common-sense way to avoid the consequences of behavioral health disorders. Prevention efforts are effective when approaches are comprehensive, address risk and protective factors, and focus on a community's unique challenges. All promotion and prevention efforts should recognize and

The majority of ND adults (90.6%) agree that preventing alcohol and other drug use among youth is important. And, almost three in four (71.6%) agree that alcohol and other drug prevention programs are a good investment because they save lives and money.

2015 ND Community Readiness Survey

address the interrelated impact of behavioral health on overall well-being. Investing one dollar in prevention can yield ten dollars of savings in health costs, criminal and juvenile justice costs, educational costs and lost productivity.⁴²

Stakeholder Feedback

In general stakeholders valued the importance of promotion and prevention. However, often stakeholders were not aware of prevention efforts occurring in the state or what evidence-based promotion and prevention services should look like. Stakeholders see situations everyday where individuals end up needing more advanced care than would have been necessary if prevention and early intervention services were available.

Currently in the state, substance abuse prevention services are primarily funded through federal grants and have guidelines that direct what funds can be spent on. Mental health promotion and mental illness prevention is a fairly new field of which best practices are still being identified.

Identified Gaps and Needs

- Workforce and best practices are still being identified, as mental health promotion and mental illness prevention are new to the state.
- Limited resources supporting mental health promotion and mental illness prevention efforts.
- There is no credentialing process in the state for prevention professionals.
- Overall, promotion and prevention tends to not be valued as a priority.

Early Intervention

A systematic approach within systems for the early identification of behavioral health disorders is critical. Research suggests that investing in early intervention services can contribute to a reduction in health care costs and help ensure the improved health and well-being of individuals. When integrated into primary health care systems, school settings, and community-based programs, screening can lead to early interventions that can prevent problems from arising.

Almost half (48.9%) of ND adults agree that there are leaders in their community who are interested in reducing access and abuse of alcohol and other drugs

2015 ND Community Readiness Survey

Stakeholder Feedback

Stakeholders identify the importance of early intervention services and at the same time identify some pretty significant gaps in the early intervention services available in the state for children and adults across all behavioral health needs (mental illness and substance abuse). Because of this gap, individuals who develop a behavioral health condition often end up needing more intensive and expensive services because the early intervention services in the continuum of care are not available. And, if the services are available they are not consistent across populations and locations. Stakeholders identified that a lack funding/reimbursement and workforce may limit the availability of early intervention services. Also, stakeholders identified the need for coordination and collaboration between systems (primary care, education, long-

⁴² Institute of Medicine and National Research Council's [Preventing Mental, Emotional, and Behavioral Disorders Among Young People report – 2009](#)

term care, early childhood development, law enforcement, criminal justice, public and private providers and other systems).

Identified Gaps and Needs

- In general, gaps in collaboration and integration with the education system, including early childhood and childcare systems exist.
- There is a need to identify the primary workforce (including credentials) responsible for implementing evidence-based screening efforts.
- There is not a consistent, universal screening utilized in the state.
- At this time, it was identified that funding is a limitation in the widespread implementation of screenings and early intervention programs.
- Where screenings are occurring in the state, often there are issues with an efficient referral process to further assessment and/or treatment services.
- In general, the current process of conducting assessments is not efficient or effective and this often delays the provision of services.

Treatment

Treatment is the use of any planned, intentional intervention in the health, behavioral and personal or family life of an individual suffering from a behavioral health disorder designed to enable the affected individual to achieve and maintain physical, mental health and a maximum functional ability. Individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs.

Stakeholder Feedback

The primary focus of the previously completed behavioral health assessments have been the behavioral health treatment system and services. Multiple needs and recommendations have been identified through these processes. As discussions about treatment services occurred in meetings with stakeholders, multiple facets of the system were identified. From the initial assessment process identifying an individual's true behavioral health need to the identification and availability of appropriate services and supports.

