

FISCAL NOTE
Requested by Legislative Council
04/09/2015

Amendment to: SB 2046

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$124,886		\$178,933
Expenditures			\$124,887	\$124,886	\$178,934	\$178,933
Appropriations			\$124,887	\$124,886	\$178,934	\$178,933

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Reengrossed SB2046 expands medicaid services for certain behavioral health services.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 requires the Department to amend the Medicaid state plan to allow for medical assistance coverage to eligible recipients for services provided by licensed marriage and family therapists. Appropriation of \$249,773, with \$124,887 being general fund and \$124,886 being federal funds, was not included in the bill but will be necessary to provide payment to licensed marriage and family therapists who provide behavioral health services.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Federal Medicaid revenues of \$124,886 would be received for medical assistance coverage to eligible recipients for services provided by marriage and family therapists.

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Reengrossed SB2046 does not include appropriation, however \$249,773, of which \$124,887 is general fund and \$124,886 is federal funds, would be necessary to provide payment for licensed marriage and family therapists who provide behavioral health services.

The 2017-2019 estimated expenditures for marriage and family therapists is \$357,867, with \$178,934 being general fund and 178,933 being federal funds.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The Department of Human Services would need an appropriation increase of \$249,773, of which \$124,887 is general fund and \$124,886 is federal funds, for this bill. The Department would need an increase in appropriation of \$357,867, of which \$178,934 is general fund and \$178,933 is federal funds, for the Medicaid grant expenditures for the 2017-2019 biennium.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 04/10/2015

FISCAL NOTE
Requested by Legislative Council
02/19/2015

Amendment to: SB 2046

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$124,886		\$178,933
Expenditures			\$124,887	\$124,886	\$178,934	\$178,933
Appropriations			\$0		\$178,934	\$178,933

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Reengrossed SB2046 expands medicaid services for certain behavioral health services and provides an appropriation.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 requires the Department to amend the Medicaid state plan to allow for medical assistance coverage to eligible recipients for services provided by licensed marriage and family therapists. Section 2 provides an appropriation of \$249,773, with \$124,887 being general fund and \$124,886 being federal funds, to provide payment to licensed marriage and family therapists who provide behavioral health services.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Federal Medicaid revenues of \$124,886 would be received for medical assistance coverage to eligible recipients for services provided by marriage and family therapists.

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Reengrossed SB2046 provides \$249,773, of which \$124,887 is general fund and \$124,886 is federal funds, to provide payment for licensed marriage and family therapists who provide behavioral health services.

The 2017-2019 estimated expenditures for marriage and family therapists is \$357,867, with \$178,934 being general fund and 178,933 being federal funds.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

An appropriation of \$249,773, of which \$124,887 is general fund and \$124,886 is federal funds, is included in this bill. The Department would need an increase in appropriation of \$357,867, of which \$178,934 is general fund and \$178,933 is federal funds, for the Medicaid grant expenditures for the 2017-2019 biennium.

Name: Debra A McDermott

Agency: Human Services

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Date Prepared: 02/19/2015

FISCAL NOTE
Requested by Legislative Council
02/06/2015

Amendment to: SB 2046

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$124,886		\$178,933
Expenditures			\$3,315,979	\$124,886	\$3,370,026	\$178,933
Appropriations			\$166,092		\$3,370,026	\$178,933

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Engrossed SB2046 expands medicaid services for certain behavioral health services, provides for reports to legislative management and provides appropriations.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 requires the ND Medicaid to amend the state plan to allow for medical assistance coverage to eligible recipients for services provided by marriage and family therapists. Section 3 provides an appropriation of \$249,773, with \$124,887 being general fund and \$124,886 being federal funds, to provide payment to licensed marriage and family therapists who provide behavioral health services.

The fiscal impact for Section 2 of this bill provides an appropriation of \$3,000,000 from the general fund for the Department of Human Services to address gaps in the state's substance abuse treatment system.

The bill also provides for an appropriation of \$25,000, all of which is general fund, to the Highway Patrol for mental health first aid training for state and local law enforcement personnel.

Not appropriated in the bill, but necessary would be an additional FTE at the cost of \$166,092, all of which is general fund, in order to address the gaps in the state's substance abuse treatment system, as well as administer the objectives of SB2045 and SB2048. Additional resources for research and evaluation services may be necessary, but at this time cannot be determined.

The Department of Human Services would need at least \$3,000,000, all of which is general fund, to continue to address the gaps in the substance abuse treatment system in the 2017-2019 biennium.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Federal Medicaid revenues of \$124,886 would be received for medical assistance coverage to eligible recipients for services provided by marriage and family therapists.

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Engrossed SB2046 provides \$3,000,000 from the general fund for the Department of Human Services to address gaps in the state's substance abuse treatment system; It also provides an appropriation of \$249,773, of which \$124,887 is general fund and \$124,886 is federal funds, to provide payment for licensed marriage and family therapists who provide behavioral health services. Engrossed SB2046 also provides for \$25,000 from the general fund for the Highway Patrol for mental health first aid training. In addition, there would be costs for an FTE of \$166,092, all of which is general fund, to address the gaps in the state's substance abuse treatment system, as well as the objectives of SB2045 and SB2048.

The 2017-2019 estimated expenditures for marriage and family therapists is \$357,867, with \$178,934 being general fund and 178,933 being federal funds. The Department would need at least \$3,000,000, all of which is general fund, to continue to address the gaps in the substance abuse treatment system. The cost to continue the FTE and the training would be \$166,092 and \$25,000 respectively.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

An appropriation of \$3,274,773, of which \$3,149,887 is general fund and \$124,886 is federal funds, is included in this bill. The Highway Patrol would need an appropriation increase of \$25,000, all of which is general fund, to continue training in the 2017-2019 biennium. The Department would need an increase in appropriation of \$3,523,959, of which \$3,345,026 is general fund and \$178,933 is federal funds, for the Medicaid grant expenditures, to address the gaps in the substance abuse treatment system, and the continuation of the FTE for the 2017-2019 biennium.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/13/2015

FISCAL NOTE
Requested by Legislative Council
12/22/2014

Bill/Resolution No.: SB 2046

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			\$3,315,979	\$124,886	\$370,026	\$178,933
Appropriations			\$290,979	\$124,886	\$370,026	\$178,933

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB2046 relates to behavioral health services and includes expanding medicaid services, the development of a data system, expanding substance abuse treatment services, law enforcement training, and consideration for a study.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 requires the ND Medicaid to amend the state plan to allow for medical assistance coverage to eligible recipients for services provided by marriage and family therapists. Using the data contained in 2013 SB2293, and considering a January 1, 2016 effective date, the fiscal impact for licensed marriage and family therapists 2015-2017 would be \$249,773, with \$124,887 being general funds. There is no estimated fiscal impact for including Licensed Professional Clinical Counselors because LPCCs are currently able to enroll under the Medicaid Rehabilitation Services option and provide services to Medicaid enrolled clients.

The fiscal impact for Section 2 is undeterminable at this time due to the need for additional information.

Section Section 3 of this bill provides an appropriation of \$3,000,000 from the general fund for the Department of Human Services to expand adult and youth substance abuse treatment services. However, the Department would need additional information in order to determine if the \$3,000,000 is adequate to expand adult and youth substance abuse treatment services.

The bill also provides for an appropriation of \$25,000, all of which is general fund, to the Highway Patrol for mental health first aid training for state and local law enforcement personnel.

Not appropriated in the bill, but necessary would be an additional FTE at the cost of \$166,092, all of which is general fund, in order to administer the expansion of the substance abuse treatment services, as well as the objectives of SB2045 and SB2048. Additional resources for research and evaluation services may be necessary, but at this time cannot be determined.

The Department of Human Services would need additional information in order to determine the fiscal impact on the 2017-2019 biennium.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Federal Medicaid revenues of \$124,886 would be received for medical assistance coverage to eligible recipients for services provided by marriage and family therapists.

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Using the data contained in 2013 SB2293, and considering a January 1, 2016 effective date, the estimated expenditures for licensed marriage and family therapist grant expenditures 2015-2017 would be \$249,773, with \$124,887 being general funds.

SB2046 provides \$3,000,000 from the general fund for the Department of Human Services to expand adult and youth substance abuse treatment services and \$25,000 from the general fund for the Highway Patrol for mental health first aid training. In addition, there would be costs for an FTE of \$166,092, all of which is general fund, to administer the expansion of the substance abuse treatment services, as well as the objectives of SB2045 and SB2048.

The 2017-2019 estimated expenditures for marriage and family therapists is \$357,867, with \$178,934 being general funds. The cost to continue the FTE and the training would be \$166,092 and \$25,000 respectively,

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

An appropriation of \$3,025,000 for Sections 3 and 4 was included in this bill. The Department of Human Services would need an increase in appropriation of \$415,865, of which \$290,979 is general fund for the Medicaid grant expenditures and the FTE for the 2015-2017 biennium. The Highway Patrol would need an appropriation increase of \$25,000, all of which is general fund, to continue training in the 2017-2019 biennium. The Department would need an increase in appropriation of \$523,959, of which \$345,026 is general fund, for the Medicaid grant expenditures and the continuation of the FTE for the 2017-2019 biennium. Due to needing additional information, the Department cannot determine what increase in appropriation is necessary for the 2017-2019 biennium for the substance abuse treatment services.

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Date Prepared: 01/13/2015

2015 SENATE HUMAN SERVICES

SB 2046

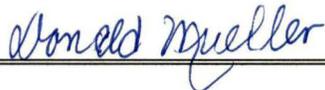
2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2046
1/14/2015
J# 21959

- Subcommittee
 Conference Committee

Donald Mueller



Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services; to provide for the development of an outcomes-based data system for behavioral health services; to provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to provide for a legislative management study.

Minutes:

Attach #1: Testimony by Rep. Kathy Hogan
Attach #2: Testimony by Dr. Cheryl Huber
Attach #3: Testimony by Emily Coler Hanson
Attach #4: Written testimony of Kristen E. Benson, Ph.D, Christi R. McGeorge, Ph.D., and Tom Stone Carlson, Ph.D.
Attach #5: Written testimony by Barbara Stanton
Attach #6: Chapter 43-53 Marriage and Family Therapy Practice
Attach #7: Data Outcome System points
Attach #8: Hope Manor Sober Living for Women brochure
Attach #9: Schulte Report

Fiscal note identified.

Alex Cronquist, fiscal analyst, legislative council, testified neither for nor against, and provided overview of SB 2046. This bill was forwarded from the Interim Human Services Committee.

Representative Kathy Hogan provided written testimony IN FAVOR of SB 2046. Rep. Hogan did not orally testify. (attach #1)

Marnie Wald introduced **Dr. Cheryl Huber**, a board certified psychiatrist at Sanford Health, spoke IN FAVOR of SB2046. Refer to (Attach #2). Testimony ends (8:25).

Senator Howard Anderson, Jr. have you identified specific things that need changing in the board of medical examiners or the state law to facilitate telemedicine services for mental health care.

Dr. Huber indicated that with medical examiners there are questions if these practices are legal? Telemedicine has existed in the state for many years, but the broader question is bringing in other internet practices, such as cameras on either end with an interaction between two providers. There have been proposals to make things very complicated to be considered a professional practice. Dr. Huber encourages not to make the process more complicated than it needs to be. Mental health services could be provided safely, and have been provided safely, for a number of years without a lot of rules to interfere.

Chairman Judy Lee stated that she was unaware of any legal barriers, there is tele-psychiatry taking place today.

Dr. Huber indicated that there are questions that have scared off numerous providers, such as face-to-face first meetings, which could make the process cumbersome. If some is receiving telemedicine services and in a crisis and a provider is away but a partner is available, how do you make some of these things work.

Senator Warner asked relative to the impediments, telemedicine, is security/privacy or reimbursement of those the issue or just quality of the interaction?

Dr. Huber answered security has not been one of the concerns that have come up. Professionalism and reimbursement questions have been raised.

Chairman Judy Lee stated they have been informed that tele-psychology has been used extremely effectively for adults, even received better by the public because of the stigma in society. Child psychiatry is less adaptable to telemedicine.

Dr. Huber indicated that child psychiatrists are in critical demand, including correctional center. There has been a proposal to possibly use telemedicine services in those places, but barriers do exist. Some child psychologists are willing to do it but don't want to get in trouble for doing it.

End of Dr. Huber testimony.

Chairman Judy Lee indicated that Representative Hogan has an amendment, so asks that the Department of Human Services review the proposed amendment.

Kurt Snyder, Executive Director of the Heartview Foundation, provided testimony (no written testimony). Mr. Snyder supports SB 2046. Mr. Snyder discussed value choices. He indicated that Senator Howard Anderson, Jr. introduce a good Samaritan bill for those who are witnessing an overdose, and avoid prosecution. This is a bill that failed last session. This is a bill that is a value choice. Mr. Snyder indicated the value choice is this: is punishing the user more important than saving a life. The interim human services committee with the Schulte consulting report along with the 400 people in the stakeholder group contributed greatly. There was no money set aside for these bills, so there will be another choice. Do we value the interim committee results (Schulte report, Attach #9) and become advocates of this? How do we value these people in our society? Mr. Snyder indicated that if the time and money is invested up front, it will save us money. Mr. Snyder

indicated that he will provide cost benefit study where it shows that every dollar spent saves 7 dollars.

End Snyder testimony. (17:02)

Emily Coler Hanson, representing Prairie St. John, testified IN FAVOR of SB 2046. Ms. Hanson also provided additional written testimony from colleagues. Oral testimony ends (22:20) (attach #3)

- Written testimony by Kristen E. Benson, Ph.D.; Christi R. McGeorge, Ph.D.; and Tom Stone Carlson, Ph.D (Attach #4)
- Written testimony by Barbara Stanton (Attach #5)
- Century Code Chapter 43-53: Marriage and Family Therapy Practice (attach #6)

There were no questions for Ms. Hanson

No other testimony given IN FAVOR of SB 2046.

OPPOSED TO SB 2046

No testimony provided opposed to SB 2046.

NEUTRAL TO SB 2046

JoAnne Hoesel, Department of Human Services, testified Neutral for SB 2046. Ms. Hoesel wants to provide some clarification on Section 2 and Section 3 of the bill. Section 2 has to do with the outcome based data system. Ms. Hoesel respectively requested that the start date be pushed back from July 1, 2015, since administrative rules, procurement, and other things to need to be done.

Ms. Hoesel distributed a document regarding the Data Outcome System (attach #7). This document identifies questions, but with all the input and interest in behavioral health in the state, we want to clarify we are going in the direction that meets expectations. Ms. Hoesel highlighted some of the questions. Is this intended for both public and private providers, and also both mental health and substance abuse providers? If so, the Department of Human Services would need statutory authority to have the private providers participate in the process. There are a number of ways to track outcomes, so would like some guidance on this. Finally, there needs to be an appropriation.

Chairman Judy Lee can you identify the appropriation?

Ms. Hoesel indicated, certainly, with some guidance. But there needs to be some context. Section 3 has to do with substance abuse treatment service expansion. Ms. Hoesel is asking for clarification of the intent is to be a granting program that implements evidence based practices, or as a voucher system similar to the earlier bill. Depending on the direction, the Department of Human Services may need to push back start date depending on what it takes to get going, such as administrative rules, procurement, and other.

Senator Howard Anderson, Jr. indicated there is a July 1st date in Section 3 as well but perhaps since that is an expansion of the program, does that cause a problem.

Chairman Judy Lee provided further clarification. Senator Howard Anderson, Jr. indicated on Page 1, line 18; the next implementation date is on Page 2, line 2.

Ms. Hoesel indicated both dates may need to be pushed back.

Senator Dever asked regarding the training for highway patrol, would the Department of Human Services be involved with that?

Chairman Judy Lee stated that the highway patrol needs to be made aware of this. Mental Health first aid training has become common entry level training programs for patrol who is coming across someone who has behavioral health problems has some idea how to communicate with them.

End Ms. Hoesel testimony (30:12)

Judith Roberts provided testimony (not written), an individual, addressed section 3 of the bill. On line 2 of the second page, it references the intoxication services. Ms. Roberts is attorney by trade who provided public defense for county in western North Dakota. Ms. Roberts opened up the first North Dakota sober living home, known as Hope Manor, located in Bismarck. In her business, there are no state or federal funds involved. Ms. Roberts provided a brochure for her business, Hope Manor (attach #8). Ms. Roberts gave examples, including intoxicated women stories. Ms. Roberts is not medically trained; insurance clearly states it is not in their realm of duties to provide medical treatment. She runs her operation as a private organization. It is crucial for organizations to take people to detox, especially for women who are very vulnerable. Ms. Roberts urges in Section 3, to look at phrase "intoxication of detox services", and the need for these services. We need 72 hours where they can get medical attention.

Testimony of Ms. Roberts ends (41:08). It was clarified that Ms. Roberts spoke IN FAVOR of SB 2046.

Closed hearing.

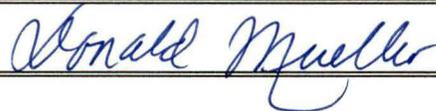
2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2046
1/14/2015
J# 21992

- Subcommittee
 Conference Committee

Donald Mueller



Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services; to provide for the development of an outcomes-based data system for behavioral health services; to provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to provide for a legislative management study.

Minutes:

No attachments.

These meeting minutes reflect the committee work on July 14, 2015, 2:00pm.

Definition Acronyms: LMFT = Licensed Marriage and Family Therapists

Definition Acronyms: LPCC = Licensed Professional Clinical Counselors

Chairman Judy Lee indicated that she understands the Licensed Marriage and Family Therapists, not stating they are not a good qualified professional, but also understands what Dr. Faust was stating that she can't do family therapy and doesn't think Licensed Marriage and Family Therapists can do the serious mentally ill diagnosis and clinical treatment. Chairman Judy Lee recognizes the difference between the two groups. Then we have the school psychologists who want to be identified as a qualified mental health professional under the children's residential treatment section of law, which seems to be an odd place for it. However, school psychologists do not have the same training as other people, including Licensed Marriage and Family Therapists, who also want to be designated as qualified mental health professionals.

Senator Dever indicated that they can't practice outside the school setting.

Chairman Judy Lee indicated they want to be recognized as professionals, but it becomes obvious that the four word phrase has a life of its own, so either we designate various categories under the umbrella of qualified mental health professional. School psychiatrist are licensed by the ESPB and only practice in the school settings and are only mental health professionals in that setting only; Licensed Marriage and Family Therapists want to do everything. What is different of the Licensed Marriage and Family Therapists program in Minnesota that we don't let them do here?

Maggie Anderson (DHS) indicated that Licensed Marriage and Family Therapists request is to get Medicaid reimbursement. Outside of scope of practice, training, licensure, the difference is Minnesota does enroll Licensed Marriage and Family Therapists in their Medicaid program and they reimburse services where North Dakota does not. SB 2293 last session, this failed to pass. Section 1 of SB 2046 the Department of Human Services will pay for services of Licensed Marriage and Family Therapists and Licensed Professional Clinical Counselors (LPCC). The Department of Human Services already pays for LPCC. Therefore, the fiscal effect for section 1 is only about Licensed Marriage and Family Therapists, with no fiscal impact for the LPCC group. Last session, there was an additional \$90,000 requested to do system changes to the MMIS system, but did not include this in here because of implementation date (asking for January 2016 implementation).

Senator Howard Anderson, Jr. asked if there is any downside allowing them to be Medicaid providers within their scope?

Maggie Anderson (DHS) indicated no. What is the intent of people wanting to be defined as a mental health professional - is it to get access to a third party payer, and if so, this is more the avenue than SB 2047. Going back to the stakeholders and Schulte report, the number one issue is availability and access to services. If it increases access to services, this is then is the fiscal effect at that point.

Senator Howard Anderson, Jr. indicated that line 11, page 1 of SB 2046, the word "entitling"; is that really what we want to say there?

Maggie Anderson (DHS) indicated that this is a good point. They think that on line 12, the "to" should be "for", for payments, and bringing the word "entitling" into it, "to" is the correct word, but perhaps it should state "the department shall adopt rules allowing licensed professional clinical counselors to enroll in the Medicaid program". If the department were to offer that amendment, then they would also recommend removing LPCC's since they are already reimbursed. They would also offer an effective date for that section.

Recording: J# 21992 (18:57)

Senator Howard Anderson, Jr. expressed his concern that in Section 4, the Highway Patrol doesn't come in with the same request for budget increase that Department of Instruction came in with.

Chairman Judy Lee asked the intern, Femi, to investigate if the Highway Patrol have any comments for SB 2046, Section 4.

Senator Howard Anderson, Jr. indicated when he saw \$50,000, he envisioned an online training course with an manual that every teacher and staff could access, and then record who successfully completed the test. The Department of Public Instruction clearly has a different method than what he envisioned.

Chairman Judy Lee indicated the training has to be different for Highway Patrol than teachers and other staff. Law enforcement is 24 hour assignment, so an online training program could work for them but something different for schools.

Maggie Anderson (Department of Human Services) informed the committee that when the fiscal note was assigned to the agency, they reached out to the other agencies, including Patrol. Major Solberg indicated \$25,000 is sufficient because course content, interest in the program, and interest from possible trainers is unknown.

Pamela Sagness, Department of Human Services, had a discussion with Highway Patrol about mental health first aid. By named "Mental Health First Aid," that is actually a specific evidence based program, the trainings are offered 40 hours classroom. There are a lot of requirements to be certified as trainer. It is a costly program within DPI, especially train-the-trainers method.

Chairman Judy Lee indicated that they said there is a training program, online assumed, it would be easier to outreach.

Ms. Sagness suggested there are probably a lot of programs, but when mental health first aide is used, it is a branded copyright program. It is an evidence based program and well supported program nationally.

V. Chairman Oley Larsen stated for discussion that he has been in education field for 18 years, and with all the issues, we have our professional development day for training. Now in V. Chairman Oley Larsen is in the private sector with health insurance, everything is a module, there are webinars. The cost and the time are at your own discretion. Professional development days in the school year continue to grow; this is 8 hours during the school year, \$900,000 for a program like that - we can modulate something.

Chairman Judy Lee said she will write an email to Mike Reitan for clarification, because he indicated training something similar to this, which accommodates their scheduling time.

Senator Dever indicated that if our expectations are that this will be taught in academy, there needs to be recognition that there are two academies.

Ms. Sagness provided further clarification on section 3. Her discussion was to differentiate between voucher in SB 2045 and recommendation to enhance services in SB 2046. In particular note is the focus on withdrawal management regarding detoxification. The Department of Human Services is working with stakeholders, and have started a discovery process in region 7, and have actually completed a document that's an assessment of the withdrawal management including consultation with Standing Rock. The Department of Human Services would like to recommend that the small committee for SB 2045 make a recommendation for the funding that is suggested in this bill. One possible difference is the voucher is by person, but some of the potential opportunities with withdrawal management issues we have comes to the fact that social detox is a licensed level of care. There are concerns whether the hospital is responsible; we have in century code that a law enforcement officer has three options: to take them to treatment center; to a hospital; have a loved one to take care of them; or put them in jail. You are aware of the issues in jail for detox since they aren't trained for that. This would provide an opportunity for discussions that are already occurring, with emphasis on what the funding could focus on, including withdrawal management needs for the state, as they are very limited.

Chairman Judy Lee agrees, including with the stakeholders who have expertise.

Senator Warner clarified the distinction that this is acute service required, and at a time when a person would not be able to make that evaluation with no time to get a voucher.

Senator Howard Anderson, Jr. asked for clarification in Section 5. There seems to be extraneous language to provide additional services. Senator Howard Anderson, Jr. asked for comments from Maggie Anderson (DHS). It appears that we are studying and doing a performance audit of Department of Human Services, is that the intention of this bill?

Maggie Anderson (DHS) indicated that the Schulte report showed concerns where Department of Human Services is a provider, because they provide direct services at the Human Service Center, State Hospital, and Life Skills and Transition Center. At the same time, the Department of Human Services also are the licensor; they are not the same people, and they've had situations where they have had to revoke license of someone at the Human Service Center. The Mental Health and Substance Abuse Division is also the developer who help look at the system, bringing in national people, putting on different workshops to roll out services, summits, various diversion programs. There has been a concern brought up in Schulte report is, should the agency who is the system oversight also provide services. The Department of Human Services has focused on the licensing pieces and always held people to the same standards. It is a decision to look at the system established years ago by legislature whether Department of Human Services structure needs to change.

Senator Howard Anderson, Jr. indicate that he comes from regulatory community where they license pharmacies and pharmacists for years, and we also do the inspecting. Most of us don't provide the funding as well, which Department of Human Services has. We license and inspect, so that might be a piece of concern. Senator Howard Anderson, Jr. indicated he is always in favor of contracting with private providers that the state doesn't need to do. Senator Howard Anderson, Jr. asked if this is germane to this bill or if we should remove the whole section?

Maggie Anderson (DHS) indicated that many of these issues meld together, including a stand-alone bill that has been introduced to study the structure of the Department of Human Services. (HB 1280)

Sen Axness asked through that discussion, wasn't there a federal change about the rule that came? Through ACA?

Maggie Anderson (DHS) indicated that she was not aware of the change. There were concerns with Legislative Council because of the appeals process. It is not uncommon for Ms. Hoesel's shop if a client at the state hospital that they didn't feel they got the service, so the front office can get a call. Ms. Anderson thinks the structure is working, to strengthen the license process, but we aren't afraid to revoke a license.

Chairman Judy Lee indicated that Schulte report particularly focused on private providers. After the Developmental Disabled lawsuit, that's all really contracted with private service in

group homes. Restructuring the Department of Human Services would be significant. We can write a response about providing services that regulates, but this is totally out of the Schulte report and not stakeholder driven. She had a professional concern about having the entity that provides the services also doing the regulating. If someone is unhappy with the outcome, can they go to another administrative law judge, there was prior heartburn about this.

Maggie Anderson (DHS) indicated that appeals ultimately go to administrative law judge. The Department of Human Services can reaccept or reject those, but they are generally not rejected unless there is a different interpretation of the law. There are options for people.

Mr. Brandon Solberg, Chief of Staff for the Highway Patrol, provided information.

Chairman Judy Lee informed Mr. Solberg about the proposed mental health training for the Highway Patrol, and asked if the \$25,000 appeared to be adequate. It is a trademarked program, so there is concern that the cost may be understated. DPI cost estimate is so much higher. Would you look at online training, or face to face training?

Mr. Solberg indicated that when he first learned of this in the bill, they understand that it was a recommendation from stakeholder group. The mental health first aid is a national certified course, where train-the-trainers could provide that to their own officers. They are an accredited agency, recognition of mental health and substance abuse is of concern and they are interested in. The \$25,000 is sufficient to get their feet wet to get an instructor and look at the course content, and then provide the 8 hour course to their officers. This is a large time commitment for them. If the content was good enough, they would definitely spread that. Not sure if \$25,000 is enough until they have had a chance to look at that. They provide law enforcement training to all agencies: police, sheriff, game and fish, BCI, through the law enforcement academies.

Senator Howard Anderson, Jr. indicated that it was never our intention in the bill to use a trademark course and a specific name.

Chairman Judy Lee indicated it was the intent of the stakeholder group.

Senator Howard Anderson, Jr. indicated that V. Chairman Oley Larsen had found other mental health first aid training courses that are available.

Chairman Judy Lee asked if they call themselves Mental Health First Aide training?

V. Chairman Oley Larsen indicated there are, on the web, others with the same name, with small letters.

Ms. Sagness indicated it is a trademark name.

V. Chairman Oley Larsen asked Mr. Solberg for some overview, do you some training now on these issues?

Mr. Solberg indicated that they provide mental health training at least once every 3 years, and that's to all agency employees including civilians. They are trained on how to recognize behaviors and how to deal with that. With officers, they provide the options that are available to getting those people assistance.

Senator Dever Alzheimer's association has talked about mental health first aid training for law enforcement. Have they done anything with this?

Mr. Solberg answered no, not that he is aware of. They do their own training where they build their own training course, where this specific bill will point us to a one certified nationally recognized course.

Chairman Judy Lee indicated that if you hear about alternative classes as an option, we would allow some openings. There needs to be a discussion with Department of Public Instruction to move beyond the grant. In order to roll it out, they need more money for everybody.

Adjourned for the week.

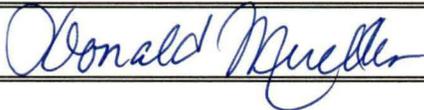
2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2046
1/27/2015
22664

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services; to provide for the development of an outcomes-based data system for behavioral health services; to provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to provide for a legislative management study.

Minutes:

Attach #1: Proposed Amendments from Pam Sagness
Attach #2: Withdrawal Management North Dakota, Region 7

These are minutes from Senate Human Services Committee on January 27, 2015, 3:15pm.

Chairman Judy Lee got a flyer from First Link who is doing capital mental health first aid training, and they received a grant to support much of the cost. In the Fargo area, they are doing three. It is \$20 for the cost for participant, it is about \$750 for each participant but the grant is subsidizing this. First Link may be interested in providing additional training. Chairman Judy Lee also exchanged messages with DPI Baesler and Valerie Fischer. It is important that we don't have an overlap.

Pam Sagness, Department of Human Services, have 2 sections that they want to address and proposed amendment. (attach #1). **Maggie Anderson** (DHS) addressed the changes in the amendment - refer to amendment. The reason we are removing LPCC's is because they are already able to be enrolled through Medicaid. (4:20)

Senator Howard Anderson, Jr. page 1, line 18, note that we wanted to change the date to 07/01/2016.

Maggie Anderson (DHS) that is in Section 2, and Pam Sagness will discuss this.

(5:10)

Pam Sagness addressed the proposed amendment, section 2. As discussed previously, this was section that may have been misplaced with behavioral health stakeholders,

outcome based, but not necessarily in a different section. Added language to SB 2045 and later in section 3 that these programs would be outcome and researched based.

Senator Howard Anderson, Jr. asked should we eliminate section 2

Ms. Sagness indicated it could be duplicative in what they have already presented.

Chairman Judy Lee indicated the language that's in here talks about developing an outcome based data system. But you are already collecting outcome measures. Is that the same.

Ms. Sagness responded this is related specifically to the software. If amendment proposed by Representative Hogan were to be identified, it will already require us to be collecting data if you add the authority to that bill, that would be duplicative to this section. The part that would not be duplicative is the reporting periodically to legislative management. There are three sections doing a similar thing, and depends on where this committee goes.

Chairman Judy Lee doesn't want redundancy and data not to be well managed. When I go back to stakeholders, I have to explain why the language was done differently.

Ms. Sagness can look at the language of SB 2045 and SB 2046. She read from the SB 2046 bill (page 2, line 13), regarding outcome reporting. This is similar language for the proposed amendment for SB 2045. Ms. Sagness was part of the stakeholders group which had brought this forward, and had worked with Brad Gibbons from the Center for Rural Health to ensure that we want to be detailed about process and outcome measures and want to bring everything together to compare. This language is broad enough and take global perspective without being so specific that we are limited.

Ms. Sagness then went on about the proposed amendment changes, Section 3. Ms. Sagness provided a copy of the Withdrawal Management North Dakota, Region 7 (attach #2). (ends 15:18).

Senator Warner asked if treatment for medical detox or withdrawal, can that be treated in general hospital or only in a specific ward. Can those beds switch back and forth?

Ms. Sagness indicated that this is one of the concerns in the hospitals and providers. People are just not receiving these services. There is no definition of what medically cleared means. Detox process gets worse over time. Someone might be declared clear, stable, but as detox progresses, this can become more severe. Part of the problem is they then go to jail or treatment center. Treatment centers in licensing rules are required to use the CWAA assessment tool, but jails and correctional centers are not trained how to use this. Human Service Centers do contract in several regions with hospital for someone with that need, but the capacity is not available.

Chairman Judy Lee discussed the crisis and moving people across the state. We have to figure out the need for beds. Only 8 hours that they can be in a medical hold for that kind of situation?

Ms. Sagness indicated there are some limitations depending if they are being held in a correctional center or if they are being held in a licensed medical detox center or hospital.

Chairman Judy Lee said it could be 8 hours, and it could be 2:00am, then where do they go.

Senator Warner asked where's the problem. Is it the physical setting, trained staff, where's the bottleneck.

Chairman Judy Lee stated that in Fargo, 2 psychiatrists left, and their staffing was below accreditation standards and if they filled the beds they had, they were going to be in trouble with the Joint Commission. Part of it is having professional staff, and limited places in state where that can be handled.

Ms. Sagness reiterated that there is a limited capacity. Referred to prior handout. There are only 6 programs that are currently licensed for that level of care in the state in private sector, and there is no bed capacity for these type of services. One of the things is that there are many issues, and assessment tried to address that, top of page 11 from funding to reimbursement or insurance coverage, policy issues, oversight and licensing issues, engagement issues. If someone is in detox center and can't get to treatment, how do we get them engaged.

Ms. Sagness then continued on her handouts. (ending 22:40)

Senator Howard Anderson, Jr. made a statement category is something we could do something about. Is that the department or the Senate Human Services Committee?

Ms. Sagness indicated the part that is easy is the strategy. Being able to identify 3 clear things that are evidence based that could make a difference, we can help. Policy issues, what does law enforcement do if they just put people in jail, they are not licensed. Law enforcement does not want to be licensed program, and that's a financial issue. In order to become licensed, they would need clinical staff.

Senator Howard Anderson, Jr. asked explain by "easily do something about". What are the steps.

Ms. Sagness said if this appropriation and recommendations of the stakeholder's group that met to talk about this, if there was the funding, the opportunity to train officers and implement the awareness that's needed for them to know when to refer someone back to a medical facility, and to work with those medical facilities as partners, and then to engage treatment providers, there is a clear process of how we could insure there are no more lives lost in jail.

Chairman Judy Lee indicated part of rub is that we don't have enough medical beds. State hospital has changed in function, that beds are used for other purposes which has impacted this. How can we find a place, even if not geographically in the right area, how do we make sure they are cared for and then moved back out to the community care setting.

Ms. Sagness stated collaboration across the system. Currently it is siloes, quite fragmented. There is a divide between private and public, between local programs competing, and need to collaborate to right size services. If you have community based options, that you are utilizing them, so that those who are the most severe are those that are getting residential beds. That is one of the keys is recognizing what the appropriate level of care is, which is what ASAM does

Chairman Judy Lee answered that we get conflicting reports which we understand.

Senator Dever stated that Ms. Sagness talked about correctional officers and Department of correction. Real issue is county jails. County sheriffs may not look at corrections for guidance. The idea of sheriffs transporting across the state, in prior session said they cannot contract with prior companies to do that.

Chairman Judy Lee indicated that may have been a mistake.

Senator Howard Anderson, Jr. indicated before we leave SB 2046, get concurrence of committee and move to do the amendments from Ms. Sagness, remove section 2, and also remove section 5 that we have studied this enough. Not a motion yet today. Also wait for amendment from Department of Human Services or from Femi.

Ms. Sagness clarified Senator Dever question, this is a county level issue with the jails, but the correctional officers are trained by Department of Corrections, and the licensing required with that. We have worked with both county jails in Region 7 and the Department of Corrections to ensure that we can train those who are currently practicing, but there truly is a sustainable option so that anyone who becomes a correctional officer would already be trained with the appropriate criteria.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2046
1/28/2015
22756

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services; to provide for the development of an outcomes-based data system for behavioral health services; to provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to provide for a legislative management study.

Minutes:

Attach #1: Spreadsheet Increase in Behavioral Health Services Contained in Various Bills.

These are minutes from the Senate Human Services Committee on January 28, 2015.

JoAnne Hoesel, Department of Human Services, provided a spreadsheet that pertains to related bills. Increase in Behavioral Health Services Contained in Various Bills, prepared by Department of Human Services January 28, 2015. (attach #1). Ms. Hoesel went through the detail in the spreadsheet.

No questions.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2046
2/4/2015
23250

- Subcommittee
 Conference Committee

Committee Clerk Signature

Donald Mueller

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services; to provide for the development of an outcomes-based data system for behavioral health services; to provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to provide for a legislative management study.

Minutes:

Attach #1: Proposed amendment in draft format

Chairman Judy Lee recapped, including proposed amendment. (3:30)

Maggie Anderson (DHS) provided a new copy of the draft amendment, with changes after discussion within Department of Human Services. (attach #1)(4:45).

Chairman Judy Lee asked if we should consider putting more money in highway patrol training.

Senator Howard Anderson, Jr. indicated they thought that would be enough.

Senator Warner moved that the Senate Human Services Committee do ADOPT AMENDMENT as provided by Maggie Anderson (DHS). The motion was seconded by **V. Chairman Oley Larsen**.

Roll Call Vote to Amend SB 2046

6 Yes, 0 No, 0 Absent. Motion approved

Senator Warner moved that the Senate Human Services Committee give a DO PASS recommendation for SB 2046 as AMENDED and re-refer to the Appropriations Committee. The motion was seconded by **V. Chairman Oley Larsen**.

Roll Call Vote to DO PASS as Amended

6 Yes, 0 No, 0 Absent. Motion approved.

Chairman Judy Lee will carry SB 2046 to the floor.

February 5, 2015

Handwritten notes: "one", "Feb 15", "1/2"

PROPOSED AMENDMENTS TO SENATE BILL NO. 2046

Page 1, line 3, replace "the development of an outcomes-based data system for behavioral health services" with "reports to the legislative management"

Page 1, line 3, after the semicolon insert "and"

Page 1, line 4, remove "an appropriation to the department of human services for substance abuse treatment"

Page 1, remove line 5

Page 1, line 6, replace "provide for a legislative management study" with "appropriations"

Page 1, line 11, replace "The" with "Beginning January 1, 2016, the"

Page 1, line 11, remove "adopt rules entitling licensed professional clinical"

Page 1, line 12, replace "counselors and" with "allow"

Page 1, line 12, after "to" insert "enroll and be eligible for"

Page 1, line 14, remove "based on federal laws and regulations"

Page 1, remove lines 15 through 20

Page 1, line 21, remove "**SUBSTANCE**"

Page 1, line 22, remove "**ABUSE TREATMENT SERVICES -**"

Page 2, line 1, replace "expanding adult and youth" with "addressing gaps in the state's"

Page 2, line 2, replace "services" with "system"

Page 2, line 2, after "including" insert "intervention,"

Page 2, line 2, after "detoxification" insert ", and recovery"

Page 2, line 3, after the period insert "The department of human services shall ensure recipients of funding under this section collect and report process and outcome measures. Recipients of funding under this section shall implement research-based programs. The department of human services shall require recipients of funding under this section to develop sustainability plans and participate in training and technical assistance."

Page 2, after line 4, insert:

"SECTION 4. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES.

There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$124,887, or so much of the sum as may be necessary, and from special funds derived from federal funds, the sum of \$124,886, or so much of the sum as may be necessary, to the department of human services for the purpose of providing payment to licensed marriage and family therapists who provide behavioral health services under Section 1 of this Act, for the biennium beginning July 1, 2015, and ending June 30, 2017."

Page 2, remove lines 10 through 18
Renumber accordingly

2/2

Date: 02/04 2015
Roll Call Vote #: 1

**2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES**
BILL/RESOLUTION NO. SB2046

Senate Human Services Committee

Subcommittee

Amendment LC# or Description: Maggie Anderson Amendments 15. 0230. 03002 Title .04000

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
Other Actions: Reconsider _____

Motion Made By Warner Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

**2015 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. SB 2046**

Senate Human Services Committee

Subcommittee

Amendment LC# or Description: 15.0230.03002 Title - 04000

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar

Other Actions: Reconsider _____

Motion Made By Warner Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2046: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2046 was placed on the Sixth order on the calendar.

Page 1, line 3, replace "the development of an outcomes-based data system for behavioral health services" with "reports to the legislative management"

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Page 2, remove lines 10 through 18
Renumber accordingly

2015 SENATE APPROPRIATIONS

SB 2046

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2046
2/12/2015
Job # 23706

- Subcommittee
 Conference Committee

Committee Clerk Signature

Kate Oliver for Rose Leming

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services.

Minutes:

SB 2046: Enhance Substance Use Disorder (SUD) System - Attachment 1
Withdrawal Management, North Dakota, Region 7: Attachment 2.

Legislative Council - Alex Cronquist
OMB - Nick Creamer

Senator Bowman called the committee to order on SB 2046.

Alex Cronquist, Legislative Council: Neutral Testimony

He explained the bill. The bill came out of interim Human Services committee. Allows them to receive appropriation under Medicaid.

Senator Mathern: State Senator, District 11, Interim Committee member: Was a follow-up to the Schulte Report which our committee funded last biennium. It was completed the study by Renae Schulte and it made recommendations to the Interim Committee.

Kurt Snyder, Executive Director, Heartview Foundation. I am here in favor of section 2 of SB 2046. The Schulte report went into great detail in regards to behavioral healthcare services. The number one thing that came out of that report is that there are not enough services. We have rural and frontier state and has difficulty in providing services. For lack of access to these services, North Dakota has seen rise in criminal justice activity. Our prison is now full - bringing costs back to cities & counties. This will help immensely to deal with population. Instead of spending \$30,000 to incarcerate, we would be helping them and their families. Pam Sagness from the Department will provide info as well.

Senator Kilzer: We looked at SB 2045 yesterday in subcommittee, and were told that there are 54 licensed vendors that provide addiction counseling. Some or how many refuse to see Medicaid patients?

Kurt Snyder: I know many in small communities will do cash business, a lot of times with Medicaid there is difficulty, without a medical director on staff they don't qualify for the partial hospitalization or the day treatment. 4 months ago I met with someone from Medicaid and we were trying to collect the information and distribute it to providers so inform them that they can bill Medicaid for these individuals.

Senator Kilzer: How extensive is this program? It's easy to say cash only and it would easily exclude Medicaid. Out of 54 vendors - how many exclude Medicaid.

Kurt Snyder: I don't know and I don't know if I can find out. There are a handful of private providers that are Medicaid approved, including Heartview Foundation, St. Alexius Hospital, and Trinity Share House. Other providers don't qualify for Medicaid. It's knowledge of how to get coverage or how to participate because you don't have a medical provider.

Pam Sagness, Dept. of Human Services: Testified in favor of SB 2046.
SB 2046: Enhance Substance Use Disorder (SUD) System - Attachment 1.
Withdrawal Management, North Dakota, Region 7: Attachment 2.

Explained attachments.

Senator Kilzer: Was this an OAR?

Pam Sagness: No this came out of the behavioral health stakeholders group and was drafted after department's budget had been submitted.

Senator Mathern: This is well laid out in terms of community and using resources. Why wasn't it a request of the department?

Pam Sagness: We have been working with withdrawal management issues with communities over the past year and have tried to identify solutions that could be a remedy to this issue. In the discovery process, we're trying to identify what the needs are.

Senator Bowman: What are some of the successful programs why not use those rather than make a new program.

Pam Sagness: The only data that is collected comes from the public sector. We wouldn't have information available. Both outcome measures would be needed for anyone receiving this funding. We want to work with Corrections, to have this be part of their curriculum. It needs funding for the initiation of that project.

Dan Hannaher, Legislative Affairs Director, Sanford Health:
Testified in favor of SB 2046.

Bruce Murry, APT Inc. Marriage and Family Therapists: Testified in favor of SB 2046.

Subcommittee: Senator Kilzer Senator Erbele, Senator Mathern.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2046
2/17/2015
Job # 23997

Subcommittee
 Conference Committee

Committee Clerk Signature

Donald Mueller for Blue DeZor

Explanation or reason for introduction of bill/resolution:

A Subcommittee hearing for Department of Human Services (Medical Assistance)

Minutes:

"Click to enter attachment information."

Senator Kilzer called the subcommittee to order on Tuesday, February 17, 2015 at 3:00 pm in the harvest Room in regards to SB 2046.

Present: Senator Kilzer, Senator Mathern, Senator Erbele
Michael Johnson, Legislative Council
Lori Laschkewitsch, OMB

Senator Kilzer asked if the Licensed Marriage and Family Therapists is a new service.

Maggie Anderson, Department of Human Services, stated it will be a new provider group that would be enrolled under Medicaid to deliver services. We currently enroll Licensed Independent Clinical Social Workers (LICSW's) Licensed Professional Clinical Counselors (LPCC), Licensed Addiction Counselors (LAC), who can provide group and individual therapy. We do not currently enroll Licensed Marriage and Family Therapists. Section 1 would direct the Department of Human Services to now enroll them, and they would be able to provide services within their scope of practice and bill Medicaid for reimbursement. Maggie Anderson (DHS) further explained that this section was amended by the Senate Human Services Committee primarily because it used language such as the department shall adopt rules to, and it also included LPCC's, but we already enroll LPCC's, so they removed that language. The intent was to have the Licensed Marriage and Family Therapists as another option for behavioral health services for clients.

Senator Kilzer asked if the stakeholder group was strongly supportive of this bill.

Senator Mathern stated that there was a general concern that there were not enough counselors located around the state for mental health and substance abuse. The Licensed Marriage and Family Therapists described that their scope of practice does include providing that type of service.

Senator Kilzer was it really not enough providers, or was there a perceived need? Senator Kilzer stated he doesn't think this would make any difference in the number of providers if this is passed.

Senator Mathern responded that the testimony heard in the interim was that as this group of professionals was not within the Medicaid profession as a list of approved providers. In some communities, they were not able to offer the service because they couldn't be reimbursed for services. The thought is that there are some of the Licensed Marriage and Family Therapists around, and if we reimbursed them like we do the other professions, they would come into the system and provide services where there are inadequate providers today. They described their scope of practice. There was also discussion that many of the substance abuse and mental health issues are many times family related. They are not just a diagnosis of a person who is ill; it may be that the family unit may need some intervention. The Licensed Marriage and Family Therapists focus on the family system versus an ill person in the family.

Senator Mathern continued reviewing the bill. Section 1 tells the Department of Human Services to enroll the Licensed Marriage and Family Therapists as providers and section 3 is stating the additional funds to pay those new providers. Sections 1 and 3 work as companions and don't work without being together.

Senator Erbele asked if Section #2 can be dropped.

Senator Mathern responded that section #2 could be separate from the other sections. He suggested that we hear what section #2 looks like after the Department of Human Services completed their work. It likely represents the greatest need.

Ms. Pam Sagness, Department of Human Services, referred to some of the information provided in her original testimony. This is in reference to when she worked with the subcommittee of public and private providers, the addiction counselors association treatment providers coalition, the department of corrections, to provide some clarity as to the intent of the funding and how it could be utilized in the state. The committee focused on gaps and not enhancements to the system. One of these gaps is substance abuse detox, both medical and social. She referred to an assessment from Region 7 that was provided previously to the committee that overviews the issues regarding detoxification services, otherwise known as withdrawal management. The key area of focus was on training and policy issues relating to if an individual is in need of medical or social detox, there are limited services across the state. Law enforcement is left with very few options other than law enforcement placements. The correctional centers are not licensed medical or social detox centers, and as a result, deaths have occurred. The department is looking to be able to utilize a sustainability plan so that this funding would be able to provide the initial training for correctional officers and ongoing training through a partnership or collaboration with the department of corrections to insure that people are referred to the appropriate level of care whether they need medical or social detox.

Senator Erbele stated that part of the Governor's budget, including increase in bed capacities with the specific purposes of reducing the incarceration rates, is there something doubling?

Ms. Sagness clarified that his would be in addition to assistance for having the bed space for social and medical detox. Social detox beds are full most of the time, and there is very limited capacity. The focus of this funding would address the issues in the systems outside of that. For example, correctional centers working with the Department of Corrections; hospitals, law enforcement, and ensuring the community supports are available. It really is a community issue, and the recommendations from the report focus on community solutions outside just the Department of Human Services.

Senator Mathern asked the \$3,000,000 left in Section 2, how many regions of the state does this apply to?

Ms. Sagness answered that this would be a pilot project that could be available to communities that are ready to deal with the withdrawal management issues. It could certainly be piloted in several regions or with training to correctional officers, could be a statewide approach and would have an impact across the state. There are opportunities for targeted focus on withdrawal management issues, but also some overall statewide training.

Senator Mathern continued your assessment of Region 7 is just an example of a need in a region. It is not a description of where the money would specifically go.

Ms. Sagness that is correct. This is just an assessment of one region. We are aware that all regions within the state have this issue.

Senator Kilzer closed the subcommittee hearing for SB 2046.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2046
2/18/2015
Job # 24089

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A BILL for an Act relating to medical assistance coverage for certain behavior health services (DHS) (Do Pass as Amended)

Minutes:

Testimony # 1

Chairman Holmberg called the committee to order on Wednesday, February 18, 2015 in regards to SB 2046. All committee members were present. Michael Johnson, Legislative Council and Lori Laschkewitsch, OMB were also present.

Senator Erbele moved the amendment # 15.0230.04001, Testimony Attached # 1. **2nd by Senator Mathern.** Senator Erbele stated he would just read the statement of purpose. He explained the amendment.

Senator Mathern: One aspect it kind of simplifies the bill so it just deals with marriage and family therapy and then it is going to move that other piece over to the next bill. One thing that's quite a loss in these amendments is eliminating their training for HP, but in our bigger discussion on how many dollars were available, it appeared that \$25,000 just was not enough to make a big difference and it really got to be a complicating factor where we're spending all our time trying to figure that piece out and then not figuring out the \$3M piece. It's a simplification of the bill

Chairman Holmberg: all in favor of the amendment say aye. It carried. Now can we have a motion on the bill?

Senator Erbele moved Do Pass as Amended on SB 2046. 2nd by Senator Mathern.

Chairman Holmberg: Call the roll on a Do Pass as Amended on SB 2046.

A Roll Call vote was taken. Yea: 13; Nay: 0; Absent: 0. This goes back to Human Services and Senator Judy Lee will carry the bill.

The hearing was closed on SB 2046.

2
18/15

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2046

Page 1, line 2, remove "; to"

Page 1, line 3, remove "provide for reports to the legislative management"

Page 1, line 3, replace "appropriations" with "an appropriation"

Page 1, remove lines 12 through 23

Page 2, remove lines 8 through 12

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment removes sections 2 and 4 of the engrossed bill which would have provided a \$3 million general fund appropriation to the Department of Human Services for substance abuse treatment services and a \$25,000 general fund appropriation to the Highway Patrol for mental health first-aid training for state and local law enforcement personnel.

Date: 2-18-15
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2046

Senate Appropriations Committee

Subcommittee

Amendment LC# or Description: 15,0230,04001

- Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
Other Actions: Reconsider _____

Motion Made By Erbele Seconded By Mathern

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Heckaman		
Senator Bowman			Senator Mathern		
Senator Krebsbach			Senator O'Connell		
Senator Carlisle			Senator Robinson		
Senator Sorvaag					
Senator G. Lee					
Senator Kilzer					
Senator Erbele					
Senator Wanzek					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

*voice vote,
Carried*

Date: 2-18-15
 Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
 BILL/RESOLUTION NO. 2046

Senate Appropriations Committee

Subcommittee

Amendment LC# or Description: _____

- Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
- Other Actions: Reconsider _____

Motion Made By Erbele Seconded By Mathern

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Heckaman	✓	
Senator Bowman	✓		Senator Mathern	✓	
Senator Krebsbach	✓		Senator O'Connell	✓	✓
Senator Carlisle	✓		Senator Robinson	✓	
Senator Sorvaag	✓				
Senator G. Lee	✓				
Senator Kilzer	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Human Sew. Judy Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2046, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2046 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "; to"

Page 1, line 3, remove "provide for reports to the legislative management"

Page 1, line 3, replace "appropriations" with "an appropriation"

Page 1, remove lines 12 through 23

Page 2, remove lines 8 through 12

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment removes sections 2 and 4 of the engrossed bill which would have provided a \$3 million general fund appropriation to the Department of Human Services for substance abuse treatment services and a \$25,000 general fund appropriation to the Highway Patrol for mental health first-aid training for state and local law enforcement personnel.

2015 HOUSE HUMAN SERVICES

SB 2046

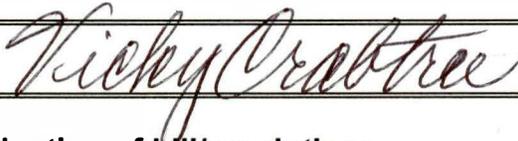
2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2046
3/9/2015
Job # 24505

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services.

Minutes:

Testimonies 1-5

Chairman Weisz opened the hearing on SB 2046.

Alex Cronquist: From Legislative Council provided information about the bill. (He read from the bill.)

Chairman Weisz: (Recorder not working. No audio)

Rep. Peter Silbernagel: From District 22 testified in support of the bill. (Recorder not working. No audio.)

Chairman Weisz: On Section 1 of the original bill it included licensed professional clinical counselors that part has been removed.

Rep. Silbernagel: I can't answer the history on that. I do know there is an effort to clarify definitions of behavioral health professions.

Chairman Weisz: On Section 4 of the original bill where you indicated it took the \$25,000 out. Does there need to be language from a policy standpoint of directing the highway patrol within their budget?