Assessment and treatment services are not necessarily consistent across the state or across systems (mental health or substance abuse). For example, services provided for individuals with a substance use disorder usually are therapy or treatment. However, individuals with a serious mental illness typically receive medication and case management services. Stakeholders identify a lack of individualized treatment and a lack of integrated care services available for consumers.

Other concerns noted were a lack of a centralized "bed count" system to ensure efficient access to open beds and transportation to inpatient facilities. Stakeholders also expressed a lack of transportation for individuals needing treatment services, at times, causing crisis beds to be utilized for housing when transportation is not available.

Another piece identified throughout most stakeholder meetings was limited services throughout the state. The service limitations reported differed by region whether workforce issues,

timeliness to access services or the availability of effective services. Stakeholders were generally not aware of the priority populations or proposed changes in the public service delivery system.

Lastly, because all substance use disorder programs are required to be licensed, there is the ability to identify the levels of services available in various areas of the state to identify gaps. Stakeholders expressed a lack of available information regarding mental health providers.

Identified Gaps and Needs

- There is a need to reduce the criminalization of behavioral health disorders. Also, reimbursement is not available for BH services for individuals in jails.
- As the field is moving to understand the chronic nature of behavioral health conditions, it has been identified that there are many limitations in the availability of community-based services (including housing, transportation, employment) to allow individuals choice of services in the least restrictive environment and to support individuals throughout their life.
- In general, behavioral health services in the state are not integrated in service provision. Also, limited collaboration or communication with community or health organizations, including the utilization and exchange of data. Also related to this integration, it was identified that when individuals change to a different level of care in service provision, the transition is often not fluid or seamless.
- Oftentimes the services available in a community are not widely known. Changes in services or processes are not always communicated widely to stakeholders and the general public.
- As has been identified in previous studies and assessments, there are gaps and needs in the behavioral health workforce. However, this limitation is not exclusively related to the number of providers. There are other considerations in this need, including the limitations in utilization of evidence-based practices among the current workforce. Also, there is a need for a single registry for mental health providers.
- Comprehensive care coordination is lacking across the system for individuals with a behavioral health condition. This includes a need for workforce capacity building about effective care coordination.
- There is a continued need for role clarification between the public and private behavioral health service systems to ensure the variety of treatment services are available to individuals.

Recovery

Recovery is the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The process of recovery is highly personal and occurs via many pathways. The Substance Abuse and Mental Health Services Administration (SAMHSA) has delineated four major dimensions that support a life in recovery: (1) Health—overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being; (2) Home—having a stable and safe place to live; (3) Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or

creative endeavors, and the independence, income, and resources to participate in society; and (4) Community—having relationships and social networks that provide support, friendship, love, and hope.

Stakeholder Feedback

Stakeholders identified limited recovery supports, including community-based services, peer support, supported employment and supported housing. Funding/reimbursement was identified as a barrier as well as a sustainable workforce and infrastructure.

Identified Gaps and Needs

- Workforce limitations (number of trained providers in evidence-based recovery services)
- Limited evidence-based services, and the infrastructure to support these services, available in the state, including sober living environments and other community-based services and supports (including housing, transportation, employment)
- Limited payment to support evidence-based recovery services

Summary and Recommendations

It is acknowledged that the foundational recommendations in this assessment require the involvement and collaboration of a variety of stakeholders. No one system can address these issues. Also, many stakeholder groups have identified service needs, communication barriers and data gaps. It is important to continue engaging stakeholder groups in order to identify more specific recommendations once infrastructure concerns have been addressed.

The following recommendations have been identified as vital foundational pieces on which further efforts can continue to be made and be sustained:

- Continuous collection, analysis and utilization of comprehensive behavioral health data.
- Development of a formal Children's Behavioral Health Leadership group.
- Support substance use disorder early intervention services.
- Mental health promotion and early identification of mental illness.
- Continue to support public service delivery system changes relating to core services and population.
- Recognition of behavioral health conditions as a chronic disease.