Rep. Silbernagel: I think there would be an intentional effort to educate and train the highway patrolman as well as safety individuals. There is similar effort in the DPI budget to educate and train teachers on that kind of background as well.

1:55

Pam Sagness: From DHS. To answer your earlier question about the removal of the licensed clinical social workers; they are previously covered.

2:11

Kristen Benson: Testified in support of the bill. (See Testimony #1)

9:20

Chairman Weisz: I know you get reimbursed from Minnesota. How does the reimbursement rate compared to other professions within the mental health?

Benson: I can't say for Minnesota. I don't know the answer to the question, but typically it is set by the program and that is what the service is reimbursed regardless of the licenses if they are classified as a behavioral mental health professional.

NO OPPOSITION

Chairman Weisz: Can I get a question answered on the fiscal note from the department?

Eric Elkins: Director of Medical Services.

Chairman Weisz: Are you assuming there will be an increase in services provided?

Elkins: Yes, we looked at utilization of claims for a similar type of provider, licensed independent clinical social workers to build this fiscal note. So we assume there will be an increase.

Chairman Weisz: The reimbursement rate would be the same.

Elkins: Correct.

Rep. Rich Becker: I'm curious as to the timing of this bill. Services have been in demand and obviously evidence to support it so why is it just coming into this legislative session?

Elkins: I believe it was brought up last session as well and it was defeated. I don't know why it has taken to now to get through as far as it has this session.

Kristen Benson: LMFTs are one of the last mental health providers to be licensed in the state of ND. They are just credentialed in ND in 2007 and the licensure laws went into effect in the last couple of years and that's part of the reason that it has taken a while for this to be recognized.

Chairman Weisz closed the hearing on SB 2046.

Testimony in support that was handed in:

Jennifer Eberle, LPC,NCC (See Testimony #2)

Tom Stone Carlson, PhD., LMFT, Christi R. McGeorge, PhD, LMIT (See Testimony #3)

Joy Ryan, Executive Vice-President of The Village (See Testimony #4)

Joni Medenwald, MSW, LICSW (See Testimony #5)

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2046
3/30/2015
Job #25578

- Subcommittee
 Conference Committee

Committee Clerk Signature



Minutes:

Chairman Weisz took up SB 2046. (No audio for part of the meeting.)

Rep. Fehr: Why is there an appropriation?

Chairman Weisz: It is part of the bill. The Senate wanted to insure this was going to be funded and added to the Appropriations budget.

Rep. Seibel: I personally think this is a good bill and I motion a Do Pass on SB 2046 and re-referred to Appropriations.

Rep. Fehr: Second.

(Audio starts at vote.)

ROLL CALL VOTE: 12 y 1 n 0 absent

Bill Carrier: Rep. Seibel

Date: 3-30-15
 Roll Call Vote #: 1

**2015 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2046**

House Human Services Committee

Subcommittee

Amendment LC# or Description: _____

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
 Other Actions: Reconsider _____

Motion Made By Seibel Seconded By Fehr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz		✓	Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen		
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Seibel

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2046, as reengrossed: Human Services Committee (Rep. Weisz, Chairman) recommends DO PASS and BE REREFERRED to the Appropriations Committee (12 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed SB 2046 was rereferred to the Appropriations Committee.

2015 HOUSE APPROPRIATIONS

SB 2046

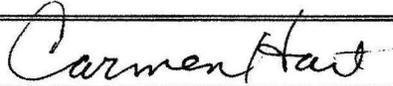
2015 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

SB 2046
4/3/2015
25803

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota century code, relating to medical assistance coverage for certain behavioral health services; and to provide an appropriation.

Minutes:

"Click to enter attachment information."

Chairman Jeff Delzer: Opened the meeting.

Representative Robin Weisz: 2046 adds licensed family and marriage therapists into the mix for Medicaid reimbursement. It has a fiscal note of roughly \$124,000. If we add them into the Medicaid mix, there will be more people that are utilizing the services that they already qualify for.

Chairman Jeff Delzer: How are they being paid now?

Rep. Weisz: They are not getting the services.

Chairman Jeff Delzer: They are not getting reimbursed from Medicaid. Are the individuals paying them or is their insurance paying them? Do they qualify for any insurance coverages?

Rep. Weisz: They are being paid through the private sector right now.

Chairman Jeff Delzer: Do we have a problem where nobody is being able to be served with the regular community?

Rep. Weisz: They are being served in the regular community, but people that qualify for Medicaid probably can't afford to pay the services, so that is why we qualify them for Medicaid.

Chairman Jeff Delzer: Are there any other counselors that are currently paid from Medicaid where they can go and receive services, and are they so overwhelmed that they can't get into it?

Rep. Weisz: Yes, they are. There are just not services available in many parts of the state for the demand that there is, the human service centers who often times aren't able to handle.

Chairman Jeff Delzer: How many of these do we have in the state compared to other services, and why would they be willing to take Medicaid if others don't want to take it?

Rep. Weisz: It isn't a matter that others don't want to take Medicaid. It is a matter of being overwhelmed with the number of professionals that are available to deal with behavioral health. I believe there are roughly 35 that are licensed in the state of North Dakota. They have as much training as licensed critical social workers which qualify.

Chairman Jeff Delzer: Are they considered licensed clinical social workers?

Rep. Weisz: No.

Chairman Jeff Delzer: The only ones they can deal with are marriage?

Rep. Weisz: No, as a licensed family marriage therapist, they can provide counseling services. That is why the federal CMS has said they are eligible for Medicaid reimbursement because they fit the criteria for behavioral health counseling services.

Chairman Jeff Delzer: It is \$250,000; how did they come up with that number?

Rep. Weisz: We asked and, of course, they would probably tell you it's a shot in the dark. They are making a guess on how many more aren't being served based on the number of licensed family marriage therapists.

Chairman Jeff Delzer: Doesn't say how many. It just gives a dollar figure.

Rep. Weisz: It's a guess. Again, these clients already qualify so we are not expanding those that qualify. Now you just have to try to make a guess of a number that are receiving services that they qualify for that would get them provided now by the addition of adding these within the pool of professionals who can already be reimbursed for Medicaid for providing the services.

Representative Nelson: Did the senate try and guess too, or was there a different number?

Rep. Weisz: As far as I know, this was the only fiscal note. The number in the engrossed version was put in as an appropriation.

Representative Nelson: This isn't the first crack at this.

Rep. Weisz: No. In the original bill they just appropriated, I believe, \$3 million. What is in front of you is allowing licensed family and marriage therapists to be reimbursed for Medicaid. It is strictly adding them as being a payer. It had the direct appropriation for \$124,000 which was a guess.

Representative Silbernagel: The intent of this bill is to compliment the professions that are out there, primarily the social workers which there are a shortage across the state and trying to backfill or expand that workforce.

Rep. Weisz: That has been the testimony in several of the bills we have had all session. There is a critical shortage of behavioral health professionals. We sent out a bill earlier having to do with adding loan repayment for behavioral health professionals. This is intended to address that shortage of professionals to deal with the demand for services.

Representative Bellew: Did you just talk about outcomes? Are we going to save money in the long run? Can we quantify anything like this? We are adding services, but I didn't see the outcome portion of it. There should be savings somewhere.

Rep. Weisz: We are not adding services. This adds a provider who is qualified to provide services that these people already qualify for. This bill does not expand income levels or anything else.

Chairman Jeff Delzer: Then there should not be any cost. We should maybe pass it without any appropriation?

Rep. Weisz: If you don't have enough providers to provide services that this body has already agreed to provide, then you are going to have a fiscal note if you now have more providers so they can actually get the services that we already said.

Chairman Jeff Delzer: Then you are expanding services?

Representative Pollert: Couldn't there be overlap between 2041 and 2048? Healthy families might be visiting about outcomes. They will deal with children, but they are still kind of therapists. Right, or is that totally different?

Rep. Weisz: They are totally different. If we don't pass this bill, there won't be any people left that have qualified for the services that this state provides. If they have a behavioral health issue and Medicaid eligible, they are eligible to receive the services, but in many cases they are not able to get the services when needed or get them at all. This bill is adding another small piece of the professionals that are able to deal with behavioral health issues. This bill is saying if you need the services, we are here to treat them, and here is another professional that can treat the condition that you are eligible for under Medicaid.

Representative Pollert: It is possible you could have the same eligible family have those services?

Representative Skarphol: Does this not just provide the opportunity for service?

Chairman Jeff Delzer: It allows these counselors to be paid for services.

Rep. Weisz: That is correct, an opportunity that they already are eligible for and aren't getting wherever they are located because there isn't another professional that can provide.

Chairman Jeff Delzer: How are these people making a living?

Rep. Weisz: If the demand for services increase like in most areas, then you may end up having more licensed family and marriage therapists in the state to help drive our economy. They make their money by billing. This doesn't mandate that they do Medicaid services, but there are licensed family and marriage therapists that have agreed they would take on Medicaid cases and provide the services in their area.

2015 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

SB 2046
4/7/2015
25892

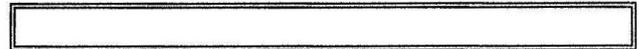
- Subcommittee
 Conference Committee



Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota century code, relating to medical assistance coverage for certain behavioral health services; and to provide an appropriation.

Minutes:



Chairman Jeff Delzer: This bill has to deal with allowing family therapist and license marriage and family therapists to take Medicaid patients and be paid by the Medicaid system. It does have an appropriation in it. I don't have the exact dollar figure but we are probably close to 2 billion dollars on the Medicaid line on SB 2012. I do not believe we need to have the appropriation in there but I do think we may have a valid opportunity to expand services a little bit if we allow the language in section one of the bill.

Representative Nelson: I move a Do Pass.

Representative Silbernagel: Seconded.

Chairman Jeff Delzer: If we are going to do a Do Pass with the money in it I cannot support the bill. If we want to take the money out because I don't think we need to have it in the budget then I could support the bill.

Representative Pollert: If you want to have a discussion now or wait a little bit that would be fine, but it is pertaining to what is happening here too as well. I don't know if they want to continue on or if you want me to talk about it because it also deals with a separate bill.

Chairman Jeff Delzer: Go ahead and discuss it and see if you can change anybody's mind. We do have a motion for a do pass with the money in it.

Representative Pollert: I am not very persuasive at anything but I'll try. There is in 2048 a FTE if that FTE stays in 2048 it could be said that that would help the department to administer this funding is out.

Chairman Jeff Delzer: When I look at this bill I don't see anything with needing services. This is strictly the money to pay for it on the Medicaid general fund side and again I don't believe there will be money in the budget to cover this much. I can support the bill without the money in it

Representative Pollert: I am the same way too I am just bringing up the other FTE because I think that is going to be an issue just like anything else. When we did autism we had an FTE and granted another one this session, well this behavior health isn't going to be any different and I look at this as part of the behavior of health.

Representative Nelson: I move to substitute that motion with a Do Pass with Section 2 removed.

Representative Silbernagel: Second.

Motion for a Do Pass with Section 2 removed.

Motion made by Representative Nelson.

Seconded by Representative Silbernagel.

Total yes 20. No 1. Absent 2.

Floor assignment Representative Nelson.

15.0230.05001
Title.06000

Prepared by the Legislative Council staff for
House Appropriations Committee
April 8, 2015

SLC
4/8/15

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2046

Page 1, line 2, remove the semicolon

Page 1, line 3, remove "and to provide an appropriation"

Page 1, remove lines 12 through 18

Re-number accordingly

REPORT OF STANDING COMMITTEE

SB 2046, as reengrossed: Appropriations Committee (Rep. Delzer, Chairman)
recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends
DO PASS (20 YEAS, 1 NAYS, 2 ABSENT AND NOT VOTING).
Reengrossed SB 2046 was placed on the Sixth order on the calendar.

Page 1, line 2, remove the semicolon

Page 1, line 3, remove "and to provide an appropriation"

Page 1, remove lines 12 through 18

Renumber accordingly

2015 CONFERENCE COMMITTEE

SB 2046

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2046
4/15/2015
26146

Subcommittee
 Conference Committee

Committee Clerk Signature

Emmery Beotherg

Donald Mueller

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for certain behavioral health services; to provide for the development of an outcomes-based data system for behavioral health services; to provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to provide for a legislative management study.

Minutes:

Attachments: n/a

The following conference committee members were present for SB 2046 on April 15, 2015, 3:30pm.

Senator Larsen, Senator J. Lee, Senator Axness
Representative Bellew, Representative Silbernagel, Representative Holman

Senator Oley Larsen asked the Representatives to explain their amendments to the bill.

Representative Bellew: It was our belief that the most important part of the bill was line 7 through 11. Since we worked on the human services budget, we know there is money in there for them to do this so we didn't think the appropriation was appropriate. That's why removed it and that's the remainder of the bill.

Representative Silbernagel: I think the key component is trying to grow the workforce and needing additional folks in the field to help address some of the mental and behavioral health issues that are out there. We are not up to speed as far as workforce goes, by allowing Licensed Marriage and Family Therapists to provide some of the services and to be paid for some of those services goes to meeting some of those needs across the state. I think our budget in human services side, there is a lot of money related to Medicaid and many of these reimbursements would apply to that.

Senator J. Lee: To clarify further, we recognize based on what the Department of Human Services people told us that there would be \$125,000 needed for the number of workers that they were projecting using and then there was a federal match for that. What I'm hearing you say is that because it would be an approved provider, they would be eligible to the big pool, correct? So what you're saying is that you are not going to add the money in

because they are additional providers. So there is a potential for us to run out of money in the pools and then they would have to go to the budget section and perhaps apply for deficiency appropriation in the next session if this entitlement goes beyond the budgeted dollars because you are not adding the extra dollars in to what this additional provider would require.

Representative Bellew agreed. We also have to realize that the Department of Human Services budget \$3,500,000,000. There is \$124,000 or \$250,000 in there to service these people.

Senator J. Lee: Well it would be \$124,000 in general fund because if we don't authorize that, we don't get the extra \$124,000 from the federal match.

Senator J. Lee said she was happy that the House did agree that the Licensed Marriage and Family Therapists can help to expand the workforce. Recognizing that the services can be performed and if there is a shortfall, that services don't end but continue the way we described.

Senator J. Lee moved the SENATE ACCEDE TO HOUSE AMENDMENTS on SB 2046. The motion was seconded by **Senator Axness**.

Discussion

The committee members did a final review of the bill.

Roll Call Vote

Senators: 3 Yes, 0 No, 0 Absent

Representatives: 3 Yes, 0 No, 0 Absent

Motion passes 6-0-0.

Senator J. Lee will carry SB 2046 to the Senate floor.

Representative Silbernagel will carry SB 2046 to the House floor.

**2015 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES**

BILL/RESOLUTION NO. SB 2046 as reengrossed

Senate "Enter committee name" Committee

- Action Taken **SENATE accede to House Amendments**
 SENATE accede to House Amendments and further amend
 HOUSE recede from House amendments
 HOUSE recede from House amendments and amend as follows
- Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen. Lee Seconded by: Sen. Axness

Senators	15			Yes	No	Representatives	15			Yes	No
Sen. Larsen	X			X		Rep. Bellew	X			X	
Sen. Lee	X			X		Rep. Silbernagel	X			X	
Sen. Axness	X			X		Rep. Holman	X			X	
Total Senate Vote				3	0	Total Rep. Vote				3	0

Vote Count Yes: 6 No: 0 Absent: 0

Senate Carrier Sen. Lee House Carrier Rep. Silbernagel

LC Number _____ of amendment

LC Number _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

REPORT OF CONFERENCE COMMITTEE

SB 2046, as reengrossed: Your conference committee (Sens. Larsen, J. Lee, Axness and Reps. Bellew, Silbernagel, Holman) recommends that the **SENATE ACCEDE** to the House amendments as printed on SJ page 1316 and place SB 2046 on the Seventh order.

Reengrossed SB 2046 was placed on the Seventh order of business on the calendar.

2015 TESTIMONY

SB 2046

Attach # 1
SB2046 01/14/15
J# 21959

Testimony in support of
SB 2046
January 15, 2015
By Kathy Hogan, Rep. District 21

Chairman Lee and members of the Senate Human Service Committee, my name is Kathy Hogan, I represent District 21 and I have been a member of the Behavioral Health Stakeholder group.

SB 2046 addresses a range of recommendations from Ms. Schulte and the Behavioral Stakeholder recommendations.

Section 1 - Expands Medicaid coverage to licensed marriage and family therapists. The training for this licensure parallels other Master Level's programs and would address some of the workforce challenges

Section 2 Addresses the need to improve the quality and quantity of behavioral health data. I have attached a proposed agenda to make this issue a collaborative approach with both the Department of Human Services and Private providers.

Section 3 Addresses the limited access to substance abuse services through the expansion of services including withdrawal management services (previously called detoxification services). The Behavioral Health Stakeholders- Children's Mental Health subcommittee felt that it was critical that prior to adding funding to services, a common vision/structure for Children's behavioral health be developed. Attached is a preliminary draft of a potential Vision and bill amendment for consideration. This could be either included as legislative intent or as an amendment.

Section 4. Addresses the need to train state and local law enforcement on mental health interventions. The fiscal note on this section is probably significantly higher than originally budgeted.

1.2

[Handwritten initials]

Section 5. Recognized that the Behavioral Health Needs in ND will take at least four to six years to fully address.

Thank you considering comments and amendments. I am more than willing to answer any questions.

Comprehensive Collaborative System of Behavioral Health Care A Vision for the Future

Children are North Dakota's most important resource. Currently many children in North Dakota face serious behavioral health challenges that are unmet. Those unmet needs result in children in juvenile court, children being placed out of home or state inappropriately and increased school dropout rates.

These challenges are best addressed through a community based family focused approach that begins with early identification of concerns, standardized screening and assessment, family and school based supports and a range of therapy, case management, training and support services that are available and accessible to address the unique needs of each child/family.

The process of developing a comprehensive behavioral health system for children will take strong state and local leadership, a commitment to collaboration across public and private organizations and four to six years to fully implement.

Key Principles:

Begin with the families and schools

- Train parents on behavioral and emotional health needs of children
- Train all teachers/child care in mental health first aid
- Expand counseling/mental health resources in the schools through funding for elementary school counselors and/or school based mental health professions.

Strengthen systems networking

- Strengthen local community collaboration between schools, providers (public and private), health care professionals, residential providers, child welfare, faith communities and juvenile court to assure that various partners use common tools, language and systems.

Establish clear definitions and data systems for services and to identify unmet needs

- Use evidence based practices across systems if feasible
- Reduce duplications in assessments/simplify referral process
- Strengthen cross systems movement of child from medical, schools, residential
- Increase child centered/family focused model at every level of care.

Expand service availability based on data

- Increase the availability of case management services for behavioral health issues
- Increase access to less restrictive therapeutic treatment options such as in-home care services, respite. Intensive in-home therapy and targeted transitional services and school based day treatment
- Increased social support systems such as peer support, family support and mentoring like Big Brother Big Sister
- Increase access to specialized services such as child psychiatric services through telemedicine.
- Expand targeted residential services to reduce out of state placements.

IT IS EXTREMELY EXPENSIVE TO DO NOTHING

1.4

15.0230.03001
Title.

Prepared by the Legislative Council staff for
Representative Hogan
January 12, 2015

PROPOSED AMENDMENTS TO SENATE BILL NO. 2046

Page 1, line 16, after "services" insert ", in collaboration with private behavioral health providers,"

Page 2, line 3, after the period insert "The funds provided for youth substance abuse treatment services must be used to begin implementation of a comprehensive collaborative system of behavioral health care."

Renumber accordingly

Attach#2

01/14/15



SB 2046 J# 21959

**Senate Human Services Committee
Sen. Judy Lee, Chair
Jan. 14, 2015
SB 2046**

Chairman Lee and Committee members: My name is Cheryl Huber. I am a board-certified psychiatrist at Sanford Health in Bismarck. Thank you for the opportunity to share with you today, on behalf of Sanford Health, our gratitude and support for the important work you are leading to improve our state's behavioral health system.

Because I am not able to testify in person for each of the behavioral health bills being considered in the coming weeks, please let me state that as a general statement our team values this important work and welcomes the opportunity to work with you to advance initiatives designed to improve access to quality, affordable behavioral health care in North Dakota.

In the years that I've worked in North Dakota, the number of inpatient mental health beds and providers—psychiatrists, therapists, other professionals with mental health expertise—have declined while the population has increased. The influx of people from other states who are accustomed to easy access to mental health treatment, geographically and in quantity, has taxed an already strained system.

As an example, this week there have been no mental health beds in the state of North Dakota. On Tuesday I fielded calls from Dickinson, Williston, Minot, Fargo and the Standing Rock Sioux Tribe Reservation about accepting patients from other facilities with no available beds or services. Equally challenging, when patients who have been hospitalized return to their homes, there are a limited number of outpatient service providers in the rural areas and little transportation services to the larger cities where more professionals practice. This problem is not limited to mental health but includes substance abuse and the large overlap between these two domains.

A few suggestions for your consideration in your discussions to improve access to mental health and substance abuse treatment for the people of North Dakota:

Our Mission:
Dedicated to the work of
health and healing

- Funding for more residential beds operated by the area human services centers. These would allow people to be released from the hospital faster to a “step down” level of care before returning to their homes.
- There are adequate numbers of professionals who can prescribe psychotropic medication when you look at primary care physicians, psychiatrists, and advance practice nurses, but they are clustered in the larger cities. Use of telemedicine services would allow these services to be extended to rural areas, increasing both access and convenience for patients.
- Qualified experienced therapists (e.g. psychologists and social workers) are in short supply. Increasing the supply of therapists and “health coaches” (nursing and counseling professionals with additional training) and “recovery coaches” (lay people with additional training) would help extend mental health and substance abuse services. Use of telemedicine services for therapy would increase access to mental health services as well.

Thank you for your leadership on these critically important issues. If you have any questions I could answer those now.

Again, thank you. Please feel free to contact our team if you have questions or need more information.

SB2046
01/14/15
J# 21959
Attach 3

Senate Bill 2046
Senate Human Services Committee
Judy Lee, Chairman
January 14, 2015

Madam Chairmen Lee and members of the Senate Human Services Committee:
Thank you for the opportunity to provide my testimony again today in support of North Dakota marriage and family therapists. Please allow me to reintroduce myself. My name is Emily Coler Hanson and I am a licensed marriage and family therapist (LMFT). I work at Prairie St. John's in Fargo as a child and adolescent therapist in the partial hospitalization program for kids on the autism spectrum. I have also worked for the Village Family Service Center in the past as an in-home therapist and for Southeast Human Service Center both as a Partnerships Care Coordinator and as a Transition Facilitator. I serve as the President of the North Dakota Association of Marriage and Family Therapists, and I am currently working on national accreditation to supervise newly licensed marriage and family therapists.

LMFT's are already included in the century code as a professional license and association (Code 43-53), yet other sections of the Century Code were not changed to reflect this law and, therefore, limit these families' access to proper—and qualified—mental health care. The law should be consistent with what has already been passed and approved. Including LMFT's in medical assistance reimbursement will provide families with additional options for qualified providers and improve treatment outcomes by incorporating a multidisciplinary approach. Simply put, this is an opportunity to expand access to approved, professional care in an area of great need for many North Dakota families.

Federal rules allow for LMFT's as providers for medical assistance and currently 38 states have reimbursement for LMFT's in their medical assistance programs. As we have other areas of the legislature that are looking at reciprocity standards in care, it is important that we consider this particular bill as more people continue to move into our state. Including LMFT's in medical assistance reimbursement also complies with recommendations from the Schulte Report.

The qualifications, training and scope of practice for LMFTs may be unclear, so I would like to this opportunity to clarify. Starting with education, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) Educational Guidelines specifically state that the student's clinical knowledge include *traditional psychodiagnostic categories, and the assessment, diagnosis and treatment of major mental health issues*. North Dakota Administrative Code (111-02-02-02) requires that as part of the LMFT educational training students have nine semester hours in *human development, human behavior, personality theory, human sexuality, psychopathology, which includes the diagnosis of mental illness and behavior pathology*. The North Dakota Century Code (43-53-01) includes that *Marriage and family therapy involves the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders*.

In addition, the licensing standards require an even number of therapy hours with individuals as couples and families of supervised practice in order to meet licensure requirements. Providing care to individuals is in no way dismissed or not included in LMFT training and practice, and it is on par with couples and families. As the century code and training requirements already outline our qualifications for licensure and practice, the argument against this seems irrelevant, as this is already clearly established within the law.

I am hopeful that this clarifies for exactly how LMFT's are qualified to work with individuals and to diagnose individual mental disorders, and that any previous misinformation you were given does not hinder your decision to support this bill or others relating to the care provided by LMFT's. Again, this is an opportunity to expand access to mental health care for all North Dakotans at a time when the need is not only great, it is growing due to a growing population.

On behalf of my fellow mental health professionals, I am strongly encouraging you to pass Senate Bill 2046 and other bills supporting the LMFT profession in ND.

I thank you for the opportunity to testify before you today.

Please feel free to contact me if you have any further questions.

Emily Coler Hanson, M.S., LMFT, CGP

701-367-3054

Emily.colerhanson@uhsinc.com

Attach #4 SB 2046
01/14/15 J# 21959

**Testimony of Kristen E. Benson, Ph.D.; Christi R. McGeorge, Ph.D.; and Tom Stone Carlson, Ph.D. before the Health and Human Services Committee
Tuesday, January 13, 2015 and Wednesday, January 14, 2015**

We are providing testimony in support of passing Senate Bill 2049 and 2046, which will classify Licensed Marriage and Family Therapists (LMFT) as mental health professionals who are able to provide diagnosis, evaluation, and treatment services covered by Medical Assistance. We are all designated as Approved Supervisors and Clinical Fellows by the American Association for Marriage and Family Therapy (AAMFT) and faculty in the North Dakota State University Couple and Family Therapy program. We would like to address Marriage and Family Therapists (MFT) scope of practice, training standards and preparation, and current federal coverage. It is important to note that current North Dakota Century Code establishes that licensed Marriage and Family Therapists are qualified to diagnosis, assess, and treat all mental health disorders (*See the attached section of the ND Century Code*). The current ND administrative rules also specify that in order to qualify for state licensure, MFTs must demonstrate that they have completed course work specifically related to diagnosis and assessment of mental health disorders (*See the attached section of the ND Administrative Rules for MFT*). Finally, MFTs are licensed in all 50 states and the District of Columbia.