Through the process of identifying these recommendations, some special considerations and populations came to light, which need further attention. Federal funding availability often directs the behavioral health services available and are an important resource in considering avenues to fill gaps in the state's behavioral health system. However, resources need to be considered in the application for federal funding and the management of these federal funds. Also, as mentioned in various ways throughout this assessment, the silos present at various levels (funding, services, providers, etc.) greatly impact the effectiveness of the behavioral health

system as a whole. True integration must be a key consideration throughout all behavioral health system efforts.

To be effective, all behavioral health services must be person-centered, where services are centered on the needs and desires of the individual. It is important to note throughout the system review there was recognition the need for consideration of special populations. The following special populations have been identified as needing further identification of needs: early childhood, transition-age youth, 18-25 year olds not in higher education, tribal members, military service members and family, older North Dakotans, persons with disabilities and individuals in jail.

Continuous Collection, Analysis and Utilization of Comprehensive Behavioral Health Data

Behavioral health epidemiological data and service data should be collected, monitored and communicated regularly to guide system and program decisions. In order for this to happen, authority and resources would need to be established. Individual agencies and programs typically track and monitor their own data. However, currently the data is not compiled to provide a picture of the broader behavioral health system.

Overall, it is recommended that a priority be placed on the utilization of comprehensive data to guide further work in the behavioral health field. Specifically, it is recommended that authority and resources be identified to require and/or incentivize data submission by programs, support the ongoing collection and analysis of the data, and communicate the data/results to stakeholders, decision-makers, and the general public.

Development of a Formal Children’s Behavioral Health Leadership Group

Many systems and agencies play a role in the children’s behavioral health system across the continuum of care. Partnership and collaboration across these systems is vital to ensure a seamless and effective system of care for children where services are streamlined and not duplicated. Stakeholders report there is currently no primary, coordinated infrastructure, authority or leadership to guide the work of children’s behavioral health across systems.

It is recommended that a formal, sustainable leadership group is established to assess and guide efforts within the children’s behavioral health system. It is recommended this group brings together the key stakeholders, including those from the following fields (among others): education, social services, behavioral health, criminal justice, medical, advocacy, etc. As arose through stakeholder discussions, it is recommended the primary items this leadership group should address are screening, early intervention services, assessment processes, transitions and coordination between services, with the ultimate goal of supporting the full continuum for children.

Support Substance Use Disorder Early Intervention Services

The early intervention services section of the continuum of care is one area that has pretty significant gaps and because of this impacts all areas of the system. It is recommended to review resources in order to ensure the evidence-based program, Screening, Brief Intervention

and Referral to Treatment (SBIRT), is provided in a consistent manner across the state. The first step should include ensuring reimbursement options for this service.

Another area where early intervention services for substance use disorders can be enhanced in the state is by expanding the required alcohol and drug education for all first offenders of alcohol-related offenses. An important consideration in this is ensuring an oversight body is established.

Finally, another area where early intervention services can be enhanced (and simultaneously fulfills a part of the first recommendation for continuous data collection and analysis) is to analyze the Department of Transportation driving under the influence data to identify individuals who may be in need of early intervention and potentially treatment services. The review of this data would also assist in ensuring the screening, assessment and treatment services provided to this high-risk population are effective.

Mental Health Promotion and Early Identification of Mental Illness

In order to enhance the health promotion services available in the state, it is recommended that resources are dedicated to developing healthy communities to support individuals' behavioral health. The goal of these efforts would be to create an environment supportive of mental health and reducing the stigma of mental illness.

Continuing with the goal of improving the early intervention services within the state's behavioral health system, it is recommended to support the implementation of consistent screenings for at-risk populations. In order to develop a plan to implement consistent screenings, collaborations with a variety of organizations and disciplines will be vital, from the education system to long-term care.

Continue to Support Public Service Delivery System Changes Relating to Core Services and Population

In the effort to enhance services available to support an individual's behavioral health, it is recommended to continue role clarification between the public and private behavioral health service delivery systems. The public service delivery system's primary role as chronic disease management, regional intervention services and 24-hour crisis services has been identified. It is also recommended that the public service delivery system continue to enhance building awareness of these service changes. This may include increased communication to general public and stakeholders, holding regional meetings and providing information to consumers.

Recognition of Behavioral Health Conditions as a Chronic Disease

With the recognition of behavioral health conditions as chronic disease, it is vital that the services available follow chronic disease management principles. Aligning with these principles, it is recommended that access to community-based recovery supports are increased. These recovery supports include supported employment, supported living (including sober living), and recovery coaches (including peer support). It is also recommended to reduce barriers to accessing already available recovery supports.

Appendix A

Resource Links

REPORTS

- Interim Human Services Committee testimony: www.legis.nd.gov/assembly/64-2015/committees/interim/human-services-committee
- Schulte Consulting, LLC Behavioral Health Planning Final Report July 22, 2014: <http://storage.cloversites.com/behavioralhealthsteeringcommittee/documents/ND%20Final%20Report.pdf>
- North Dakota Behavioral Health Stakeholders Group Reports
 - Building Stronger Behavioral Health Services in North Dakota: Framing Key Issues and Answers – 7/18/2014: <https://ruralhealth.und.edu/projects/nd-behavioral-health/pdf/building-stronger-behavioral-health-services-nd-summary-report.pdf>
 - November 17, 2015 Summary Reports: <https://ruralhealth.und.edu/projects/nd-behavioral-health/pdf/summary-report-nov-2015.pdf>
 - Behavioral Health Stakeholder Survey, June 2016

DATA

- United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, & Inter-University Consortium for Political and Social Research. National survey on drug use and health. Retrieved from www.samhsa.gov/data/population-data-nsduh
- North Dakota Office of Attorney General, Bureau of Criminal Investigation. Crime in North Dakota. Retrieved from www.ag.nd.gov/Reports/BCIReports/CrimeHomicide/Crime14.pdf
- North Dakota Department of Transportation. North Dakota Crash Summary. Retrieved from www.dot.nd.gov/divisions/safety/docs/crash-summary.pdf
- Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System Survey data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
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Appendix B

Description of a Good and Modern Addictions and Mental Health Service System⁴³ – Excerpts

Draft – April 18, 2011

As outlined in this brief, a modern behavioral health service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern behavioral health service system is **accountable, organized, controls costs and improves quality, is accessible, equitable, and effective**. It is a public health asset that improves the lives of Americans and lengthens their lifespan.

The vision for a good and modern behavioral health system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a “good” and “modern” system of care is to provide a full range of high quality services to meet the range of age, gender, cultural and other needs presented. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidenced-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. A good system should also promote healthy behaviors and lifestyles, a primary driver of health outcomes.

CORE STRUCTURES AND COMPETENCIES FOR A MODERN SYSTEM

1. **Workforce.** The modern system must have experienced and competent organizations and staff. Recruitment and retention efforts will need to be enhanced, especially to increase the available pool of culturally, ethnically and racially diverse practitioners. Providers will need to embrace team-based care and collaboration with other systems as a way of doing business. Licensure requirements need to evolve and certification requirements need to be strengthened for those professions that do not currently require formal licensure. The workforce must also develop an improved ability to use technology to provide, manage and monitor quality care.

Four critical efforts loom large: (1) redeployment of the shrinking professional workforce to positions of consultation and oversight; (2) augmentation of the existing workforce to include trained family, youth and peer supports as part of the paid workforce; (3) a more concerted pre-professional training effort to prepare new frontline and professional providers for the modern delivery system that is consumer- and family-driven, youth-guided, recovery/resiliency-oriented and evidence-based; and (4) a robust continuing training effort to develop, enhance, and sustain providers’ capacity to access, interpret, and apply performance data and research findings on an ongoing basis to improve care.