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), which is recognized by the Department of Education as the national accrediting agency for clinical training programs in marriage and family therapy, maintains rigorous standards for marriage and family therapy training (*See attached accreditation standards highlighting required education related to diagnosis and assessment*). In addition to coursework that covers mental health diagnosis and assessment, theories, clinical skills, ethics, and research, students complete a total of 500 face-to-face hours of direct therapy with individuals, couples, and families. Of these 500 hours, at least 250 hours must be with couples and families, which is unique to Marriage and Family Therapy as it is the only discipline that requires clinical hours with couples and families. Students typically graduate with at least 250 direct therapy hours with individuals, which is often times more clinical experience with individuals than graduates of programs from other mental health disciplines. It is important to note that marriage and family therapy training programs count clinical hours differently than all other mental health disciplines; MFT students are only allowed to count actual time in the therapy room with clients. Other disciplines allow students to count all hours in their clinical experience, including paperwork, supervision, phone conversations, educational

conferences, etc. If marriage and family therapy students were allowed to count all of these activities than their overall clinical experience would amount to over 3,000 hours. Additionally, for every 5 hours of therapy students provide, students must receive a minimum of 1 hour of supervision with an AAMFT approved supervisor. Supervision includes both case report and observation of live clinical work by way of video recording, audio recording, and from behind a one way mirror.

Marriage and Family Therapy Core Competencies were developed in 2004 in an effort to ensure that LMFTs are prepared to work within the larger mental health system. While there are 128 competencies, the primary domains of the core competencies include 1) Admission to Treatment; 2) Clinical Assessment and Diagnosis; 3) Treatment Planning and Case Management; 4) Therapeutic Interventions; 5) Legal Issues, Ethics, and Standards; and 6) Research and Program Evaluation. More specifically, in addition to their advanced expertise in relationship dynamics, the core competencies ensure that LMFTs are able to conduct tasks that all mental health clinicians would be expected to do, for example, mental health assessment and suicide assessment. For example, the diagnosis course at NDSU involves a thorough review of the *Diagnostic and Statistical Manual* (DSM, the official handbook of mental diagnoses) and requires master's students to demonstrate competence in the diagnosis and assessment process. As a profession, LMFTs value comprehensive training that prepares practitioners to work effectively with clients who face a wide range of concerns, from mental health diagnosis such as depression and anxiety to parent-child dynamics.

At the federal level, LMFTs are currently authorized as one of the five core providers of mental health services as recognized by the Health Resource Administration (HRSA), which includes marriage and family therapy, psychiatry, clinical psychology, clinical social work, and psychiatric nursing. The federal government recognizes Marriage and Family Therapy in nine primary capacities; through the Department of Veterans Affairs, the Department of Defense, the Department of Education School Early Intervention Services, the National Health Service Corps (NHSC), the Department of Transportation Substance Abuse Program, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT), and Indian Health Services. The recognition of LMFTs by these notable federal agencies reflects the competence of the profession to diagnose and treat a range of conditions for individuals, couples, and families. Thank you for your consideration.

Marriage and Family Therapist Training Requirements and Competence in Assessment and Diagnosis of Mental Health and Behavioral Disorders

North Dakota Century Code

<http://www.legis.nd.gov/cencode/t43c53.pdf?20150112163239>

CHAPTER 43-53

MARRIAGE AND FAMILY THERAPY PRACTICE

43-53-01. Definitions.

5. "Marriage and family therapy" means the *diagnosis and treatment of mental and emotional disorders*, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Marriage and family therapy involves the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to *individuals*, couples, and families *for the purpose of treating such diagnosed nervous and mental disorders*.

North Dakota Administrative Code

<http://www.legis.nd.gov/information/acdata/pdf/111-02-02.pdf?20141216113922>

History: Effective July 1, 2010.

General Authority: NDCC 28-32-02, 43-53-05

Law Implemented: NDCC 43-53-06

111-02-02-02. Educational requirements - Determination of equivalent degree

Administrative Rule 111 2.a

a. Nine semester hours in human development covering human development, human behavior, personality theory, human sexuality, *psychopathology including the diagnosis of mental illness, and behavior pathology*;

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) Educational Guidelines

http://www.aamft.org/imis15/Documents/COAMFTE/Accreditation%20Resources/Accreditation%20Standards_Version%2011_style%20update%202013.pdf

102. Area II: Clinical Knowledge

102.01 Area II content will address, from a relational/systemic perspective, psychopharmacology, physical health and illness, *traditional psychodiagnostic categories, and the assessment, diagnosis and treatment of major mental health issues*.

Attach #5 SB2046
01/14/15
J# 21959

Senate Bill 2046

Senate Human Services Committee

Judy Lee, Chairman

January 14, 2015

Madame Chairman Lee and members of the Human Services Committee:

My name is Barbara Stanton. I am employed by Prairie St. John's and specialize in working with children and adults on the autism spectrum and their families/caregivers. I am submitting this testimony in support of **SB 2046** specifically the section related to the payment for behavioral health services provided to recipients of medical assistance by marriage and family therapists.

My master's degree is from North Dakota State University in child development family sciences specializing in marriage and family therapy. At that time North Dakota did not license marriage and family therapists so instead I was licensed as a Professional Clinical Counselor (LPCC). Now I am a Licensed Marriage and Family Therapist (LMFT) and am an approved supervisor for marriage and family therapists in the state of North Dakota.

This unique program taught me how to effectively and successfully work with the complex issues presented by children, families, and systems. It also prepared me to work with individuals and multiple behavioral health issues. I was educated in theory and traditional elements of diagnosing and treatment. But beyond that, I was trained to look at the "big picture" when working with individuals and families. I was taught to look at issues from multiple perspectives, to be curious about the why something is happening, and to collaborate in order to build success.

I also have a doctorate in counseling psychology from The University of Massachusetts Amherst which was a program that was accredited by the American Association of Psychologists (APA). Of the two disciplines, family therapy continues to be the foundation for my work.

The code of ethics, requirements for supervision, comprehensive training, and the fundamental beliefs held by family therapists is what drew me to the field initially and keeps me in the profession. I am proud to identify myself as a family therapist. We consistently take interns and hire therapists with an LMFT at Prairie St. John's. We recently selected an LMFT to be the primary therapist in our new Autism Spectrum Disorder Partial Hospitalization Program due to her training, skills in diagnostics and her therapeutic skills working with children, caregivers, and systems.

Families and individuals in North Dakota with Medical Assistance should have the opportunity to choose a Licensed Marriage and Family Therapist (LMFT) who has specialized training in working with children, adults and families. Those professionals should be reimbursed for their work.

Thank you for your time in reading this and considering this important bill and the needed changes to behavioral health.

I strongly encourage you to pass SB 2046.

Attach # 6
SB2046 01/14/15
J# 21959

**CHAPTER 43-53
MARRIAGE AND FAMILY THERAPY PRACTICE**

43-53-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Advertise" includes the issuing or causing to be distributed any card, sign, or device to any person; the causing, permitting, or allowing any sign or marking in or on any building, radio, or television; or advertising by any other means designed to secure public attention.
2. "Associate marriage and family therapist" means an individual who has completed the educational requirements for a marriage and family license and who has successfully passed the licensing examination, but who has not yet successfully completed the supervised work experience requirement for licensure as a marriage and family therapist.
3. "Board" means the North Dakota marriage and family therapy licensure board.
4. "Licensed marriage and family therapist" means an individual who holds a valid license issued under this chapter.
5. "Marriage and family therapy" means the diagnosis and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Marriage and family therapy involves the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.
6. "Practice of marriage and family therapy" means the rendering of marriage and family therapy services to individuals, couples, and families, singly or in groups, whether the services are offered directly to the general public or through organizations, either public or private, for a fee, monetary or otherwise.
7. "Qualified supervision" means the supervision of clinical services, in accordance with standards established by the board, by an individual who has been recognized by the board as an approved supervisor.
8. "Recognized educational institution" means any educational institution that grants a master's or higher degree that is recognized by the board and by a regional accrediting body, or a postgraduate training institute accredited by the commission on accreditation for marriage and family therapy education.
9. "Use a title or description of" means to hold oneself out to the public as having a particular status by means of stating on signs, mailboxes, address plates, stationery, announcements, calling cards, or other instruments of professional identification.

43-53-02. Representation to the public.

Effective January 1, 2006, except as specifically provided otherwise under this chapter, only an individual licensed under this chapter may use the title "marriage and family therapist" or the abbreviations "MFT". A licensee shall display prominently the licensee's license at the principal place of business of the licensee.

43-53-03. Exemptions.

1. An individual is exempt from the requirements of this chapter if:
 - a. The individual is practicing marriage and family therapy as part of that individual's duties as an employee of a recognized academic institution or a governmental institution or agency while performing those duties for which the individual is employed by such a facility, institution, or agency.
 - b. The individual is a marriage and family therapy intern or individual preparing for the practice of marriage and family therapy under qualified supervision in a training institution or facility or supervisory arrangement recognized and approved by the board if:

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- (1) The individual is a student in a master's program of marriage and family therapy; and
 - (2) The individual is designated by a title such as "marriage and family therapy intern", "marriage therapy intern", "family therapy intern", or other title clearly indicating such training status.
 - c. The individual is a member of the clergy of any religious denomination and providing services within the scope of ministerial duties.
 - d. The individual is a volunteer for or is employed by a nonprofit agency or community organization and the individual does not hold out to the public that the individual is a licensed marriage and family therapist.
2. This chapter does not prevent any person licensed by the state from doing work within the standards and scope of practice of that person's profession, including the practice and advertising of marriage and family therapy services.

43-53-04. Marriage and family therapy licensure board.

1. The North Dakota marriage and family therapy licensure board consists of five members. The governor shall appoint the board members to serve terms of four years, except for those first appointed one member must continue in office for two years, two for three years, and two, including the chairman, for four years.
2. The governor shall appoint members of the board from among individuals who meet the following qualifications:
 - a. At least three members must be licensed practicing marriage and family therapists; and each must have been for at least five years immediately preceding appointment actively engaged as marriage and family therapists in rendering professional services in marriage and family therapy; in the education and training of master's, doctoral, or postdoctoral students of marriage and family therapy; or in marriage and family therapy research. A member under this subdivision must have spent the majority of the time devoted by that member to such activity during the two years preceding appointment residing in this state.
 - b. At least one member must be a representative of the general public and may not have any direct affiliation with the practice of marriage and family therapy or another mental health profession.
 - c. The initial appointees, with the exception of any representative of the general public, are deemed to be and become licensed practicing marriage and family therapists immediately upon appointment and qualification as members of the board.
3. The governor shall nominate a new member to fill a vacancy on the board within thirty days of the vacancy. A member chosen to fill a board vacancy must be appointed for the unexpired term of the board member whom that member is succeeding. Upon the expiration of a member's term of office, a board member shall continue to serve until a successor is appointed. An individual may not be appointed more than once to fill an unexpired term or appointed to more than two consecutive full terms. A member may not serve as chairman for more than four years. The appointment of any member of the board automatically terminates thirty days after the date the member is no longer a resident of this state.
4. The governor may remove any member of the board or the chairman from the position as chairman for neglect of duty or malfeasance or conviction of a felony or crime of moral turpitude while in office, but for no other reason. A member may not be removed until after a hearing on the charges and at least thirty days' prior written notice to such accused member of the charges and of the date fixed for such hearing.
5. A board member may not participate in any matter before the board in which that member has a pecuniary interest, personal bias, or other similar conflict of interest. A board member shall serve without compensation but is entitled to be reimbursed for the member's actual and necessary expenses incurred in the performance of official board business.

43-53-05. Board powers and duties.

1. The board shall administer and enforce this chapter. The board shall adopt rules as the board determines necessary.
2. The board shall examine and pass on the qualifications of all applicants and shall issue a license to each successful applicant. The board shall adopt a seal which must be affixed to all licenses issued by the board.
3. The board may authorize expenditures determined necessary to carry out this chapter.
4. Three of the members of the board constitute a quorum. The board may employ attorneys, accountants, experts, and other employees as necessary for the proper performance of the board's duties.
5. The board shall adopt a nationally recognized code of ethics for the practice of marriage and family therapy.
6. The board shall establish continuing education requirements for license renewal.
7. The board shall publish an annual list of the names and addresses of all individuals licensed under this chapter.

43-53-06. Licenses.

1. Each individual desiring to obtain a license as a practicing marriage and family therapist shall submit an application to the board, upon such form and in such manner as the board prescribes. An applicant shall furnish evidence that the applicant:
 - a. Is of good moral character;
 - b. Has not engaged in any practice or conduct that would be a ground for discipline under this chapter; and
 - c. Is qualified for licensure pursuant to the requirements of this chapter.
2. An individual who was actively practicing marriage and family therapy in this state before January 1, 2008, and whose application is received by the board before January 1, 2010, may be issued a license by the board if the applicant meets the qualifications set forth in subdivisions a and b of subsection 1 and provides evidence to the board that the applicant meets educational and experience qualifications as follows:
 - a. An appropriate graduate degree, as defined by the board, from a regionally accredited institution so recognized at the time of granting such degree.
 - b. At least five years of clinical experience in the practice of marriage and family therapy, and membership or certification by an appropriate professional organization, as defined by the board.
3. An applicant may be issued a license by the board if the applicant meets the qualifications set forth in subsection 1 and provides satisfactory evidence to the board that the applicant:
 - a. Holds a master's degree or a doctoral degree in marriage and family therapy from a recognized educational institution, or a graduate degree in an allied field from a recognized educational institution and graduate level coursework which is equivalent to a master's degree in marriage and family therapy, as determined by the board.
 - b. Has successfully completed two calendar years of work experience in marriage and family therapy under qualified supervision following receipt of a qualifying degree.
 - c. Has passed the examination administered or adopted by the board.
4. An applicant may be issued an associate marriage and family therapist license by the board if the applicant meets the qualifications set forth in subsection 1 and has provided the board with satisfactory evidence that the applicant meets the requirements in subdivisions a and c of subsection 3. Associate marriage and family therapists must practice under the supervision of a board-qualified supervisor and must obey the same laws and rules as a marriage and family therapist. An associate marriage and family therapist license lasts for one year and may be renewed for up to four additional years.

- 6.4
5. The board may adopt rules concerning reinstatement of lapsed licenses, voluntary termination, or emeritus status.
 6. The board may require an applicant for licensure or a licensee to submit to a statewide and nationwide criminal history record check. The nationwide criminal history record check must be conducted in the manner provided by section 12-60-24. All costs associated with obtaining a background check are the responsibility of the applicant or licensee.

43-53-07. Examination.

1. The board shall conduct an examination at least once a year at a time and place designated by the board. Examinations may be written or oral as determined by the board. The board may create its own examination or adopt a nationally recognized examination. In any written examination each applicant must be designated so that the applicant's name is not disclosed to the board until the examination has been graded. Examinations must include questions in such theoretical and applied fields as the board determines most suitable to test an applicant's knowledge and competence to engage in the practice of marriage and family therapy. An applicant is deemed to have passed an examination upon affirmative vote of at least four members of the board.
2. Any applicant who fails an examination conducted by the board may not be admitted to a subsequent examination for a period of at least six months.

43-53-08. License by endorsement.

The board shall issue a license by examination of credentials to any applicant licensed or certified as a marriage and family therapist in another state for which the requirements for the license or certificate are equivalent to or exceed the requirements of this state, provided the applicant submits an application on forms prescribed by the board and pays the original licensure fee prescribed by this chapter.

43-53-09. Fees.

A fee, as determined by the board, must be paid to the board for original licensure. A fee may also be established for the licensure examination. A license is valid for two years and must be renewed biennially, with the renewal fee being determined by the board. The board may also establish a fee for a duplicate license. Any applicant for renewal of a license that has expired must be required to pay a late fee determined by the board. The board may also establish a fee for continuing education sponsors. The fees established under this section must be adequate to establish and maintain the operation of the board. Payment of a late fee is not a defense to a charge of practicing without a license.

43-53-10. Disciplinary proceedings.

1. The board may deny an application or institute a disciplinary proceeding concerning a licensee on the following grounds:
 - a. Conviction by a court of competent jurisdiction of an offense that the board determines to be of such a nature as to render the licensee unfit to practice marriage and family therapy. The board may compile, maintain, and publish a list of such offenses.
 - b. Violation of ethical standards of such a nature as to render the licensee unfit to practice marriage and family therapy. The board shall publish such ethical standards.
 - c. Fraud or misrepresentation in obtaining a license.
 - d. Any just and sufficient cause that renders a licensee unfit to practice marriage and family therapy.
2. An applicant may be denied a license, and a licensee may be suspended or revoked, placed on supervised or unsupervised probation, required to take corrective action, attend continuing education, or fined up to two hundred dollars per violation for the reasons set forth in subsection 1. A licensee may not be disciplined under this section

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except by majority vote of the full board, notwithstanding any other provision of this chapter. The board may also charge the licensee with its reasonable expenses and reasonable attorney's fees for any disciplinary matter resulting in disciplinary action.

3. Any person may file a complaint with the board seeking discipline of a licensee. The complaint must be in a form prescribed by the board and must be verified under oath by the complainant or a duly authorized officer of a complainant. If the board determines that a complaint alleges facts that, if true, would require discipline of a licensee, the board promptly shall institute a hearing. If the board determines a complaint does not state facts warranting a hearing, the complaint may be dismissed. The board may institute a hearing for discipline of a licensee on its own motion.
4. Any person may be permitted to intervene and participate in board hearings on denial, suspension, or revocation of licenses upon a showing of an interest in such proceeding.
5. Any individual who has been suspended or revoked may not apply to the board for vacation of the suspension until the time specified in the board's order is complete or for reinstatement of the license until one year after the board's order or such other time as specified in the board's order is complete.

43-53-11. Limitations of practice - Divorce proceedings.

1. If both parties to a marriage have obtained marriage and family therapy by a licensed marriage and family therapist, the therapist may not testify in a spousal support or divorce action concerning information acquired in the course of the therapeutic relationship. This subsection does not apply to custody actions.
2. There is no monetary liability on the part of and no cause of action may arise against any licensee in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except if the patient has communicated to the licensee a serious threat of physical violence against a reasonably identifiable victim or victims.
3. The duty to warn of or to take reasonable precautions to provide protection from violent behavior arises only under the limited circumstances specified under subsection 2. The duty is discharged by the licensee if reasonable efforts are made to communicate the threat to the victim or victims and to a law enforcement agency.
4. No monetary liability and no cause of action may arise under this chapter against any licensee for confidences disclosed to third parties in an effort to discharge a duty arising under subsection 2 according to subsection 3.

43-53-12. Penalty.

Any person who practices without a license in violation of this chapter is guilty of a class B misdemeanor.

Data Outcome System

#7
SB 2046
01/14/15
J# 21959

1. Is this intended for both public and private providers?
2. What statutory authority is needed to include private providers?
3. Is this intended for both mental health and substance abuse providers?

Here are three data level tiers to provide a framework for the committee's decision making.

Each level tier is tied to data purpose and intended use and each level require varied resources for successful implementation.

Tier One provides service detail on **who** was served, **what** were the issues, **what** service was provided.

1. Total number of people served
2. Referral source
3. Gender of those served
4. Age of those served
5. Primary drug used and/or presenting problem
6. Primary diagnosis
7. Military involvement
8. Service provided to the client

Tier One would guide decisions tied to the state's service needs, service capacity, service trends, and workforce training needs.

Tier Two includes the Tier One elements but adds data elements that describe the functioning changes of the clients served and more detail on what services were provided.

1. Client Living arrangement
2. Client Employment status
3. Client Criminal justice involvement
4. Client's Social Connection
5. Client's hospitalization occurrences
6. Evidence-based programs provided

Tier Two adds data elements tied to service outcomes and would be collected at least at admission and discharge in order to determine change.

Tier Three includes data from the first two tiers but adds data collection after discharge. The same data is captured but is collected at a later date to measure sustained illness management.

#7.2

This tier is the most labor-intensive and data-rich.

The Department is not able to provide cost projections at this time but is hopeful that the information provided will assist the committee as it moves forward with their decision on a outcome database.

The Problem

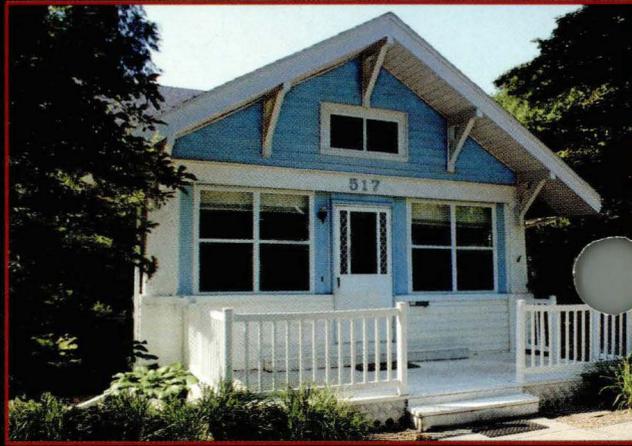
More than 23 million people in our country suffer from a serious alcohol or drug problem and millions more are in pain because of a spouse, child or friend who needs help. The human and social costs of disease are devastating tearing through families and destroying lives. People rarely find their way to Hope Manor by mistake and by the time an alcoholic or addict reaches us, they often feel life is over. Absolutely powerless, they are unable to stop drinking or using drugs. Friends and loved ones, while hoping for the addict's sobriety, may privately wonder if it is even possible. The exhaustion of alcoholism and addiction overpowers everyone. The disease just wears you out. Lack of a stable, alcohol and drug free living environment can be a serious obstacle to recovery. Destructive living environments can derail recovery for even highly motivated individuals.

Fortunately,
there is a solution!

Find and "Like"

Hope Manor -Sober Living For Women
on Facebook

Welcome Home



Hope Manor:

Our mission is to provide an environment where people can apply the tools of recovery in a comfortable, safe and stable environment so that the individual has the opportunity to realize true freedom in sobriety.

**Write to us at:
Hope Manor**

PO Box 1301
Bismarck, ND 58502
701.955.4993

HopeManorND@gmail.com

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HOPE
MANOR

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Sober Living For Women

*We have been called to heal wounds;
to unite what has fallen apart and to bring
home any who have lost their way.*

- St. Francis

www.HopeManorND.org

The Solution

Sober Living Homes in North Dakota

Research shows that the #1 factor for success in early recovery is environment.

So at Hope Manor we have taken great care to see that the time spent in sober living is done in a setting that is conducive to reflection followed by action.

Our homes are designed to create a sense of comfort and security that allows our clients to let go of the physical concerns and focus on the personal journey that lies ahead. We address each of these concerns by offering the newly sober person a warm and embracing, fully furnished place to live, at an affordable price.

At Hope Manor Sober Living Homes our message speaks to the power of recovery to change lives, that suffering can be eliminated and that life can be full of purpose and meaning. The foundation of our new life in recovery is rigorous honesty, service to others and personal responsibility.

At Hope Manor we freely share the tools and methods of our common success -

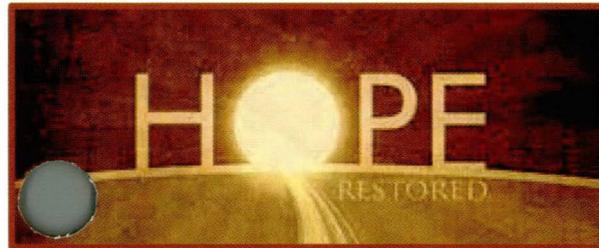
1. Physical Sobriety
2. Emotional Sobriety
3. Spiritual Sobriety

Living Life Sober One Day at a Time

The most critical component in a plan for recovery is willingness and time. Addiction cannot be treated in 7 or 21 days. Most newly sober alcoholics and drug addicts need an environment strongly committed to supporting their new found sobriety.

At Hope Manor, our residents learn that long term recovery is about finding new tools and practicing them in daily life. It would be easy to promote the idea that this is a simple process, but it wouldn't be honest.

The path we share with the people who live in Hope Manor is based on the 12 Steps, successfully used in recovery programs like Alcoholics Anonymous and Narcotics Anonymous for the better part of a century.



We have a solution. We do it one day at a time around here and we do it together.

The Program

Research shows that the 12 Step approach for alcoholism and addiction has been proven to be the most successful in producing long term results. At Hope Manor daily attendance at 12 Step groups is mandatory and we also utilize spiritual teachers, workshops, retreats and seminars to assist our residents.

The 12 Step process involves and encompasses the mind, body and spirit. Recovery of the mind is a vital aspect of our program because the goal is not to just stop, but to stay stopped and to be able to enjoy life on life's terms. However, we must also always keep in mind that the 12 Step path is a spiritual path, a spiritually based journey.

You cannot sell recovery. Recovery, through the 12 Steps, is and must always remain, completely free. But you can create a safe space for recovery to take hold.

That is what we do here at Hope Manor every day. What may seem impossible to you now has become a joyful reality for many and it can be your future too.

To see if Hope Manor is the place for you please call us at **701.955.4993**

Attach #9
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01/14/15
J# 21959 Section
A



Schulte CONSULTING, LLC

Behavioral Health Planning FINAL REPORT

July 22, 2014

*Prepared for
The State of North Dakota*

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Des Moines, IA 50309

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Executive Summary

The North Dakota mental health and substance abuse system is in crisis.

Countless stories were told during the study period about challenges facing North Dakota when trying to access services. Children are being sent out of state for treatment after failing at every in state placement first. Providers are closing practices due to changes in benefits packages and reimbursement options. Drug use is on the rise and is seen as a critical issue in the West. Data to measure needs in the state is incomplete with collection only within the public sector. Legacy services, not data driven with proven outcomes, are being used state wide making it difficult to fight for additional funding in the legislature. Sky-rocketing bad debt at hospitals is a reality throughout the state. These stories are only a glimpse of the challenges facing the mental health and substance abuse system.

The Bad News

Many of the challenges facing North Dakota are self-imposed: choosing a poor essential health benefits package for Medicaid, refusing to spend state funds on services, and not applying for Medicaid waivers to assist with chronic mentally ill. Having cut off each funding source separately, the system has not been able to maintain core services, let alone add services desperately needed due to population growth.

Workforce shortages are debilitating. Although funding contributes to this challenge, the strength of independent licensing boards has harmed reciprocity and made obtaining licensure “difficult to impossible” where many from out of state do not even apply. In addition, lack of coursework for licensure within the state hampers individuals from seeking credentials. Few reimbursement opportunities outside of the Human Service Center (HSC) system makes it difficult to attract quality providers leaving critical shortages state wide.

Even Worse News

North Dakota has a unique challenge in the Western region. Where services are poor across the state, the situation is dire in the West. Cost of living, lack of housing, and other challenges in the oil patch make hiring nearly impossible in the lower paid service areas. Additionally, the increase in population is significantly adding to the mental health crisis in numbers by the quantity of people seeking treatment and difficulty of the issues being reported. More intravenous drug users, increased sex trafficking, growing numbers of physical assaults, and domestic violence reports are only part of the picture out west. The lack of infrastructure is causing a great deal of stress on behavioral and physical healthcare workers. The situation is dire.