⁴³ Description of a Good and Modern Addictions and Mental Health Service System, Draft – April 18, 2011; http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

2. **Empowered Health Care Consumers.**

Health care consumers/families need information and tools to allow them to promote and reinforce their role as the center of the health care system. At a minimum, this will include a system that supports health literacy, shared decision making, and strategies for individuals and families to direct their own care. Shared decision making should become the standard of care for all treatment services. Participant direction of services allows individuals and their caregivers (when appropriate) to choose, supervise and in some instances, purchase the effective supports they need rather than relying on professionals to manage these supports. Health care consumers and families will also need access to user-friendly information on the effectiveness of available services in order that they may truly make informed health care decisions.

3. **Information Technology.** To achieve optimum individualized care, a modern health system should include a structure in which all holistic outcomes, measures and indicators of health are collected, stored and shared with the individual and all of those providers who are associated with care of the individual. To that end, interoperable, integrated electronic health records will be necessary, as will community-wide indicators of behavioral health disorders. Additionally, appropriate security mechanisms and informed consent should drive this system while taking into account protection of individual rights and support to ensure appropriate linkages to services.

4. **Funding and Payment Strategies.** In the public sector, individuals/families/youth with complex mental and substance use disorders receive services funded by federal, state, county and local funds. These multiple funding sources often result in a maze of eligibility, program and reporting specifications that create funding silos featuring complicated administrative requirements. If services are to be integrated, then dollars must be also intertwined. In the same way that Medicaid will be required to streamline eligibility and

PRINCIPLES

These principles should apply to the provision of behavioral health services and cross the lifespan of individuals who need and use these services.

- Preventing and treating behavioral health disorders is integral to overall health.
- Services shown to be effective must be available to address current health and behavioral health disparities and be relevant to, and respond to, the diverse cultures and languages of individuals and families.
- A wide range of effective services and supports should be available based on a range of acuity, disability, engagement levels and consumer preferences. The consumer's resilience and recovery goals in their individualized service plan should dictate the services provided.
- The system should use information and science to deliver services. Services should be provided in convenient locations in order to reduce barriers, identify needs as early as possible, and engage individuals in care as early and as easily as possible.
- Wherever possible, the health system should support shared decision making with adult consumers, with youth and with families.
- Effective care management that promotes independence and resilience is key to coordinating health and specialty care.
- Service delivery must achieve high quality standards and results as well as outcomes that are measurable and are measured.
- Technology will be an important tool in delivering services. This includes telehealth, web-based applications and personal digital assistants that assist individuals in their recovery. Increased use of technology will expand access to and coordinate care rather than always relying on location-based service delivery.
- Services that are proven effective or show promise of working will be funded and should be brought to scale; ineffective services and treatments that have not shown promise will not be funded.

enrollment, the good and modern system must either blend or braid funds in support of comprehensive service provision for consumers, youth and families.

5. **Quality and Performance Management.** Quality improvement through the use of outcomes and performance measures is a cornerstone of the Affordable Care Act. A renewed focus on quality will also help payers link performance improvement with payment while moving away from the current incentives to provide more care without evidence of improved outcomes.
6. **Sustainable Practice Improvement.** Key to a modern behavioral health system will be an ethic of—and standard operating procedures for—continuous practice improvement to incorporate new evidence and to ensure more accountability, with a focus on “practice-based evidence” as well as evidence-based practice. Standards being developed by national organizations can guide providers (agencies, group practices and individual practitioners) in their efforts to reshape their practice and to sustain changes over time.
7. **Continued Partnerships.** While the good and modern system focuses on the need for better integration of primary care and behavioral health, this does not supplant the continued need to work with other systems that serve individuals with behavioral health disorders. Links between the good and modern system and the child welfare, criminal and juvenile justice, education and aging systems are more critical than ever.