Caution

The proposal to combine county and state behavioral health services is not good for behavioral health services in North Dakota. Although, we do recognize the benefit of taking behavioral health off the backs of the property tax payer, in North Dakota, that only strengthens the dominance of DHS services. In this system, that decision would eliminate one remaining funding stream and decrease service providers once again.

Lawsuits are happening across the country in which states are not offering a choice of services to individuals or requiring that they seek only institutional care. The need for home and community based services is critical with changes in the federal landscape and the expectation of integration of individuals with needs into the general population. The desire to alleviate the pressures of institutional care, long term care and behavioral health treatment and to increase quality services can only be achieved within greater access to community based services. Research proves that better outcomes are seen when individuals are closer to family and natural supports.

The Good News

In spite of the bleak news, there are options. North Dakota has all the resources and experience it needs to turn things around. This study breaks down the challenges in the MH/SA system into opportunities, goals, and strategies. Within each



section, quotes of North Dakotans are used to emphasize the specific challenges. The document delineates 51 strategies to implement change in these key areas:

- Service Shortages
 - Improve Access to Services
 - Conflict-free case management
 - Access to crisis assessment
- Expand Workforce
 - Oversight for licensing issues and concerns
 - Increase use of lay persons in expanding treatment options
- Insurance Coverage Changes Needed
 - Increase funding options for services for youth and adults
 - Increase behavioral health professional coverage in Medicaid and private insurance
- Changes in DHS Structure and Responsibility
 - Build transparency and choice in services
 - Consider structural changes to DHS
- Improve Communication
 - Create an integrated system of care
 - Improve record sharing
 - Improved communication among MI ISA service providers
- Data Collection and Research
 - Determine what providers are available within the state and map gaps
 - Determine what services are available outside the HSC system for youth and adults
 - Use data to determine the best use of limited funding on treatment

A request for future interim study committees is made to address these additional areas of need. Follow up recommendations are made in the document. Additional time and resources are needed to address the following five issues:

1. Transportation - Urban and rural plans are needed in order to create access standards for core services.
2. Judicial matters – 24-hour holds, termination of parental rights, and court committals need to be addressed.
3. Definition of core services – Standardization of core services with outcomes and access standards are needed.
4. Tribal partnerships – Long standing partnerships are needed to address disproportionate numbers of Native Americans in treatment and detention placements.
5. Advocate training – Advocates need a stronger voice in North Dakota in order to assist with pressing forward changes needed in the system.

The Best News

North Dakota is fully equipped to deal with the behavioral health crisis at hand.

North Dakota has a history of pulling together to address workforce shortages. A great example of cutting edge programming is the corrections system. Financial options to either pay outright or partner with the federal government to care for persons with mental illness and substance disorders are possible. And, universities are willing to provide the data based outcomes research necessary to improve the system. The legislature must decide the best course of action and act. The strategies outlined in the study will set the course for much needed change. With proper leadership and oversight, North Dakota has the resources to become a model program for the nation in mental health and substance abuse services.



Introduction

The task assigned “to create a plan based on specific goals and objectives to improve behavioral health services in North Dakota” has been a challenging yet invigorating opportunity. The people of North Dakota should be proud of their hard work and dedication to serving persons with behavioral health and substance abuse issues. Both chambers of the legislature, both political parties and the executive branch should be commended for their willingness to participate and speak honestly about the challenges facing the state. Advocates and stakeholders should be excited about the momentum being built and the vision being cast for change.

Our first task was to identify stakeholders and gaps in the service system. In order to do this, Schulte Consulting, LLC, traveled to North Dakota six times in a course of six months. During that travel, over 35 face-to-face meetings were held with various groups and individuals. Five public hearings were conducted statewide. Throughout the study, bi-weekly public conference calls occurred. Over 414 separate people participated for a total of over 19,738 minutes logged by North Dakotans. These calls do not include our one-on-one conversations or private calls made outside the conference call program. Finally, well over 230 documents, not including email, were reviewed and considered for this report.

This report focuses on six main goals and strategies for improvement followed by recommendations for continued work. The goals chosen incorporate issues seen across geographic areas, age ranges, and demographics. Examples and strategies are used throughout to highlight the various regional discussions and groups. Citations and links for specific recommendations are throughout the body of the document. The appendix that follows includes five sections: acronyms used in the document, strategies broken down by impact and cost, evidence-based practices in North Dakota, a bibliography of substantive documents reviewed for this project, and an implementation plan with prioritized action steps.

Opportunity 1: Service Shortages

The number one concern across the state can be summed up in one phrase: “*Not enough services.*” The statement includes services at all levels from preventative services, case management, substance abuse services including residential, detox, psychiatric services, lack of state children’s residential services, etc. Many blame lack of funding for this issue. It is crucial to look at funding for behavioral health services collectively, rather than in individual pieces. Tools for funding include, but are not limited to, Medicaid waivers; federal block grants; essential health benefit plans; state funding; insurance company investments; property taxes; Medicare; business investment; and other sources of federal funding. When every tool is being cut in silos, without regard to the impact on behavioral health services as a whole, there will be problems. The current crisis in North Dakota stems from exactly that issue.

De-linking services from state government is key to improving state funding opportunities. As long as providing services equals growing the size and scope of state government, funding for services will be problematic politically. De-linking is possible in many ways including, but not limited to, privatizing services; using federal monies like Medicaid and Medicare to expand funding options; increasing expectations of private insurance coverage; and increasing essential benefits offered in Medicaid plans. The consistent call for a hold even budget is evidence that services must be separated from state government if funding is to be addressed. In spite of these challenges, there are options available to improve the system with funding other than state funds.

Three challenges addressed in this section include:

- Access to services
- Lack of case management
- Lack of crisis assessment options

Goal 1: Improve access to services

In spite of funding challenges, several strategies are plausible to increase service access and availability. There is no one-stop-shop in North Dakota for services. Those programs outside of the Human Service Center (HSC) system, are not tracked nor included in data. It is difficult to determine the actual gaps in the service system without a registry of services or providers.



Examples:

What services are available in North Dakota? "That issue is very real. We do not know what is available." – MHSA Director

"We are seeing a definite increase in young substance abusing consumers age 24 and younger and a definite increase in IV use, primarily methamphetamine." - A Lake Region HSC staff

Strategy	Who is responsible	Timing	Financial Options and Cost Estimate
1. Increasing use of telemedicine	DHS; legislature; providers; advocates; consumers and families	Today	Federal grants like HRSA ¹ Insurance community reinvestment Cost: \$1K to \$10K per site for equipment
2. Use of critical access hospitals (CAH) ^{2,3} for BH services	DHS; legislature	Today	Current CAH funds allow BH services
3. Create bed management system MN Model ^{4,5}	DHS; legislature	65 th Legislative Assembly	State funding Cost: \$200K implementation \$25K sustaining
4. Utilize HCBS waivers for MHSA services MT Model ⁶	DHS; legislature	Today	Federal Medicaid funding Most state's cost neutral: ND evaluating at present
5. Increase substance abuse services including detox	Legislature; DHS	64 th Legislative Assembly	SAMHSA block grant; state funding; alcohol tax; private funding Cost: \$2-10M depending on funding source chosen

1. <http://www.hrsa.gov/ruralhealth/about/telehealth/>
2. https://www.ndhealth.gov/HF/PDF_files/Hospital/hospital_feb_2014.pdf
3. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network/MLN/MLNProducts/downloads/critaccesshospfctshst.pdf>
4. <http://www.health.state.mn.us/divs/orhpc/rhac/presentations/behealth.pdf>
5. <http://www.mnmhaccess.com/>
6. <http://www.dphhs.mt.gov/amdd/services/hcbswaiver.shtml>

Goal 2: Conflict-Free case management⁷

The issue of lack of care coordination or case management was the second most common concern noted throughout the state. Challenges include not being able to access case management, with the lack of choice due to having only one provider of services (DHS), a culture of dependence upon the government system, and a lack of uniform eligibility criteria for program participation.

Examples:

"In North Dakota, the culture has been for consumers to have case management for life, which fills up the case load rather than provide openings for persons in crisis." – Bismarck area provider

"IDDT [Intensive Dual Disorder Treatment] is awesome but it only helps a selected few." – South East HSC provider



“There are no provisions for emergency admittance for kids until all the paperwork is done. So if we are hung up on a form or a note that takes us a week to get it back, that kid may have to be sent home for three or four days. Once we get the paperwork completed they will say that the child is better because he’s been out of a psychiatric facility and no longer eligible for care.” –Private provider

“North Dakota facilities act like they are doing you a favor if they take a teen... [And] they always need one more piece of information before they can give an answer. Out-of-state facilities give one an answer quickly and most times the answer is yes.” –State program director

Strategies	Who is Responsible	Timing	Financial Options and Cost Estimate
1. Increase access to IDDT ⁸ - expand statewide	DHS; legislature; Governor	Today	State funding; private contract options; discontinue less effective services and transfer funds Cost: Estimate in process in ND to determine if staff resources are needed
2. Privatize case management to add choice	DHS; Legislature; Governor	65 th Legislative Assembly	Cost savings: transfer cost to private or county providers
3. Partner case management/care coordination with peer support ⁹	DHS; legislature; advocates; consumers and families	65 th Legislative Assembly	Use existing Recovery Center staff to assist in care coordination; state funds to grow peer support through private entities Cost: no state funds if using Medicaid waiver to expand or use integrated health model

7. <http://www.balancingincentiveprogram.org/resources/example-conflict-free-case-management-policies>

8. <http://www.centerforebp.case.edu/stories/southeast-center-in-north-dakota-achieves-significant-outcomes-honored-as-champion-of-integrated-treatment>

9. <http://www.innovations.ahrq.gov/content.aspx?id=3387>

Goal 3: Access to crisis assessment

Huge challenges occur when trying to access evaluations for individuals in crisis. A system is needed outside of emergency rooms and the state hospital for assessment. In addition, the persons screening for placement should have the proper credentials to provide behavioral health assessments, rather than lower level practitioners, practicing outside their scope of practice, who are allowed to veto a doctor or mental health professional’s recommendation. Transportation becomes a huge barrier to assessment in the current limited options.

Examples:

“Mobile crisis data is very good. However, in Fargo it was only used by a few individuals who really liked the program and rated it high every time.” – Fargo provider

“Mobile crisis is not a well-publicized program. They refused to come assist our clients.” – County staff

“If we had proper crisis assessment on children, placements could be made that could help kids succeed rather than being placed wherever there is an opening, even if inappropriate. Openings are usually out-of-state, far from their families.” – Provider



Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Increase after hour options like Devils Lake NIATx ¹⁰ walk in clinic and create after hour intake options	DHS; HSCs	Today	Adjust current work schedules to accommodate
2. Increase mobile crisis in urban areas after hours	DHS; HSCs	65 th Legislative Assembly	State funding; private contract options; block grant funding; adjust current work days/times Cost: \$120K-\$200K per urban location per year
3. Use telemedicine for crisis assessments IA model	DHS; legislature; providers; advocates; consumers and families	64 th Legislative Assembly	Federal grants like HRSA ¹¹ Insurance community reinvestment ¹¹ Cost: \$225K per region
4. Model after eICUs to create ePsychiatry in the state ¹²	DHS; legislature; providers; advocates	64 th Legislative Assembly	Medicaid; Medicare; private insurance; insurance community investment ¹¹ Cost: \$1.7M conferencing fee and support (20 sites)

10. <http://www.niatxfoundation.net/>

11. <http://www.magellanoflowa.com/for-providers-ia/community-reinvestment.aspx>

12. http://www.nursezone.com/nursing-news-events/devices-and-technology/Critical-Care-Beyond-the-Bedside-The-Collaborative-Effort-of-the-eICU-Team_24170.aspx

Opportunity 2: Expand Workforce

Challenges in providing services are complicated by the workforce shortage throughout the state of North Dakota. The shortage is statewide but is exacerbated in the Western part of the state due to the growth in the Oil Patch. One large issue that must be addressed is the licensing challenges that make North Dakota non-competitive with neighboring states for behavioral health workers. Reciprocity issues, lack of required education available, burdensome licensing requirements, and lack of coordinated oversight of licensing boards can all be addressed to facilitate the building of this state's workforce. Also, the increased use of peers, family peers, recovery coaches and other lay persons to support the professional staff is required to expand service opportunities in the state and build evidence-based practices.

Two challenges addressed in this section include:

- Professional licensing issues
- Lack of use of peers, family support peers, recovery coaches and other alternatively trained persons

Goal 1: Oversight for licensing issues and concerns

An important area to address is the individual licensing boards operating in the state of North Dakota. These boards have not standardized their requirements; education experience and internship expectations, reciprocity, etc., making every license unique and challenging to obtain, in various ways. Some boards require face-to-face meetings to approve licensure but only meet a couple of times a year. Providers have a difficult time even contacting the board with questions. Without options for provisional license status, providers cannot bill or be paid equitably while waiting for a board to meet. Not being able to be fully reimbursed for six or more months, proves to be a significant deterrent to those who may be interested in relocating to North Dakota.



Other licenses like the Licensed Addiction Counselor (LAC), require a set of educational courses that are above national accreditation standards and are not even available in the state. The LAC also requires a large unpaid internship to complete that cannot be counted concurrently with other mental health licenses like the Licensed Professional Counselor (LPC) and doctorate level psychologist. Although Century Code 43-45-05.1 states that the LAC “board may grant reciprocity,” reciprocity is “difficult to impossible” according to many who have been licensed in other states trying to relocate to North Dakota. With the extreme shortage of workforce in behavioral health areas, especially LACs, this issue must be addressed quickly.

Examples:

A private organization tried to recruit an LAC from Iowa who had 3 levels of licensure in Iowa including a national accreditation for licensed addiction counseling. “The candidate could not obtain an LAC in North Dakota without completing several required educational courses. The University of Mary actually asked our candidate to teach one of the courses that North Dakota determined that she herself needed to obtain licensure.” – Bismarck provider

“I applied four times to three different VA programs in the state of North Dakota, and did not even get an email response back.” – Elle Victoria-Gray, Schulte Consulting, LLC

“The extreme lack of substance abuse treatment options in Western North Dakota for youth and adults is a crisis situation. I cannot stress that enough.” – Western provider

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create an oversight system for licensing boards utilizing public health as overseer	Legislature; Department of Public Health	64 th Legislative Assembly	No funding required
2. Change Behavioral health professional definition in 25-03.2-01 for MA level like IA ¹³ model or two levels including practitioner level in MN ¹⁴ model	Legislature; DHS	64 th Legislative Assembly	No funding required
3. Create reciprocity language to “shall” accept all professional licenses meeting international ¹⁵ and national accreditation standards and qualified state equivalent for each BH license.	Legislature	64 th Legislative Assembly	No funding required
4. Make sure all educational requirements are available within state and preferably online for access	Legislature; licensure boards	Today	Adjust course offerings to reflect required courses.

13. <https://www.legis.iowa.gov/docs/ico/code/228.1.pdf>

14. <https://www.revisor.mn.gov/statutes/?id=245.462>

15. <http://internationalcredentialing.org/>

Goal 2: Increase use of lay persons in expanding treatment options

The use of peers, family support peers, recovery coaches, and other persons with lived experience, is an evidence-based practice and a growing national trend with good treatment outcomes. In rural areas with behavioral health professional



shortages, like North Dakota, using peers and other interested persons like teachers, law enforcement personnel, emergency workers, etc., are instrumental to expanding the workforce. In addition, increasing the number of out-stationed workers in the community is key to improving access to critical services.

Examples:

“Recovery Coaches have been trained and are a successful part of our program.” - Bismarck provider

“We need to recruit and retain local behavioral health providers, which are established and rooted in the local areas to work with us on the tribal lands, especially mid-level providers [like a dental assistant to a dentist. We need both levels.]” - Indian Affairs staff and regional staff

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Increase use of peer support and recovery coaches ¹⁶	DHS; providers; advocates	65 th Legislative Assembly	State funding; private contracts; federal grants; Medicaid ¹⁷ Cost: Depends on source of funding \$750K
2. Increase training for law enforcement, emergency personnel, corrections and teachers using MH First Aid ¹⁸ and other training	DHS; providers; advocates	64 th Legislative Assembly	MH First Aid is a low cost program- \$15-\$25 per person
3. Increase law enforcement in schools	Schools; advocates; providers; law enforcement	65 th Legislative Assembly	State funding; federal grants Cost: \$50K per officer
4. Increase education opportunities for behavioral health providers	Universities; online learning	64 th Legislative Assembly	Re-prioritize existing courses to train new providers

16. <http://www.recoverycoaching.org/>

17. <http://cmhconference.com/files/2013/cmh2013-1a.pdf>

18. <http://www.mentalhealthfirstaid.org/cs/>

Opportunity 3: Insurance Coverage Changes Needed

The third area requiring attention is the use of insurance including federal Medicaid, Medicare and private third party funders to address gaps in the behavioral health system in North Dakota. Two specific issues include lack of funding for various services and lack of coverage for licensed professionals to provide services.

The Century Code is inconsistent with the current Essential Health Benefits (EHB) package selected. North Dakota Century Code 26.1-36-08 authorizes 60 day minimum for inpatient treatment; 120 days minimum for partial hospitalization and 20 outpatient visits for substance abuse treatment. North Dakota Century Code 26.1-36-09 authorizes a minimum of 45 days for inpatient, a minimum of 120 days for partial hospitalization, minimum of 120 days for residential treatment for youth 21 years and under, and 30 hours of outpatient treatment. The current EHB package allows insurance providers to decrease services to the level of services recommended in the Sanford plan selected.

The Affordable Care Act (ACA) allows a decrease in services, especially residential substance abuse treatment in Medicaid in order to cover more total lives. There are multiple complaints to the Attorney General and pending lawsuits regarding changes made in the state based on the chosen EHB plan for Medicaid. Upon the final ruling, a change in North Dakota code to reflect this decision may be necessary. Also, the ACA has expanded mental health coverage through the use of Medicaid, Health Care Exchanges, and the Mental Health Parity and Addiction Equity Act (MHPAEA). Medicaid Alternative Benefit Packages (ABPs) must comply with MHPAEA. If surgical/physical treatments are covered, then



behavioral health services are covered to the same extent. This federal law is also inconsistent with the Century Code sections 26.1-36-08 and 26.1-36-09.

Two challenges addressed in this section include:

- Lack of funding options for services
- Lack of coverage for providers

Goal 1: Increase funding options for services for youth and adults

There is a large gap in funding options for services in North Dakota. The following is an incomplete list of services that do not have coverage, including: residential treatment for adolescent substance abuse; lower level residential treatment (between acute hospital care and outpatient services) for adults; private insurance options for IDDT and other evidence-based programs; ambulance coverage for “behavioral or suicidal issues;” and in state detox option. In addition, the current system encourages failure at various treatment levels before authorizing treatment. This is not recovery focused treatment. Parity for mental health services is not currently happening within the state as mandated by federal law.

Examples:

“Treatment is a privilege.” – Eastern ND Consumer

“Everything in North Dakota is a work around, rather than a system of care.” – Grand Forks provider

“We adjusted to the Essential Benefits Package selected.” – NDBCBS testimony

“There is still a strong sense that substance abuse is self-induced and therefore shouldn’t be paid for in North Dakota.” – Comment at public meeting

... “Minnesota offers a lot more for help so these people can be successful in their recovery. North Dakota needs to offer more aftercare programs and support.” – Concerned mom after denied insurance coverage

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Re-evaluate Essential Health Benefit Package selected ¹⁹ and unintended consequences	Legislature; DHS; and providers	Today	None Needed
2. Determine if insurance coverage meets federal parity standards	Legislature; DHS; and insurance department	Today	None Needed
3. Decide whether to maximize federal funding options or increase use of state and private funds to fill gaps	Legislature; DHS	Today	None Needed
4. Determine what 3 rd party payers should be covering	Legislature; DHS	Today	None needed
5. Apply for Medicaid waiver for SDMI Population MT Model ⁶	DHS	Today	Medicaid funding, may be state funding match Cost: ND currently calculating possible cost

19. <http://www.nd.gov/ndins/uploads/18/ehbcommunication.pdf>



Goal 2: Increase behavioral health professional coverage in Medicaid and private insurance

In spite of the workforce shortages in the state, many qualified behavioral health professionals are not reimbursed in the state. Licenses like Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor, Licensed Master of Social Work (LMSW), and Licensed Addiction Counselors (LAC), and all other qualified behavioral health providers must be reimbursed in the state to grow the workforce.

Examples:

“I am an LAC and it easier for me to work in Minnesota than in North Dakota.” – Valley City LAC

“I moved to North Dakota with a license from Wyoming, and cannot get reimbursed.” – Devils Lake provider

“North Dakota is one of only three states in the country that does not extend reciprocity for internationally credentialed professionals. We have had the opportunity to hire behavioral health providers, with these credentials, for tribal regions in North Dakota but were unable to, as a result.” – Indian Health Services administrator

“I was an experienced clinical psychologist, licensed in two states, on the national registry and in good standing. When I applied for a job in North Dakota, they said I would need to retake my national exams again because they could not accept my old scores. That’s why I work in South Dakota.” – Director of government mental health services

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Change administrative code to reimburse qualified Behavioral Health Professionals as defined above. IA Model ²⁰	Legislature	64 th Legislative Assembly	Medicaid, 3 rd party funders
2. Increase funding to assist BH professionals in training including LACs	Legislature	65 th Legislative Assembly	State funding; insurance reinvestment Cost: \$45K per position

²⁰Iowa Code 249A.15A added Licensed Marital and Family therapists, Licensed Master Social Workers, Licensed Mental Health Counselors, and Certified Alcohol and Drug counselors to providers reimbursed by Medical Assistance in Iowa.

Opportunity 4: Changes in DHS Structure and Responsibility

When looking at the system in North Dakota, one thing that sets it apart from many other systems is the almost total reliance on DHS as provider of services. In this role, there is no independent appeal mechanism for families or consumers. DHS is the provider, regulator and oversight to itself. The lack of checks and balances makes a very poor business model in any field. Determining which parts of the system that only the Department can do and allowing others including the private sector to provide services that they do well, will strengthen choice for consumers and oversight for the system as a whole.

Two challenges addressed in this section include:

- Lack of transparency and choice in services
- Proposed structural changes

Goal 1: Build transparency and choice in services

Although some may think that this DHS directed system is more functional and streamlined, in actuality it has created less competition and thereby a lower standard of care. Private entities, which are few, must compete against the large human service centers for funding. The HSCs are the sole provider of many services not giving consumers any options.



On the youth side of services, the counties play a funding role, yet have limited to no control over services selected or even management of cases. Counties are seen as funders through property taxes, but are not allowed to provide services that they could do, often more effectively, closer to the community, the consumer and his or her family. In a state where all available providers are needed in order to get the work accomplished, the dominance of the HSC system of care is counter-productive.

Examples:

“If you get on to the bad side of DHS, you will be put into a situation where you cannot succeed” - Department of Corrections staff

“We have a list of inmates banned from HSCs, yet they are the only provider of services needed.” – Department of Corrections staff

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create an independent appeal process for consumers IA model ²¹	Legislature; advocates; families and consumers	64 th Legislative Assembly	Re-allocation of funds
2. Standardize and distribute rules for uniform access to HSCs	DHS; Legislature oversight; advocates; families and consumers	Today	No funding needed
3. Encourage hiring throughout the state not just in HSCs	DHS; Providers; advocates	Today	No funding needed
4. Increase oversight and accountability for contracts with an independent appeal process	DHS; Legislature	64 th Legislative Assembly	Re-allocation of funding prioritizing oversight over provider function
5. Create list of all services only provided by DHS	DHS; legislative council; legislature oversight	Today	Staff time

21. <https://www.legis.iowa.gov/docs/ico/code/331.394.pdf>

Goal 2: Consider structural changes to DHS

This may be the most needed yet most difficult piece of this plan to implement. The legislature must decide which services only DHS can do and should be doing, and which services others can do. They should determine if other providers, including county providers, could assist in growing access in the state. In addition, DHS needs to move away from “legacy” services that do not show proven outcomes and instead fund evidence-based services.

Caution: The proposal to combine county and state behavioral health services is not good for behavioral health services in North Dakota. Although, we do recognize the benefit of taking behavioral health off the backs of the property tax payer, in North Dakota, that would only strengthen the dominance of DHS services. In this system, that decision would eliminate one remaining funding stream and decrease service providers once again.

If a structural change should occur to combine county and state systems, governance boards made up of counties within the region could be lifted up as one way to balance the system. If county managers or commissioners were raised up to have oversight of the monies spent, that would be a great way to add much needed checks and balances to the system. That governance structure could also be an option for an independent appeal process that is currently missing.



Examples:

“Some providers do not give quality care but there is little to no recourse for a family or choice of other providers.” – Provider of youth services

“Counties have many financial responsibilities for children that are unfunded mandates.” – Eastern North Dakota county staff

“It is not uncommon for suicidal Native American juveniles to be housed in jails awaiting placement...to stay for months at a time in these adult jails without being provided educational or counseling services. Tribal governing authorities and tribal courts need to initiate a conversation with the State of North Dakota to discuss services for Native juveniles.” – Member of the state judiciary

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Change HSCs to oversight; regulatory functions; and program management at state hospital like ND DD system	DHS; Legislature	65 th or 66 th Legislative Assembly	Re-allocation of funds
2. Improve coordination of care with county service system for youth	DHS; Legislature; counties	Today	Staff time; county and state funding; Chaffee funds ²²
3. If counties combine with State, create regional governance system NE Model ²³	DHS; Legislature	66 th Legislative Assembly	State and county funding re-allocation
4. Legislative oversight of HSC system to uphold powers and duties outlined in 50.06-05.3	Legislature and Executive branch	64 th Legislative Assembly	State funding re-allocation

22. <http://www.nrcyd.ou.edu/chafee>

23. <http://www.region5systems.net/nebraska-behavioral-health-regions>

Opportunity 5: Improve Communication

Another state wide concern relates to poor communication within the system of Human Services. This was observed and verbalized in every region throughout the state. There was a pervasive lack of information and knowledge of what DHS was doing, unavailable data on services or providers outside of the HSCs, inconsistent knowledge of services available, lack of coordinated care and discharge planning, unknown openings of HSC positions; a lack of integrated treatment planning, and many other examples.

Three challenges addressed in this section include:

- Lack of integrated physical and behavioral health treatment
- Lack of record sharing and real time information
- Lack of communication between HSCs and everyone else

Goal 1: Create an integrated system of care

Without effective communication, care coordination is not possible. The key to integrated care is working partnerships with all providers, advocates and consumers at the table. When there is a lack of trust and/or animosity among parties, the objective to provide coordination on any level is not possible. The majority of HSCs were noted as having poor to no



coordination with providers outside of their own system. One region, Devils Lake, was noted as working well with others. In fact, many stated that Devils Lake region should be a model for others to follow. Challenges were noted in transition between corrections and HSCs. Reintegration into the community has been difficult with delays in getting services and lack of prioritization for those most at risk of re-offending. In the past, inmates have moved from evidence-based practices within the correctional system to antiquated and punitive services in the HSC system. In a letter dated July 9, 2014, DHS is currently partnering with ND Department of Corrections to offer evidence based options outlined in the 2nd Chance Grant application to develop a comprehensive and collaborative approach to reducing crime and recidivism.

Individuals with traumatic brain injuries or autism spectrum disorders are not seen as included in behavioral health services. Yet, in an integrated physical and behavioral health system, they should not be excluded. Public health assessments in North Dakota indicate that behavioral health is a significant need. In addition, chronic conditions of obesity and diabetes make the top of the list. These are the exact issues addressed in integrated health programming across the country.

Examples:

“Of surveys taken across our region, Behavioral Health is always top three. Other issues include chronic health conditions like obesity and diabetes.” – Public health employee

“Traumatic brain injury is included in the MHSA division, but there is no dedicated staff time or funding to move forward the services needed.” – Brain injury advocate

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Creation of Integrated health services including care coordination in Medicaid IA Model ²⁴	DHS; Legislature	65 th Legislative Assembly	Federal Medicaid funding; state funding; block grants Cost savings projected in Iowa
2. Seek additional federal funding for age 0-5 Visiting Nurses programs for BH	DHS	64 th Legislative Assembly	Federal funding
3. Strengthen Advocacy voices in ND	DHS; Providers; stakeholders; Advocates	Today	No funding needed

24. <http://dhs.iowa.gov/ime/about/initiatives>

Goal 2: Improve record sharing

Treatment time is often wasted waiting for paper document transfers between providers for releases of information (ROI) and other treatment documents. Technology is available to maintain HIPAA compliance while getting information in real time. Working toward a global standardized ROI that could be shared across providers would be a first step to more coordinated care. For example, in Iowa, the Certification of Need (CON) is a one page document. The authorization for insurance is only two pages. North Dakota’s Universal Application (UA) started out as nine pages and is now over fourteen pages in length due to complications with the CON process. Streamlining the record exchange protocols, record sharing requirements and the length of time for decisions to be made, is key to timely treatment. Timely treatment saves lives, not to mention time and money.

Note: DHS clarified that the CON form in North Dakota for Ascend is only one page. The Psychiatric Residential Treatment Facility (PRTF) Review and the North Dakota under 21 Acute Review form are both three pages each. The question remains, how does the process require dozens of pages of additional documentation for an admission? There has to be a more streamlined option to benefit everyone in North Dakota.

Examples:

“Every time I see a new provider, I have to start over and re-tell my story.” – Western North Dakota consumer



“The Universal Application for residential treatment can be very daunting for many families. If it is not filled out completely, with all documentation, the application is not considered. This often causes delays of 1-4 weeks resulting in lost placements.”- Executive at residential facility

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Review record sharing options for ND and stream line	Legislative council; DHS; Legislature	Today	Staff time
2. Change regulations to accept electronic releases and all other treatment documentation	Legislature; DHS	64 th Legislative Assembly	Cost reduction in printing and transportation
3. Streamline application process for residential facilities ^{25 26}	Legislature	Today	Cost reduction in time and processing

25. <http://www.humana-military.com/library/pdf/RTCApplication.pdf>

26. <http://harborpointbhc.com/files/2013/05/Family-Form-Tri-North.pdf>

Goal 3: Improved communication among MHSA service providers

Improved communication is key to increasing services and workforce in North Dakota.

Examples:

“Western North Dakota hospital wants to build psychiatric services, yet cannot get DHS to sit down and brainstorm solutions that might work.” – Williston hospital executive

“The Century Code directs people to jail rather than treatment.” – Eastern ND county jail staff

“I am moving to Colorado next week. When our provider closed, I could not find another position here in my community.” There was a current opening at the HSC in this community. – Licensed prescriber Devils Lake

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Intra agency council for coordination of services Idaho model ²⁷	DHS; Corrections; DPH; Education; Vocational Rehabilitation; Veterans Affairs; DD and others.	65 th Legislative Assembly	Staff time, reallocation of priorities within departments
2. Improve regional communication HSCs to all providers	Stakeholders/advocates lead; DHS at the table; Legislative Oversight	Today	Staff time, re-allocation of resources
3. Standardize policies and procedures that foster better communication including job vacancies	DHS; Legislative oversight	Today	Staff time

27. <http://www.bhic.idaho.gov/>



Opportunity 6: Data Collection and Research

Of all the assignments given to this project, collecting objective data became the most difficult and cumbersome task. North Dakota has no collecting mechanism of data of services or providers outside of the HSC system. Many children of minority status are disproportionately represented in the child welfare system. Yet, there is no data available that separately tracks who these kids are or where they go. This is especially true for children from tribal communities.

The Corrections system in North Dakota recently underwent overwhelming culture change in order to become more data driven and evidence focused in provision of services. The MHSA division would do well to consider following their example of allowing data to drive funding decisions rather than less objective measures.

Three challenges addressed in this section include:

- Lack of data for providers outside the HSC system
- Lack of data for services provided outside the HSC system
- Lack of data driven services utilized for treatment

Goal 1: Determine what providers are available within the state and map gaps

Without a comprehensive list of providers in the state, there is no way to determine the exact shortage of providers. There is a long list of providers needed in the HSC service system. There are also multiple private providers and unemployed providers, throughout North Dakota, unwilling to work in the public sector. They are unaccounted for in the current system.

Examples:

“There is no central data collection system outside the HSC system for providers or services.” – MHSA Director

“We have no separate data for tribal children, our out-of-state placement data includes all youth.” – DHS Interstate compact employee

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create a provider registry GA model ²⁸ veterans model ²⁹	DHS; Legislature	65 th Legislative Assembly	Staff time; possible state funding Cost \$200K
2. Give task of oversight of licensing boards to public health	DHS; Legislature; Department of Public Health	64 th Legislative Assembly	Staff time

28. http://news.emory.edu/stories/2014/04/star_providers_registry_launches/index.html

29. <http://www.starproviders.org/>

Goal 2: Determine what services are available outside the HSC system for youth and adults

Without a comprehensive list of providers, it is not possible to create a comprehensive list of services available for the residents of North Dakota. Providers with national accreditation are not required to submit data to DHS, and by that measure are not held accountable for services provided.

Examples:

“I had no idea those services were available in my community.” – Conference call participants

“Where is that located again?” – Commonly heard among providers on calls and in public meetings.



Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Create a repository for services using 211/ First Link ³⁰	Legislature; DHS; providers; advocates; stakeholders	64 th Legislative Assembly	Currently funded; state funding; private sources
2. Map current resource distribution outside the HSC system	DHS; Legislature; advocates; stakeholders	Today	State funds; current resources re-allocated

30. <http://www.myfirstlink.org/>

Goal 3: Use data to determine best use of limited funding on treatment

Without the use of fidelity standards and outcome measurements, it is impossible to prove if the funding provided for services are worth the money. Research is needed to determine which evidence-based services work in North Dakota, specifically, with the population present. In most systems, current funding can be used more efficiently and with better outcomes. Research is critical to the advancement of behavioral health systems in states. In a state like North Dakota, which has not had excess funding coming into the system, research becomes even more critical to advance the system.

Example:

“Corrections now prioritizes inmates who receive services based on research, showing which inmates will benefit from treatment. They get it.” – Service provider

Strategies	Who is Responsible	Timing	Finance Options and Cost Estimate
1. Use universities or other current systems to build outcomes based system ³¹	DHS; Universities	Today	Re-allocation of current funds
2. Create list of “legacy” services and cost to state and consider reinvesting in evidence-based services.	DHS; legislature; providers; advocates	Today	Staff time; state funds

31. <http://www.thenationalcouncil.org/wp-content/uploads/2013/12/BHCOE-draft-FINAL-12-18-13.pdf>

Follow up Recommendations:

As with any statewide system review, there are multiple pieces that require further investigation and review in order to move forward in a coordinated direction. This section will outline several areas that require additional time and resources in order to create a comprehensive recommendation.

- **Transportation:** In any rural state, transportation is a huge issue. Critical questions range from who transports someone to the state hospital to how a person gets himself to treatment. Due to the complicated nature of this subject, partnerships between federal and state funding sources, and the agencies required, this issue should be looked at separately and in greater detail.
- **Judicial matters:** Due to the number of additional agencies and branches of government involved in issues including the 24-hour hold, termination of parental rights, and court committals, an interim committee should be established to fully investigate each need and set forth a plan.
- **Definitions of services:** Due to the various definitions of services and differing expectations across regions, future work should center on finding agreement in core service definitions and access standards. Advocates, providers and consumers should come to the table with DHS to more clearly define exactly what services are and are not available in the state. Additionally, standardized procedures must be agreed



upon and applied uniformly for access to services and hospitalization, based on qualified mental health professionals working within their licensure and scope of practice.

- **Tribal partnerships:** Due to the short nature of this study, necessary relationships with tribal partners were not able to be cultivated in a manner conducive to significant change. In addition, the partnership between state and federal government requires additional stakeholders to be at the table in order to truly build a plan for the future.
- **Advocate training:** The advocate voice for MHSA services could be much stronger in the state. Helping people find their voice and learn how to advocate for change is imperative to move any huge system forward. The advocate voice and inclusion in all change is critical to the process. Building an advocate base can be done in many ways and would help create the change needed.
- **Future interim study:** As with any system change, this process is only truly beginning. It will require the legislature to follow the process and maintain oversight into future Legislative Assemblies. Leadership of this process needs to remain independent of the state system if true system change is to be expected and accomplished.

In conclusion, there are multiple opportunities available to the state of North Dakota for improving the behavioral health system. Opportunities exist to address service shortages, expand the behavioral health workforce, improve insurance coverage, change the DHS structure, improve communication, and increase data collection and research. Although lack of funding can be a challenge to implementing some recommendations, there are many strategies outlined in this document that are of low cost and high impact. These are specifically noted in Appendix B. An implementation plan of prioritized strategies is noted in Appendix E.

The people of North Dakota are asking for change. Many examples of issues were outlined throughout the document. There are pockets of great work being done with very innovative providers and services being offered. The challenge is getting those services provided across the state to all North Dakotans and offering choice to the consumer. This report outlines opportunities for advancement of the behavioral health system. The strategies, if implemented, would provide uniform access to efficient services giving choice to the consumer and families.



Appendix A

Common Acronyms

BH – Behavioral Health

CAH - Critical Access Hospitals

CON – Certification of Need

DD – Developmental Disabilities

DHS –North Dakota Department of Human Services

eICU – Electronic Intensive Care Unit

HIPAA – Health Insurance Portability and Accountability Act

HSC – Human Service Center

IDDT – Integrated Dual Disorder Treatment

LAC – Licensed Addiction Counselor

LMFT – Licensed Marriage and Family Therapist

LMSW – Licensed Master Social Worker

LPC – Licensed Professional Counselor

MA – Master’s Level clinician

MH – Mental Health

MHSA – Mental Health Substance Abuse Division of DHS

NIATx – Originally meant “Network for the Improvement of Addiction Treatment.” Now called NIATx to reflect expansion to broad based behavioral healthcare.

RT – Residential Treatment

SAMHSA – Substance Abuse and Mental Health Services Administration

TBI – Traumatic Brain Injury

VA – Veterans Affairs



Appendix B

Low Cost High Impact Strategies

Opportunity 1: Service Shortages

Goals	Low Cost High Impact Strategies
Improve access	Utilize HCBS waiver for MHSA services MT Model
Improve access	Use of Critical Access Hospitals for BH services
Access to crisis assessment	Increase After Hour options like Devils Lake NIATx Walk in Clinic

Opportunity 2: Expand Workforce

Goals	Low Cost High Impact Strategies
Oversight for Licensing Issues	Make all Education Requirements Available in State (or remove requirements)
Oversight for Licensing Issues	Change Behavioral Health Professional definition in 25-03.2-01 for MA level -see IA Model or two levels including a practitioner level in MN Model
Oversight for Licensing Issues	Create Reciprocity language to "shall" accept all professional licenses meeting international and national accreditation standards and qualified state equivalent for each BH license.

Opportunity 3: Insurance coverage changes needed

Goals	Low Cost High Impact Strategies
Increase funding options for services for youth and adults	Re-evaluate Essential Health Benefit Package selected and unintended consequences
Increase funding options for services for youth and adults	Determine if insurance coverage meets federal parity standards
Increase funding options for services for youth and adults	Determine what 3 rd party payers should be covering
Increase funding options for services for youth and adults	Apply for Medicaid waiver for SDMI population. MT Model
Increase behavioral health professional coverage in Medicaid and private insurance	Change administrative code to reimburse qualified behavioral health professionals

Opportunity 4: Changes in DHS structure and responsibility

Goals	Low Cost High Impact Strategies
Build transparency and choice in services	Standardize and distribute rules for uniform access to HSCs
Build transparency and choice in services	Encourage hiring throughout the state not just in the HSCs
Build transparency and choice in services	Create list of all services only provided by DHS
Consider structural changes to DHS	Coordinate care with county service system for youth



Opportunity 5: Improve Communication

Goals	Low Cost High Impact Strategies
Create an integrated system of care	Strengthen Advocacy voices in ND
Improve record sharing	Review record sharing options for ND and streamline
Improve record sharing	Change regulations to accept electronic releases and all other treatment documentation
Improve record sharing	Streamline application process for residential facilities
Improved communication among MHSA service providers	Improve regional communication HSCs to all providers
Improved communication among MHSA service providers	Standardize policies and procedures that foster better communication including job vacancies

Opportunity 6: Data Collection and Research

Goals	Low Cost High Impact Strategies
Determine what providers are available within the state and map gaps	Give task of oversight to the group created to oversee licensing issues
Determine what services are available outside the HSC system for youth and adults	Map current resource distribution outside the HSC system
Use data to determine best use of limited funding on treatment	Use universities to build outcomes based system
Use data to determine best use of limited funding on treatment	Create list of "legacy" services and cost to state and consider reinvesting in evidence-based services



Appendix C

Evidence-Based Practices, Best Practices & Promising Practices currently in parts of North Dakota

Crisis Stabilization Services means short term individualized mental health services provided to an individual following the crisis screening or assessment which are designed to restore the individual to prior functional level. Mental Health crisis stabilization services shall be provided in a setting that is safe and appropriate.

Dialectical Behavioral Therapy (DBT) means a therapy designed to help people change patterns of behavior that are not effective, such as self-harm, suicidal thinking and substance abuse. This approach works helping individuals identify triggers that lead to reactive states and building coping skills.

Eye Movement Desensitization and Reprocessing (EMDR) means a one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning.

Evidence-Based Mobile Response means an on-site, face-to-face mental health crisis service for individuals experiencing a mental health crisis. Mobile crisis staff have the capacity to intervene, wherever the crisis is occurring, including but not limited to the individual's place of residence, emergency rooms, police stations, outpatient mental health settings, schools, recovery centers and any other locations where the individual lives, works, attends school, and socializes.

Equine-Assisted Therapy (EAT) means a treatment that includes equine activities and/or an equine environment in order to promote physical, occupational, and emotional growth in persons suffering from ADD, Anxiety, Autism, Cerebral Palsy, Dementia, Depression, Developmental Delay, Genetic Syndromes (such as Down Syndrome), traumatic brain injuries, behavioral issues, abuse issues, and many other mental health problems.

Targeted Capacity Expansion Technology-Assisted Care (TCE-TAC) means a piloted program utilizing a private social network (similar to Facebook) to provide support and education to its members. In August of 2013, a Bismarck provider was awarded a grant funded by SAMHSA to enhance and expand its social network, NAR (Network Assisted Recovery) and study the effectiveness of it as a treatment tool. NAR is available for individuals who have completed primary treatment.

Illness Management and Recovery (IMR) means a curriculum used to help people to develop personal strategies for coping with mental illness and moving forward with life. IMR practitioners use a combination of motivational, educational, and cognitive-behavioral techniques.

Individual Supported Employment means services, including ongoing supports, needed by an individual to acquire and maintain a job in the integrated workforce at or above the state's minimum wage. The outcome of this service is sustained paid employment that meets personal and career goals.

Integrated Dual Disorder Treatment (IDDT) means an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services.

Integrated Health Homes means a service model that facilitates access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. Services may include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.



Matrix Model means an intensive outpatient treatment approach for stimulant abuse and dependence that was developed through 20 years of experience in real-world treatment settings. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period.

Mindfulness-Based Stress Reduction (MBSR) means a form of psychoeducational training for adolescents and adults with emotional or psychological distress due to medical conditions, physical pain, or life events. MBSR is designed to reduce stress and anxiety symptoms, negative mood-related feelings, and depression symptoms; increase self-esteem; and improve general mental health and functioning.

Motivational Interviewing (MI) means a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change. The examination and resolution of ambivalence becomes the key goal.

Nurtured Heart Approach (NHA) means a social emotional strategy that transforms negative behaviors into positive behaviors, increases interrelatedness and connectivity among family members, couples, teachers and students.

Parent-Child Interaction Therapy (PCIT) means a treatment program for young children with conduct disorders that place emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.

Peacemakers Program is a traditional Native American approach to justice that focuses on healing and restoration rather than punishment including local elders working with juveniles using traditional Native methods.

Peer Recovery Coaches means a one-on-one relationship in which a peer leader uses their own substance abuse recovery experience to encourage, motivate and support a peer seeking to establish or strengthen his or her own recovery.

Peer Support Services means a service provided by a peer support specialist, including but not limited to, education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.

Permanent Supportive Housing means voluntary, flexible supports to help individuals with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community.

Solution-Focused Group Therapy (SFGT) means a strengths-based group intervention for clients in treatment for mental or substance use disorders that focuses on building solutions to reach desired goals.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) means a 16-session group intervention specifically designed to address needs of chronically traumatized adolescents living with ongoing stress and experiencing problems in several areas of functioning.

Structured Sensory Intervention for Traumatized Children, Adolescents and Parents At-risk Adjudicated Treatment Program (SITCAP-ART), means a program for traumatized adolescents 13-18 years on probation for delinquent acts. These youth, court ordered to attend the program, are at risk for problems including dropping out of school, substance abuse, and mental health issues.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) means a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents.

Youthworks means a program for at risk youth and runaway by maintaining a 24/7 crisis line answered by licensed professionals to help with crisis intervention and referrals.



Appendix D

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Appendix E

Implementation Plan

In Process or Beginning Today

Action Steps	Legislation Required	Priority
DHS shall utilize CAHs for behavioral health services utilizing telemedicine to its full potential	None	High
DHS shall utilize HCBS waiver and SDMI waiver for MHSa services	None	High
DHS shall continue to expand IDDT services throughout regions	None	High
DHS shall increase after hour options like Devils Lake NIATx walk in clinic including assessment options	None	High
DHS or Legislature along with universities shall make sure all required BH coursework is available in ND	None	High
Legislature shall re-evaluate Essential Health Benefit option selected partnering with other interim committee	None	High
Legislature and executive branch shall determine if insurance coverage meets federal parity standards and determine what core services should be covered.	None	High
DHS shall create opportunities to strengthen advocacy voices to assist in making system change	None	High
DHS shall review record sharing options and stream line including application for residential facilities	None	High
DHS shall document efforts to improve communication among providers, including county youth providers	None	High
DHS shall standardize policies and procedures that foster better communication including HSC admission access criteria and job vacancies	None	High
DHS and stakeholders together shall map current resource distribution inside and outside of HSC system including "legacy" services and services ONLY provided by DHS	None	High

2015 Legislature

Action Steps	Legislation Required	Priority
Legislature shall increase funding for adult and youth substance abuse services including detox	Yes- Appropriations	High
Legislature shall authorize use of telemedicine for crisis assessment and remove barriers for full utilization	Yes	High
Legislature shall increase funding for equipment for CAHs to create ePsychiatry	Yes- Appropriations	High
Legislature and DHS shall create an oversight system for licensing boards utilizing public health as overseer	Yes	High
Legislature shall change definition of behavioral health professional in Century Code to include all qualified professionals	Yes	Medium
DHS or Legislature shall create reciprocity language for BH professionals	Maybe	High



DHS shall train law enforcement as first responders using MH First Aid	Yes - Appropriations	High
Legislature shall change Century code to reimburse all qualified behavioral health professionals	Yes	High
Legislature shall create an independent appeal process for consumers increasing oversight and accountability	Yes	High
DHS shall seek to maximize federal funding for Visiting Nurses and other 0-5 prevention programs	No	High
DHS or Legislature shall change regulations to accept electronic documentation including ROIs	Maybe	Medium
DHS shall assist First Link/211 in obtaining access to provider information	No	Medium
DHS shall partner with universities to build an outcomes based data system	Maybe	Medium
Legislature create an interim committee to look at DHS structure changes and provide oversight to current HSC system including defining core services throughout system	Yes	High
Legislature create an interim committee to study judicial issues such as 24 hour hold, termination of parental rights; and court committals	Yes	High

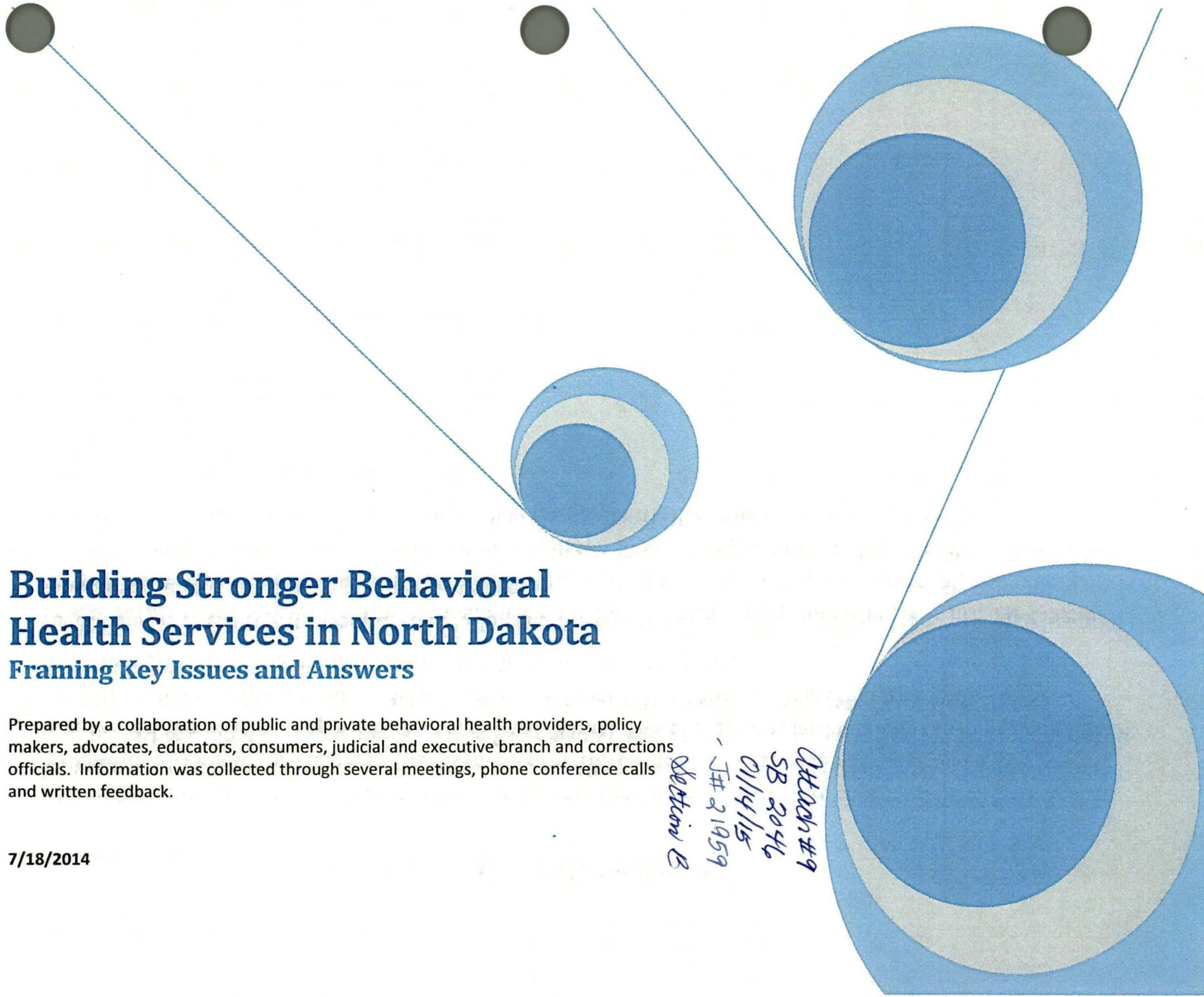
2017 Legislature

Action Steps	Legislation Required	Priority
Legislature shall create a bed management system and provider registry	Yes	Medium
DHS shall privatize case management to add choice	Maybe	Medium
Legislature shall increase funding for peer support and recovery coaches, mobile crisis, and law enforcement in schools	Yes- Appropriations	Medium
Legislature shall increase funding to BH professionals in training including LAC	Yes- Appropriations	Medium
Legislature pass legislation to begin DHS structural changes outlined in 2015 Legislative Assembly	Yes	Medium
DHS and Legislature shall move toward integrated health in Medicaid including care coordination with peer support	Yes	Medium
DHS shall create an intra-agency council for coordination of services	No	Medium
Legislature shall create an interim committee to continue DHS changes and address transportation issues across agencies	Yes	High

2019 Legislature

Action Steps	Legislation Required	Priority
DHS shall continue structural changes outlined in 2017 Legislative Assembly	No	Medium
Legislature shall authorize interim committee to monitor transition of DHS structure and monitor unintended consequences.	Maybe	High





Building Stronger Behavioral Health Services in North Dakota

Framing Key Issues and Answers

Prepared by a collaboration of public and private behavioral health providers, policy makers, advocates, educators, consumers, judicial and executive branch and corrections officials. Information was collected through several meetings, phone conference calls and written feedback.

7/18/2014

*Attachment #9
SB 2046
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Acknowledgements

This project was a volunteer driven initiative that was dependent on the voluntary contributions of participants, facilitators, experts and presenters. Thanks to the over 100 participants that have been involved in this process over the last five months. (Appendix A – list of Participants) This process was facilitated by the Behavioral Health Steering Committee which included Senator Judy Lee, Senator Tim Mathern, Representative Kathy Hogan, Representative Pete Silbernagel, Joy Ryan, Rod St. Aubyn and John Vastag.

Special thanks to the Dakota Medical Foundation and the Health Policy Consortium (HPC) who provided financial support for various meetings/materials/meals/website. Both of these organizations are strongly committed to improving the quality and accessibility of community based services for persons with behavioral health issues. Special thanks also to Sanford Health for providing the administrative support services of Pam Posey.

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THE PROCESS

Background Information

In the fall of 2013, a group of concerned individuals met to discuss the emerging behavioral health challenges. After reviewing the legislative initiative to review existing services and identify unmet needs, it was agreed that a private parallel process could be helpful in identifying key issues and potential solutions. The group decided that a two day working session would be held in February 2014 with key stakeholders from both various provider organizations and also related partners.

Stakeholder Meeting I

The stakeholder meeting had two distinct components. The first day began with an environmental scan of behavioral health in North Dakota prepared by Dr. Nancy Volgletanz-Holm and presented by Dr. Gwen Halaas, UND School of Medicine. The participants then spent the afternoon identifying and prioritizing key challenges in three areas of behavioral health: Adult Mental Health; Children's Mental Health; Adult/Adolescent Substance Abuse. A SAMSHA template of the components of a comprehensive system of behavioral health care was shared.

The second day the participants worked to identify recommendations and solutions for the issues and challenges identified on the first day. Only the top four to six areas of concern were addressed in the group process although additional recommendations were suggested by the participants. Thirty three individuals participated in the first session.

Stakeholder Meeting 2

A second stakeholder session was held in Bismarck on March 25th at the UND Center for Family Medicine to share the preliminary findings and begin the development of specific action steps. Thirty eight individuals participated in the second session. This session resulted in the preliminary list of recommendations and action steps.

Additional Feedback

The recommendations from the second meeting were shared with all stakeholders and individuals who had indicated interest. They were given a month to provide feedback or additional suggestions.

Recommendation Reviews – Conference Calls

Three phone conference calls were held in early June to review the recommendations/action plans prior to publication of this document.

Website

A website was developed to provide additional access to information on the process. It is currently available at:

<http://www.ndbehavioralhealth.com/#/home>

“Final Report - Road Map for the Future”

The steering committee recognizes that implementation of all of the recommendations in this report will take a number of years. It is the intent of this document, that it be used in collaboration with the recommendations of the Legislative Consultant, Renee Schulte, to begin to address the myriad of issues. Many of the issues can be addressed through administrative action while others will require legislation and or funding.

THE RECOMMENDATIONS

Full recommendations

The recommendations in this report are organized into five areas; Adult Mental Health, Children's Mental Health, Adult/Adolescent Substance Abuse, Work Force Development and Legislative Recommendations.

Workforce development had major similarities across all of the program areas and for this reason was combined into one set of recommendations. The recommendations for legislative consideration during the 2015 session were combined into one section for easier access to policy makers as to the roadmap ahead.

Some of the recommendations can be accomplished administratively by various groups such as insurers, state level departments or local groups.

Legislative Recommendations

The recommendations for legislative consideration during the 2015 session were then combined into one document.

Adult Mental Health Recommended Action Plan

Strategic Initiative 1: Increase accessibility to behavioral health services through a more consistent, coordinated and transparent system of care

Adult Goal 1.1 Identify core services available in all regions of the state including public and private providers. Have a consistent public sector delivery system that is routinely monitored based on public data.

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
HSC provide data on current core services provided including outcome measures if available.	DHS/Medical School	To be done by Jan 2015	Data routinely provided like quarterly budget update.
Establish a unified system of DHS core services – that are available and accessible through HSC or private providers by vouchers. (Use SAMSHA Guidelines/Grid)	ND Legislature	* 2015 session	Regular data reporting on provision of core services by regions. (like quarterly budget summary)
Review data to identify where service is lacking or inconsistencies between regions.	DHS	2015 session	Regular reporting to legislators like the quarterly update.
Study option of having both public and private BH providers and insurers using common data system.	DHS/Medical School	2017 legislative session	Comprehensive data system

Expand eligibility for case managers beyond federal definitions to assure that all people with functional needs have access to services – including privatization of case management.	DHS	2017	Reduce numbers of persons in jails with behavioral health issues.
Establish a state level structure that coordinates seamless systems of care, i.e. DHS/DPI/DoC/Dept. of Health, Insurance Department, and School of Medicine.	Governor's office	Sept 2015	Report to interim legislative committee on ongoing for the next four years.
Expand Peer support systems.	DHS/MHA	2017	Reduce inappropriate use of crisis services
Expand use of telemedicine to some or all core services offered through human services.	DHS/Private providers Develop inventory of current services and potential expansion services	Beginning in 2015	Assure that telemedicine behavioral health services has increased access to rural areas.
Address telemedicine reimbursement from insurers.	Insurers and ND Insurance Commissioner, private and public providers	2017 legislative session	Prepare a report and recommendations for 65 th session regarding technology and policy needs.
Establish training for 1 st responders on BH core services.	DHS and Law enforcement	2017	All first responders trained.
Establish and publish a 24 hour response system statewide for BH core services.	DHS and First Link, First responders	2017	System in place including evaluation and data components.
Establish 4 Adult Mental Health Assessment Centers in the 4 largest communities in ND. Establish a Hennepin county model; may need to look at the 72 hour hold that MN has in place; develop process to make sure people have a correct diagnosis.	Hospital Association, Medical Association, DHS, Legislature	*2015 session	First system established by 2016 with additional assessment centers added through 2019.

Assure that payers understand and support through funding the key components of core services.	DHS and Insurers, Insurance Department	2017	May or may not require legislation.
Add to Medicaid dollars with state funding for IMD exclusion.	DHS , Stakeholders, legislators	2017	Broader access to appropriate service.

Adult Goal 1.2 Identify and inform consumers/partners of available services

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Make consumers aware of the services provided/211 and through SAMHSA directory.	Need a professional marketing plan (similar to Easy as Pie campaign)	*2015 leg session	At completion.
Assure that 211 has access to all funded provider information including for profit providers.	First Link and DHS	2015	At completion.
Establish electronic application system for public BH services.	Sheldon Wolff /DHS	2017	Full implementation.

Adult Goal 1.3 Strengthen relationships between providers

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Expand role of regional BH Task Forces (CCC's) from all of the different partners to address cross system issues and develop joint training.	Director of each HSC shall convene with local law enforcement partners, hospital association, medical association, private agencies, EMS, public health, FQHCs, legislators, homeless programs, counties.	Within 6 months	Regular meetings will be held at least quarterly and minutes will be maintained. At least one annual training will be held in each region.
Better coordination with all partners through improved communication – i.e. newsletters, e-mail.	DHS/Law Enforcement/UND/ ND Association of Psychologist, Psychiatrists, social workers and addiction counselors	2017	

Adult Goal 1.5 Develop crisis response system with accountability standards

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Involve key Behavioral Health partners (EMS, law enforcement, health care providers, and private providers partners, homeless clinics, public health in the crisis mobile response team (Southeast Region) to develop outcome standards.	DHS – SE; Fargo and Cass County Law Enforcement, first responders.	By January 1, 2015 have a formal report on opportunities, any limitations and recommendations	At completion.
Expanding the crisis mobile response team to other regions with outcome standards and reporting requirements based on the pilot project.	DHS	*2015 legislative session	To have crisis response services available in all regions by 2019.

Adult Goal 1.6 Improve Discharge Planning and Coordination

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Involve key Behavioral Health partners (law enforcement, health care providers, and private partners) in one region to develop discharge planning protocols in one region including the establishment of outcome measures. Fund a one year pilot project for one year.	DHS Private providers Private insurance companies; DHS for HSC clients; Medicaid funding (traditional and expansion populations)	* 2015	

Expanding the discharge planning protocols to other regions with outcome standards and reporting requirements based on the pilot project.		2017	
Determine what is needed for county jails to access medical information for clients. Can the jails have electronic access to provider's health records?	Sheldon Wolf and requesting assistance from Mike Mullen - In collaboration with the Court system and the CGIS system, consider options	2015	At completion.

Strategic Initiative 2: Identify and address changes in Rules/NDCC/Licensing issues

Adult Goal 2.1 Review and Revise commitment procedures/processes

Action Steps	Key Leaders	Date implemented	Outcome
<p>Action Steps</p> <p>Support DHS Task Force Expand involvement to other stakeholders to address hearing and dispositional hearing timelines.</p> <p>Support Interim Health Care Reform committee changes in expert examiners including the expansion of nurse practitioners as health care expert witnesses.</p>	<p>Key Leader</p> <p>Dr. Etherington, Interim Committee State's Attorneys</p>	<p>Date implemented</p> <p>6 months * 2015 legislation</p>	<p>How to Measure</p> <p>Report by October 2014. Simplify procedures.</p>

Adult Goal 2.3 Revise the NDCC to permit Law Enforcement to access behavioral health information to assure public safety

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Establish mechanism so that law enforcement can access information on individuals who may have been committed.	Commitment task force (Dr Etherington)	6 months May need 2015 legislation	At completion.
Amend law to allow Attorney General to review commitment records prior to issuing concealed weapons requests records.	Attorney General/ BCI	6 months	

Children and Adolescent Mental Health Recommended Action Plan

Strategic Initiative 1: Increase accessibility to specialized behavioral health services through a more consistent, coordinated and transparent system of care.

Children/Adolescent Goal 1.1 Identify core services available in all regions of the state including public and private providers. Have a consistent public sector delivery system that is routinely monitored based on public data.

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Identify actual HSC children’s services with common definitions and data by service by region.	DHS, Stakeholders, Legislature	Fall 2014	At completion.
Adopt core service standards or grid for children/adolescent mental health through DHS.	ND legislature, Stakeholders	*2015	At completion.
Identify unmet children’s needs by region.	Advocacy groups: Family Voices, MHA, NAMI, Autism taskforce, DHS , providers Stakeholders	Fall 2015	At completion.
Establish children/adolescent assessment network or centers in each region of state to incorporate attendant/shelter care with a system like STEP at DBR.	DHS, Stakeholders, DJS/Youthworks, DBGR	* 2015	More consistent comprehensive assessments to ensure that functional needs are addressed. Decrease the number of children inappropriately placed in county or DJS custody.

Assure that the assessment process is consistently utilized by various providers.	DHS, Advocacy groups: Family Voices, MHA, NAMI, Autism taskforce, DHS, providers, Stakeholders,	July 2017	To assure appropriate services at appropriate level of care for children.
Expand case management throughout the system regardless of payment streams including DJS/Counties/HSC/schools (No wrong door for case management for children) Allow PDD into system.	DHS/DJS/Counties, Schools Stakeholders	2017 biennium	To assure that children with mental health needs have access to services.
Expand peer mentoring.	DHS/MHA, Stakeholders	2017 Biennium	At completion.
Expand eligibility and funding for parent to parent case management.	Stakeholders	2017 Biennium	At completion.
Establish regional children's BH Task Force from all of the different partners to address cross system issues and develop joint training.	Director of each HSC shall convene with schools, juvenile court private providers, hospitals, Stakeholders	Within 6 months	Regular meetings will be held at least quarterly and minutes will be maintained. At least one annual training will be held in each region.
Expand awareness and utilization of children's crisis services at HSC's through education/networking.	DHS, First Link, stakeholders, legislators	July 2016	At completion based on DHS data.
Inform the public of the children's mental health issues to reduce the stigma and increase early intervention through education and media efforts.	DHS, MHA, Stakeholders	* 2015	Ongoing

Children/ Adolescent Goal 1.2 Evaluate residential treatment service options/expand community alternatives

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Review current in-state residential service options to determine if the current system is meeting the needs of children including a review of level of care and geography.	DHS, Stakeholders	Six months	At completion – monitor bed utilization for residential treatment length of stay.
Expand eligibility for family support and partnership. (both insurance and Medicaid)	DHS, Stakeholders	Next biennium	At completion.
Expand behavioral health services including family support and partnership programs on the reservations to reduce unnecessary use of residential treatment.	DHS/Tribes, Stakeholders	Next biennium	Reduced inappropriate use of residential.
Review reimbursement mechanisms and NDCC so parents don't have to give up custody to get services.	DHS/Legislature bill draft , Stakeholders	Next Biennium	DHS will provide information on utilization of this system and prepare recommendation to address any unmet needs and inform partners of the process.
Expand community alternatives by applying for a Medicaid waiver for HCBS services for at least half of the available options	DHS Stakeholders	Next biennium	At completion. To be evaluated at the end of the biennium.
Assure that the assessment process is consistently utilized by various providers.	DHS, Advocacy groups: Family Voices, MHA, NAMI, Autism taskforce, DHS , providers, Stakeholders	July 2017	Assure appropriate services at appropriate level of care for children.

Strategic Initiative 2: Expand availability of behavioral health services within the schools.

Children/Adolescent Goal 2.1 Expand onsite behavioral health services within the schools.

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps Establish a system to allow for MH providers in schools similar to Yellowstone County in Montana.	Key Leader DPI and DHS , Stakeholders	Date implemented Next biennium	How to Measure At Completion earlier intervention in less restrictive environment.
Establish Mental Health Day Treatment Programs in schools i.e. Partial hospitalizations.	DPI/DHS, Stakeholders	Next biennium	At completion broader array of services reduction in out of home placements.
Expand options for school districts to contract directly with non-profit agencies to provide onsite behavioral health services that will augment not replace school counselors.	Human Services Committee recommend expansion of funding under DPI for school districts to have the option of hiring qualified mental health professionals (LP, LICSW, LPCC, LMFT) to provide assessment and coordinated referral of students with complex or critical clinical needs (e.g. chemical abuse, self-injurious behavior, thoughts of harm to self or others). Stakeholders		

Strategic Initiative 3: Establish early childhood behavioral health screening and assessment.

Children/ Adolescent Goal 3.1 Establish consistent early childhood behavioral health screening, assessment and treatment to be available for all pre-school children.

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps Fund and expand routine standardized screening using evidence based practice throughout the state to routinely screen all 2, 3 and 4 year olds at primary care sites. – Pilot project in 2015 Full implementation in 2017	Key Leader DHS/DPI, Stakeholders, Legislators	Date implemented * 2015 Legislature	How to Measure Evidence based system implemented across the state integrated into primary care system.
Evaluate outcome data on behavioral health screening tools done with Health Tracks – monitor referral patterns and unmet needs.	DHS, Stakeholders	By January 2015	Recommend changes in system based on evaluation.

Adult/Adolescent Substance Abuse Recommended Action Plan

Strategic Initiative 1: Increase accessibility to specialized behavioral health services through a more consistent, coordinated and transparent system of care.

Substance Abuse Goal 1.1 Identify core services available in all regions of the state including public and private providers. To have a consistent public sector delivery system that is routinely monitored based on public data.

Action Steps	Key Leaders	Date implemented	Outcome
Adopt ASAM Core Services Grid - one for Adult and one for Adolescent. (See Appendix B - 3)	ND Legislature, Stakeholders	*2015	Clear expectations.
Evaluate availability of current services within the grid. Need to know what the unmet needs are – (supply/demand) – waiting lists.	DHS/ SA Providers NDACA/NDATPC/DHS, Stakeholders	2015	Common vision, knowledge of resources, identify holes, common language and measurements. Systematic planning to address unmet need.
Expand use of private providers to provide DHS core services based on new grid including allowing private providers access to Medicaid funding.	NDACA/NDATPC/DHS, Stakeholders	*2015	Expanded availability of services.
Establish a simplified transparent web site (use DHS/SAMSHA information)	DHS/First Link , Stakeholders	Six months	More public information.

that is easily accessible to the public through 211.			
Expand use of recovery navigators/coaches.	NDACA/NDATPC/DHS, Stakeholders	2017 Legislative session	Implemented state wide with performance standards.

Substance Abuse Goal 1.2 **Expand Medical and Social detoxification resources**

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Assess current services and develop a plan to assure services in all regions. Support local efforts to build comprehensive detox structure.	NDACA/NDATPC/DHS, Stakeholders, Law Enforcement, Public Health, Legislators	January 2017	Completion of plans in 8 regions.
Expand the behavioral health training model first responders used in Cass County to the whole state and integrate into Post Training standards.	JICC workgroup and MHA , Stakeholders	* Legislation July 2016	Full implementation of training.

Substance Abuse Goal 1.3 **Identify funding structures both public and private that support a comprehensive system of care.**

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Adopt ASAM Core Services Grid. Work with insurance providers to fund the grid.	SA Providers and DHS/Insurers NDACA/NDATPC/DHS, Stakeholders, Legislators	July 2015	Consistency between insurers and public funders.
Expand Medicaid to Licensed addiction agencies and others that are eligible for 3 rd party reimbursements.	Legislature , Stakeholders	July 2015	Implemented

Strategic Initiative 2: Inform the public of the risks of substance abuse through education and media efforts to reduce abuse.

Substance Abuse Goal 2.1 Develop a major public information campaign and primary prevention initiative.

Action Steps	Key Leaders	Date implemented	Outcome
Market 211	DHS and FirstLink, Stakeholders	One year/on-going	Completion
Develop formal statewide effort with local community involvement.	Governor's office DHS/Health Department Local Public Health, Stakeholders	Ongoing	Completed and maintained.
Expand Parent Lead initiative.	DHS/DPI , Stakeholders	Ongoing	

Behavioral Health Workforce Development Recommended Action Plans

Strategic Initiative 1: Increase the availability of training professionals in all of the behavioral health fields.

Workforce Goal 1.1 To build a network or system of planning that assures that all interested parties/systems are working together.

Action Steps	Key Leaders	Date implemented	Outcome
Action Step	Key Leaders	Date implemented	Outcome
Develop behavioral health workforce.	ND AHEC RU Ready ND, NDUS, Various professionals Boards/Organizations	2016 – 2022	Gain of 40 behavioral health care workers.
Tuition assistance for behavioral health students, including tuition buy-downs, Internship stipends.	NDUS	2016	Assist 65 NDUS students taking behavioral health programs and 40 complete programs.
Advocate behavioral health students as part of the Inter-Professional Education (IPE) approach to clinical rotations.	ND AHEC UND NDUS, Various professional Boards/organizations	2016—2022	Gains in teamwork and understanding of 40 students in behavioral health.

Workforce Goal 1.2 Expand and train substance abuse workforce and key partners.

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Require that all primary care physicians have 2.5 CEU's of substance abuse training annually.	Medical Association, Medical School, Stakeholders, various other professional Boards and Associations, NDUS		Completed

Provide basic training in schools on behavioral health issues for teachers, child care providers using Mental Health First Aide model.	DPI and ND University System, Stakeholders, NDSU Extension	*July 2015	When fully implemented it will.
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Adult Mental Health Goal 1.4 Expand and train workforce and key partners.

Action Steps	Key Leaders	Date implemented	Outcome
Action Steps	Key Leader	Date implemented	How to Measure
Establish a focus group that will promote the training and integration of primary care with behavioral health.	UND – Medical School, DHS, LTC Association, Hospital Association	By 2016	Completed.
Require and fund the infrastructure for telehealth/e-psychiatry in all hospitals and human service centers.	Department of Health/ Department of Human Service - ND Legislature, ND Hospital Association	2017	Completed so that telehealth is available in all parts of the state.
Fund professional education for high need areas i.e. LAC. Change laws and regulations to allow students in training to be reimbursed.	NDSU/UND and various funders		
STEM type program for Behavioral Health.			
Implement Rural MH and SA Tool Box.	CAH, Rural Health, MHA, DHS and Health Department, ND Hospital Association	*January 2015	Completed by 2017 in at least 4 regions and an additional 4 regions by 2019.

Work Force issues 1.5 Adult Mental Health Review Licensing requirements for various mental health/LAC professionals.

Action Steps	Key Leaders	Date implemented	Outcome
Establish professional licensing board standards to allow: <ol style="list-style-type: none"> 1. One year of practice if licensed in another state. 2. Process for meeting ND licensing standing during the 1 year period. 3. Reciprocity of licenses between Montana, South Dakota and Minnesota. 4. Method for issuing licenses within 30 days. 	Various Licensing Boards	* 2015 legislative session	
Improve timeliness of approval for new providers by licensing boards and MA/Insurers.	Various Licensing Boards		
Require that private 3 rd party payers include coverage for couples and marriage & family therapy as part of behavioral health services and include all licensed mental health professionals with established competencies in couples, relationship, and family therapy as eligible providers.	Human Services Committee recommend a bill be drafted that requires all 3 rd party insurers operating in the state of ND to provide coverage for CPT Codes for Family Psychotherapy (e.g. 90846 Family Psychotherapy without the patient present, 90847 Family Psychotherapy, conjoint psychotherapy with the patient present, and 90849 Multiple-Family Group Psychotherapy). Coverage will include Licensed Psychologists, Licensed	*2015 legislative session	Expand service providers.

	Independent Clinical Social Workers, Licensed Professional Clinical Counselors and Licensed Marriage and Family Therapists. Providers will need to have established, with their licensure boards, competencies in providing marital and family psychotherapy.		
State amend its Medicare and Medicaid plan to include LPCC and LMFT Licensed Professionals in its coverage. Our state has grown and our population has very diverse needs; to exclude highly competent providers from the mix of clinicians qualified to receive Medicare and Medicaid reimbursement severely limits the options of people in need. Past efforts to amend the plan have received push back from those who wish to maintain their exclusivity in providing services. It is time to move past that narrow focus and provide a more comprehensive and health focused array of professionals.		* 2015 legislative session	
Extend prescription privileges to qualified Licensed Psychologists. Currently New Mexico and Louisiana have set		*2017 legislative session	

licensure standards and license qualified psychologists to prescribe certain medications related to nervous and mental health disorders. Additional qualified prescribers will help alleviate wait times for access to Psychiatrists or Clinical Nurse Specialists which has gone from weeks to now months. Those waits have created a great deal of frustration for persons in need of prescription services who then seek those services through emergency care or walk in clinics, creating both increased costs and a lack of continuity in care.

BEHAVIORAL HEALTH STAKEHOLDERS PRIORITY RECOMMENDATIONS FOR 2015

ALL ACTIONS IN GREEN REQUIRE LEGISLATION or FUNDING IN 2015

ALL ACTIONS IN PURPLE WILL REQUIRE LEGISLATION OR FUNDING IN 2017

ALL ACTIONS IN BLACK ARE ADMINISTRATIVE AND COULD BE STARTED IMMEDIATELY

Substance Abuse

Action Steps	Key Leaders	Date implemented	Outcome
CORE SERVICES Adopt ASAM Core Services Grids - one for Adult and one for Adolescent. Define HSC Roles, move to a private and/or voucher system whenever possible.	ND Legislature, Stakeholders	*2015	Clear expectations, for public and private providers. Regular data reporting and possible expansion of available resources.
EXPAND MEDICAID Expand Medicaid to Licensed addiction agencies and others that are eligible for 3 rd party reimbursements.	Legislature , Stakeholders/ NDACA/NDATPC/DHS	July 2015	Expansion of available resources Could be administrative rather than legislative.
TRAIN 1st RESPONDERS Expand the behavioral health training model for first responders used in Cass County to the whole state and integrate into Post Training standards.	JICC workgroup and MHA , Stakeholders	July 2016	Full implementation of training.
INSURANCE COVERAGE Work with insurance providers to fund ASAM Core Service.	SA Providers and DHS/Insurers NDACA/NDATPC/DHS, Stakeholders Legislators,	On – going	Consistency between insurers and public funders. (Administrative)

ADULT MENTAL HEALTH

Action Steps	Key Leaders	Date implemented	Outcome
<p>CORE SERVICES Established a unified system of DHS core services – that are available and accessible through HSC or private providers by or vouchers. (Use SAMSHA Guidelines/Grid)</p>	DHS and ND Legislature	* 2017 session	DHS will provide data on provision of NDCC core services by regions (like quarter budget summary) starting 1/2015. Next interim to study core adult mental health needs to make recommendations to Legislature. (Administrative)
<p>ASSESSMENT CENTERS Establish 4 Adult Mental Health Assessment Centers in the 4 largest communities in ND. Train Critical Access Hospitals to triage behavioral health issues including access to telemedicine to Mental Health Assessment Centers.</p> <p>Establish a Hennepin county “like” model; may need to look at the 72 hour hold that MN has in place; to include developing process to make sure people receive a diagnosis or the correct diagnosis.</p>	Hospital Association, Medical Association, DHS, Legislature	*2015 session	Establish four assessment units, one every 6 month starting January 1, 2016.
<p>HCBS WAIVER Expand the range of community based services through mental health HCBS waiver to assure access in both rural and urban.</p>	DHS	*2015 session	Fully implementation statewide – target Date 2017. (Administrative)

<p>FIRST LINK/211 Assure that 211 has access to all funded provider information including for profit providers (make it a requirement for MA and contracts). Assure that consumers aware of services through 211 and SAMHSA director.</p>	<p>First Link and DHS</p>	<p>2015</p>	<p>At completion</p>
<p>MOBILE CRISIS UNITS Expanding the crisis mobile response team to other regions with outcome standards and reporting requirements after the establishment of comprehensive assessment services.</p>	<p>DHS</p>	<p>*2017 legislative session</p>	<p>To have crisis response services available in all regions by 2019.</p>
<p>DISCHARGE PLANNING Involve key Behavioral Health partners (law enforcement, health care providers, and private partners) in one region to develop discharge planning protocols in one region including the establishment of outcome measures. Fund a one year pilot project for one year.</p>	<p>DHS Private providers Private insurance companies; DHS for HSC clients; Medicaid funding (traditional and expansion populations)</p>	<p>* 2015</p>	<p>Consistent system of care for hospital discharges.</p>

<p><u>Commitment Related Legislation</u> Support DHS Task Force that addresses hearing timelines.</p> <p>Support changes in expert examiners including the expansion of nurse practitioners as Health care expert witnesses.</p> <p>Establish mechanism so that law enforcement can access information on individuals who may have been committed.</p>	<p>Dr. Etherington, Interim committee, State's attorneys</p>	<p>* 2015 legislation</p>	<p>Report by October 2014 Legislation should be prepared by DHS. (Administrative and Legislative)</p>
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Children/Adolescent Mental Health

Action Steps	Key Leaders	Date implemented	Outcome
<p>ASSESSMENT SERVICES Establish children/adolescent assessment network or centers in each region of state to incorporate attendant/shelter care with a system like STEP at DBR. These services should include access through critical assess hospitals using telemedicine.</p>	<p>DHS, Stakeholders DJS/Youthworks, DBGR</p>	<p>* 2015</p>	<p>More consistent comprehensive assessments to ensure that functional needs are addressed. Decrease the number of children inappropriately placed in county or DJS custody.</p>
<p>CORE SERVICES Adopt core service standards or grid for children/adolescent mental health through DHS.</p>	<p>DHS, ND legislature, Stakeholders</p>	<p>*2017</p>	<p>DHS will provide data on provision of NDCC core services by regions (like Quarterly budget summary) starting 1/2015. Next interim to study core Adult mental health needs to prepare recommendations to Legislature. (Administrative)</p>
<p>PRE-SCHOOL SCREENING/ASSESSMENT Evaluation outcome data on behavioral health screening tools done with Health Tracks and Healthy Steps – monitor referral patterns and unmet needs. Prepare Recommendations to establish routine standardized screening using evidence based practice throughout the state to routinely screen all 2, 3 and 4 year olds at primary care sites. – Pilot project in 2015 Full implementation in 2017.</p>	<p>DHS/DPI, Stakeholders, Legislators</p>	<p>* 2015 Legislature</p>	<p>Evidence based system implemented across the state integrated into primary care system. Interim committee monitoring next session. (Administrative and Legislative)</p>

WORKFORCE DEVELOPMENT

Action Steps	Key Leaders	Date implemented	Outcome
<p>LICENSING STANDARDS Establish professional licensing board standards for mental health professionals to allow</p> <ol style="list-style-type: none"> 1. One year of practice if licensed in another state. 2. Process for meeting ND licensing standing during the 1 year period. 3. Reciprocity of licenses between Montana, South Dakota and Minnesota. <p>Method for issuing licenses within 30 days.</p>	<p>Various Licensing Boards</p>	<p>* 2015 legislative session</p>	<p>Reduce barriers for applicants and increase providers.</p>
<p>LAC STIPEND Expand numbers of LAC by Establishing a stipend program for LAC interns that would be forgiven if LAC practices in state for 4 years. Proposed \$25,000/applicant.</p>	<p>NDACA/NDATPC/DHS, Legislature, Stakeholders, various other professional Boards and Associations, NDUS</p>	<p>*July 2015 40 slots – \$1, 000,000</p>	<p>Increase LAC</p>
<p>LAC TRAINING SLOTS Expand LAC training slots by providing stipends for organizations that offer training slots. (\$5,000/slot)</p>	<p>Legislature, Stakeholders, Six LAC training Consortiums</p>	<p>*July 2015 40 slots - \$200,000</p>	<p>Increase LAC</p>

<p>STUDENT LOAN BUY DOWNS Establish a student loan buy down system for licensed BH clinical staff.</p>	<p>Legislature, DHS, NDUS</p>	<p>July 2015</p>	<p>Increased BH providers throughout state.</p>
<p>TRAIN PARTNERS Provide basic training in schools on behavioral health issues for teachers, child care providers using Mental Health First Aid model.</p>	<p>DPI and ND University System, Stakeholders, NDSU Extension</p>		<p>When fully implemented it will provide a network of trained first responders. This could be administrative or if funding needed consider in 2017.</p>
<p>BROADEN INSURANCE Encourage private 3rd party payers include coverage for couples and marriage & family therapy as part of behavioral health services and include all licensed mental health professionals with established competencies in couples, relationship, and family therapy as eligible providers. Provide coverage for CPT Codes for Family Psychotherapy (e.g. 90846 Family psychotherapy without the patient present, 90847 Family psychotherapy, conjoint psychotherapy with the patient present, and 90849 Multiple-family group psychotherapy).. Providers will need to have established competencies by their licensure boards.</p>	<p>Legislature, Insurance Providers, DHS, Various Licensing Boards Including Psychologists, Social Workers, Licensed Counselors, Licensed Marriage and Family Therapists.</p>	<p>July 2015</p>	<p>Expand available service providers Administrative – work with 3rd party payers.</p>

<p>EXPAND MEDICAID Amend state Medicaid plan to include LPCC and LMFT licensed Professionals in its coverage. It is time to provide a more comprehensive array of professionals.</p>	<p>DHS May require additional matching funds.</p>	<p>July 2015</p>	<p>Increase numbers of providers and expand consumer options.</p>
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ALL ACTIONS IN GREEN REQUIRE LEGISLATION or FUNDING IN 2015

ALL ACTIONS IN PURPLE WILL REQUIRE LEGISLATION OR FUNDING IN 2017

ALL ACTIONS IN BLACK ARE ADMINISTRATIVE AND COULD BE STARTED IMMEDIATELY

APPENDIX A

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BEHAVIORAL HEALTH TALKING POINTS

Attach #9
SB 2046
01/14/15

1/9/2015

J# 21959
Section C

1) HB 1040 – Scope of Practice in Involuntary Commitment Proceedings
Health Care Reform Review Committee
First Draft

PURPOSE: This bill expands the scope of practice for Advanced Practice Registered Nurses in involuntary commitment proceedings.

BACKGROUND: Interim committee testimony indicated that advanced practice registered nurses are often primary care providers. This bill helps address the scope of practice for these practitioners.

C.2

15.0133.01000

Sixty-fourth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1040

Introduced by

Legislative Management

(Health Care Reform Review Committee)

1 A BILL for an Act to amend and reenact sections 25-03.1-02, 25-03.1-04, 25-03.1-06,
 2 25-03.1-07, 25-03.1-08, 25-03.1-10, 25-03.1-11, 25-03.1-16, 25-03.1-17, 25-03.1-18.1, and
 3 25-03.1-19, subsection 3 of section 25-03.1-21, and sections 25-03.1-23, 25-03.1-25,
 4 25-03.1-26, 25-03.1-27, 25-03.1-41, and 25-03.1-42 of the North Dakota Century Code, relating
 5 to scope of practice in involuntary commitment proceedings; and to provide a penalty.

6 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

7 **SECTION 1. AMENDMENT.** Section 25-03.1-02 of the North Dakota Century Code is
 8 amended and reenacted as follows:

9 **25-03.1-02. Definitions.**

10 In this chapter, unless the context requires otherwise:

- 11 1. "Advanced practice registered nurse" means an individual who is licensed as an
 12 advanced practice registered nurse under chapter 43-12.1 within the role of certified
 13 nurse practitioner or certified clinical nurse specialist, and who is functioning within the
 14 scope of practice in one of the population foci as approved by the state board of
 15 nursing. This chapter does not expand the scope of practice of an advanced practice
 16 registered nurse beyond the scope of practice established by the state board of
 17 nursing.
- 18 2. "Alternative treatment order" means an involuntary outpatient order for a treatment
 19 program, other than hospitalization, which may include treatment with a prescribed
 20 medication.
- 21 ~~2-3.~~ "Chemically dependent person" or "person who is chemically dependent" means an
 22 individual with an illness or disorder characterized by a maladaptive pattern of usage
 23 of alcohol or drugs, or a combination thereof, resulting in social, occupational,
 24 psychological, or physical problems.

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- 1 ~~3-4.~~ "Consent" means voluntary permission that is based upon full disclosure of facts
- 2 necessary to make a decision and which is given by an individual who has the ability
- 3 to understand those facts.
- 4 ~~4-5.~~ "Court" means, except when otherwise indicated, the district court serving the county
- 5 in which the respondent resides.
- 6 ~~5-6.~~ "Department" means the department of human services.
- 7 ~~6-7.~~ "Director" means the director of a treatment facility or the director's designee.
- 8 ~~7-8.~~ "Expert examiner" means a licensed physician, psychiatrist, psychologist trained in a
- 9 clinical program, advanced practice registered nurse, or licensed addiction counselor
- 10 appointed by the court to examine the respondent and to provide an evaluation of
- 11 whether the respondent is a person requiring treatment.
- 12 ~~8-9.~~ "Independent expert examiner" means a licensed physician, psychiatrist, psychologist
- 13 trained in a clinical program, advanced practice registered nurse, or licensed addiction
- 14 counselor, chosen at the request of the respondent to provide an independent
- 15 evaluation of whether the respondent is a person requiring treatment.
- 16 ~~9-10.~~ "Magistrate" means the judge of the appropriate district or juvenile court or a judge
- 17 assigned by the presiding judge of the judicial district.
- 18 ~~10-11.~~ "Mental health professional" means:
- 19 a. A psychologist with at least a master's degree who has been either licensed or
- 20 approved for exemption by the North Dakota board of psychology examiners.
- 21 b. A social worker with a master's degree in social work from an accredited
- 22 program.
- 23 c. ~~A registered nurse with a master's degree in psychiatric and mental health~~
- 24 ~~nursing from an accredited program~~An advanced practice registered nurse.
- 25 d. A registered nurse with a minimum of two years of psychiatric clinical experience
- 26 under the supervision of ~~a registered nurse as defined by subdivision c~~ or of an
- 27 expert examiner.
- 28 e. A licensed addiction counselor.
- 29 f. A licensed professional counselor with a master's degree in counseling from an
- 30 accredited program who has either successfully completed the advanced training
- 31 beyond the master's degree as required by the national academy of mental

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1 health counselors or a minimum of two years of clinical experience in a mental
2 health agency or setting under the supervision of a psychiatrist or psychologist.

3 ~~44.12.~~ "Mentally ill person" or "person who is mentally ill" means an individual with an
4 organic, mental, or emotional disorder ~~which~~that substantially impairs the capacity to
5 use self-control, judgment, and discretion in the conduct of personal affairs and social
6 relations. "~~Mentally ill person~~"The term does not include an individual with an
7 intellectual disability of significantly subaverage general intellectual functioning
8 ~~which~~that originates during the developmental period and is associated with
9 impairment in adaptive behavior, although ~~a person~~an individual who is intellectually
10 disabled may also suffer from a mental illness. Chemical dependency does not per se
11 constitute mental illness, although ~~persons suffering from that condition~~a person who
12 is chemically dependent may also be ~~suffering from mental illness~~a person who is
13 mentally ill.

14 ~~42.13.~~ "Person requiring treatment" means a person who is mentally ill or a person who is
15 chemically dependent, and there is a reasonable expectation that if the
16 ~~person~~individual is not treated for the mental illness or chemical dependency there
17 exists a serious risk of harm to that ~~person~~individual, others, or property. "~~Serious-risk-~~
18 ~~of harm~~"means a substantial likelihood of:

- 19 a. ~~Suicide, as manifested by suicidal threats, attempts, or significant depression-~~
20 ~~relevant to suicidal potential;~~
- 21 b. ~~Killing or inflicting serious bodily harm on another person or inflicting significant-~~
22 ~~property damage, as manifested by acts or threats;~~
- 23 e. ~~Substantial deterioration in physical health, or substantial injury, disease, or~~
24 ~~death, based upon recent poor self-control or judgment in providing one's shelter,~~
25 ~~nutrition, or personal care; or~~
- 26 d. ~~Substantial deterioration in mental health which would predictably result in-~~
27 ~~dangerousness to that person, others, or property, based upon evidence of~~
28 ~~objective facts to establish the loss of cognitive or volitional control over the~~
29 ~~person's thoughts or actions or based upon acts, threats, or patterns in the~~
30 ~~person's treatment history, current condition, and other relevant factors, including~~
31 ~~the effect of the person's mental condition on the person's ability to consent.~~

- 1 ~~43-14.~~ "Private treatment facility" means any facility established under chapter 10-19.1 or
2 10-33 and licensed under chapter 23-16 or 50-31.
- 3 ~~44-15.~~ "Psychiatrist" means a licensed physician who has completed a residency program in
4 psychiatry.
- 5 ~~45-16.~~ "Public treatment facility" means any treatment facility not falling under the definition of
6 a private treatment facility.
- 7 ~~46-17.~~ "Qualified service organization" means a person ~~or entity~~ that provides services to a
8 treatment facility such as data processing, bill collecting, dosage preparation,
9 laboratory analysis, or legal, medical, accounting, or other professional services, and
10 which agrees that in dealing with patient records, it is bound by the confidentiality
11 restrictions of this chapter, except as otherwise provided for by law.
- 12 ~~47-18.~~ "Respondent" means ~~a person~~ an individual subject to petition for involuntary
13 treatment.
- 14 19. "Serious risk of harm" means a substantial likelihood of:
- 15 a. Suicide, as manifested by suicidal threats, attempts, or significant depression
16 relevant to suicidal potential;
- 17 b. Killing or inflicting serious bodily harm on another individual or inflicting significant
18 property damage, as manifested by acts or threats;
- 19 c. Substantial deterioration in physical health or substantial injury, disease, or death
20 based upon recent poor self-control or judgment in providing one's shelter,
21 nutrition, or personal care; or
- 22 d. Substantial deterioration in mental health which would predictably result in
23 dangerousness to that individual, others, or property, based upon evidence of
24 objective facts to establish the loss of cognitive or volitional control over the
25 individual's thoughts or actions or based upon acts, threats, or patterns in the
26 individual's treatment history, current condition, and other relevant factors,
27 including the effect of the individual's mental condition on the individual's ability to
28 consent.
- 29 ~~48-20.~~ "Superintendent" means the state hospital superintendent or the superintendent's
30 designee.

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1 ~~49-21.~~ "Third-party payer" means a person or ~~entity who~~ that pays, or agrees to pay, for
2 diagnosis or treatment furnished to a patient on the basis of a contractual relationship
3 with the patient or a member of the patient's family, or on the basis of the patient's
4 eligibility for federal, state, or local governmental benefits, and includes any person or
5 ~~entity~~ providing audit or evaluation activities for the third-party payer.

6 ~~20-22.~~ "Treatment facility" or "facility" means any hospital, including the state hospital at
7 Jamestown, or any evaluation and treatment facility that provides directly, or by direct
8 arrangement with other public or private agencies, emergency evaluation and
9 treatment, outpatient care, and inpatient care to ~~persons~~ individuals suffering from a
10 mental disorder or chemical dependency.

11 **SECTION 2. AMENDMENT.** Section 25-03.1-04 of the North Dakota Century Code is
12 amended and reenacted as follows:

13 **25-03.1-04. Screening and admission to a public treatment facility.**

14 Under rules adopted by the department, screening of an individual to a public treatment
15 facility for observation, diagnosis, care, or treatment for mental illness or chemical dependency
16 must be performed, in person ~~whenever~~ when reasonably practicable, by a regional human
17 service center. This screening must be performed in the region where the individual is physically
18 located. Upon the request of a court, a law enforcement official, a qualified mental health
19 professional, the individual's legal guardian, a minor's parent or legal custodian, or the individual
20 requesting services, the regional human service center shall conduct a screening. If a request
21 for screening is made by a qualified mental health professional and the individual that is the
22 subject of the screening does not authorize the disclosure of the individual's protected health
23 information, upon the request of the regional human service center, any mental health
24 professional who has treated the individual within the previous six months shall disclose,
25 subject to the requirements of title 42, Code of Federal Regulations, part 2, to the human
26 service center any relevant protected health information regarding that treatment. Upon receipt
27 of the request, the regional human service center shall arrange for a screening of the individual
28 and must, if appropriate, treat the applicant, or refer the applicant to the appropriate treatment
29 facility. Upon admittance to a public treatment facility, the superintendent or director shall
30 immediately designate a physician, psychiatrist, psychologist, advanced practice registered
31 nurse, or mental health professional to examine the individual.

1 **SECTION 3. AMENDMENT.** Section 25-03.1-06 of the North Dakota Century Code is
2 amended and reenacted as follows:

3 **25-03.1-06. Right to release on application - Exception - Judicial proceedings.**

4 Any ~~person~~individual voluntarily admitted for inpatient treatment to any treatment facility or
5 the state hospital must be orally advised of the right to release and must be further advised in
6 writing of the rights under this chapter. A voluntary patient who requests release must be
7 immediately released. However, if the superintendent or the director determines that the patient
8 is a person requiring treatment, the release may be postponed until judicial proceedings for
9 involuntary treatment have been held in the county where the hospital or facility is located. The
10 patient must be served the petition within twenty-four hours, exclusive of weekends and
11 holidays, from the time release is requested, unless extended by the magistrate for good cause
12 shown. The treatment hearing must be held within seven days from the time the petition is
13 served.

14 **SECTION 4. AMENDMENT.** Section 25-03.1-07 of the North Dakota Century Code is
15 amended and reenacted as follows:

16 **25-03.1-07. Involuntary admission standards.**

17 ~~A person~~An individual may be involuntarily admitted under this chapter to the state hospital
18 or another treatment facility only if it is determined that the individual is a person requiring
19 treatment.

20 **SECTION 5. AMENDMENT.** Section 25-03.1-08 of the North Dakota Century Code is
21 amended and reenacted as follows:

22 **25-03.1-08. Application to state's attorney or retained attorney - Petition for**
23 **involuntary treatment - Investigation by qualified mental health professional.**

24 1. Any ~~person~~individual eighteen years of age or over shall present the information
25 necessary for the commitment of an individual for involuntary treatment to the state's
26 attorney of the county where the respondent is presently located, or which is the
27 respondent's place of residence, or to an attorney retained by that ~~person~~applicant to
28 represent the applicant throughout the proceedings. The attorney shall assist the
29 ~~person~~applicant in completing the petition. The petition must be verified by affidavit of
30 the applicant and contain assertions that the respondent is a person requiring the
31 treatment; the facts, in detail, that are the basis of that assertion; the names,

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1 telephone numbers, and addresses, if known, of any witnesses to those facts; and, if
2 known, the name, telephone number, and address of the nearest relative or guardian
3 of the respondent, or, if none, of a friend of the respondent.

4 2. The petition may be accompanied by any of the following:

5 4-a. A written statement supporting the petition from a psychiatrist, physician,
6 psychologist, advanced practice registered nurse, or addiction counselor who is
7 practicing within the professional scope of practice and who has personally
8 examined the respondent within forty-five days of the date of the petition.

9 2-b. One or more supporting affidavits otherwise corroborating the petition.

10 3. In assisting the person applicant in completing the petition, the state's attorney may
11 direct a qualified mental health professional designated by the regional human service
12 center to investigate and evaluate the specific facts alleged by the applicant. The
13 investigation must be completed as promptly as possible and include observations of
14 and conversation with the respondent, unless the respondent cannot be found or
15 refuses to meet with the mental health professional. A written report of the results of
16 the investigation must be delivered to the state's attorney. Copies of the report must
17 be made available upon request to the respondent, the respondent's counsel, and any
18 expert examiner conducting an examination under section 25-03.1-11. The state's
19 attorney or retained attorney shall file the petition if the information provided by the
20 petitioner or gathered by investigation provides probable cause to believe that the
21 subject of the petition is a person requiring treatment. A state's attorney who
22 determines there are insufficient grounds for filing a petition may refer the applicant to
23 other community resources. A state's attorney's decision not to institute proceedings
24 may be reviewed under section 11-16-06.

25 **SECTION 6. AMENDMENT.** Section 25-03.1-10 of the North Dakota Century Code is
26 amended and reenacted as follows:

27 **25-03.1-10. Involuntary treatment - Court-ordered examination.**

28 If the petition is not accompanied by a written supportive statement of a psychiatrist,
29 physician, psychologist, advanced practice registered nurse, or addiction counselor who has
30 examined the respondent within the last forty-five days, the court shall order the respondent to
31 be examined by an expert examiner of the respondent's own choice or one appointed by the

1 court. The order must state the date and time within which the respondent must appear; the
2 address to which the respondent is to report; a statement that if the respondent fails to appear
3 at the appointed place at or before the ordered date and time, the respondent may be
4 involuntarily taken into custody and transported to the appointed place; and a statement that the
5 expert examiner may consult with or request participation in the examination by a qualified
6 mental health professional and may include with the written examination report any findings or
7 observations by that mental health professional. Accompanying the order must be an
8 explanation of the intended uses and possible effects of this examination. The examination may
9 be conducted at a treatment facility, at the respondent's home, or at any other suitable place in
10 the community. A request for examination at the state hospital must be screened and approved
11 by a regional human service center. The respondent may be accompanied by one or more
12 relatives or friends at the place of the examination. The costs of the court-ordered examination
13 must be borne by the county that is the respondent's place of residence.

14 **SECTION 7. AMENDMENT.** Section 25-03.1-11 of the North Dakota Century Code is
15 amended and reenacted as follows:

16 **25-03.1-11. Involuntary treatment - Examination - Report.**

- 17 1. The respondent must be examined within a reasonable time by an expert examiner as
18 ordered by the court. If the respondent is taken into custody under the emergency
19 treatment provisions of this chapter, the examination must be conducted within
20 twenty-four hours, exclusive of holidays, of custody. Any expert examiner conducting
21 an examination under this section may consult with or request participation in the
22 examination by any qualified mental health professional and may include with the
23 written examination report any findings or observations by that mental health
24 professional. This examination report, and that of the independent examiner, if one
25 has been requested, must be filed with the court. The report must contain:
- 26 a. Evaluations of the respondent's physical condition and mental status.
 - 27 b. A conclusion as to whether the respondent is a person requiring treatment, with a
28 clear explanation of how that conclusion was derived from the evaluation.
 - 29 c. If the report concludes that the respondent is a person requiring treatment, a list
30 of available forms of care and treatment that may serve as alternatives to
31 involuntary hospitalization.

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- 1 d. The signature of the examiner who prepared the report.
- 2 2. For purposes of any examination conducted pursuant to this section:
- 3 a. An evaluation of a respondent's physical condition may be made only by a
- 4 licensed physician or, psychiatrist, or advanced practice registered nurse.
- 5 b. An evaluation of a respondent's mental status may be made only by a licensed
- 6 physician, psychiatrist, advanced practice registered nurse, or psychologist
- 7 trained in a clinical program.
- 8 c. An evaluation of whether the respondent is chemically dependent may be made
- 9 only by a licensed physician, psychiatrist, advanced practice registered nurse,
- 10 licensed addiction counselor, or licensed psychologist trained in a clinical
- 11 program.
- 12 3. If the expert examiner concludes that the respondent is not a person requiring
- 13 treatment, the court may without taking any other additional action terminate the
- 14 proceedings and dismiss the petition. If the expert examiner concludes that the
- 15 respondent is a person requiring treatment, or makes no conclusion thereon, the court
- 16 shall set a date for hearing and shall give notice of hearing to the persons designated
- 17 in section 25-03.1-12. If the respondent is in custody and is alleged to be suffering
- 18 from mental illness or a combination of mental illness and chemical dependency, the
- 19 preliminary hearing date must be within four days, exclusive of weekends and
- 20 holidays, of the date respondent was taken into custody through emergency
- 21 commitment under section 25-03.1-25 unless a delay or continuance is concurred in
- 22 by the respondent or unless extended by the magistrate for good cause shown. If a
- 23 preliminary hearing is not required, the treatment hearing must be held within four
- 24 days, exclusive of weekends and holidays, of the date the court received the expert
- 25 examiner's report, not to exceed fourteen days from the time the petition was served.

26 **SECTION 8. AMENDMENT.** Section 25-03.1-16 of the North Dakota Century Code is
27 amended and reenacted as follows:

28 **25-03.1-16. Medication pending treatment order.**

29 A patient who has requested release or a ~~person~~ an individual who is the subject of a
30 petition for treatment has the right to refuse medication and other forms of treatment before the
31 preliminary or treatment hearing. However, a physician may prescribe medication or a less

1 restrictive alternative if it is necessary to prevent bodily harm to the respondent or others or to
2 prevent imminent deterioration of the respondent's physical or mental condition. The patient has
3 the right to be free of the effects of medication at the preliminary or treatment hearing by
4 discontinuance of medication no later than twenty-four hours before the hearing unless, in the
5 opinion of the prescribing physician, the need for the medication still exists or discontinuation
6 would hamper the respondent's preparation for and participation in the proceedings.

7 **SECTION 9. AMENDMENT.** Section 25-03.1-17 of the North Dakota Century Code is
8 amended and reenacted as follows:

9 **25-03.1-17. Involuntary treatment - Right to preliminary hearing.**

10 A respondent who is in custody under section 25-03.1-25 and who is alleged to be mentally
11 ill or to be suffering from a combination of chemical dependency and mental illness is entitled to
12 a preliminary hearing. At the preliminary hearing the magistrate shall review the medical report.
13 During the hearing the petitioner and the respondent must be afforded an opportunity to testify
14 and to present and cross-examine witnesses, and the court may receive the testimony of any
15 other interested person. The magistrate may receive evidence that would otherwise be
16 inadmissible at a treatment hearing. At the conclusion of the hearing, if the court does not find
17 probable cause to believe that the individual is a person requiring treatment, the petition must
18 be dismissed. The ~~person~~individual must be ordered discharged from the treatment facility if
19 that ~~person~~individual has been detained before the hearing. If the court finds probable cause to
20 believe that the respondent is a person requiring treatment, it shall consider less restrictive
21 alternatives to involuntary detention and treatment. The court may then order the respondent to
22 undergo up to fourteen days' treatment under a less restrictive alternative or, if it finds that
23 alternative treatment is not in the best interests of the respondent or others, it shall order the
24 respondent detained for up to fourteen days for involuntary treatment in a treatment facility.

25 The court shall specifically state to the respondent and give written notice that if involuntary
26 treatment beyond the fourteen-day period is to be sought, the respondent will have the right to a
27 treatment hearing as required by this chapter.

28 **SECTION 10. AMENDMENT.** Section 25-03.1-18.1 of the North Dakota Century Code is
29 amended and reenacted as follows:

1 **25-03.1-18.1. Court-authorized involuntary treatment with prescribed medication.**

2 1. a. Upon notice and hearing, a treating psychiatrist may request authorization from
3 the court to treat ~~a person~~ an individual under a mental health treatment order
4 with prescribed medication. The request may be considered by the court in an
5 involuntary treatment hearing. As a part of the request, the treating psychiatrist
6 and another licensed physician ~~or, psychiatrist, or advanced practice registered~~
7 nurse not involved in the current diagnosis or treatment of the patient shall certify:

- 8 (1) That the proposed prescribed medication is clinically appropriate and
- 9 necessary to effectively treat the patient and that the patient is a person
- 10 requiring treatment;
- 11 (2) That the patient was offered that treatment and refused it or that the patient
- 12 lacks the capacity to make or communicate a responsible decision about
- 13 that treatment;
- 14 (3) That prescribed medication is the least restrictive form of intervention
- 15 necessary to meet the treatment needs of the patient; and
- 16 (4) That the benefits of the treatment outweigh the known risks to the patient.

17 b. The court shall inquire whether the patient has had a sufficient opportunity to
18 adequately prepare to meet the issue of involuntary treatment with prescribed
19 medication and, at the request of the patient, the court may continue the
20 involuntary treatment hearing for a period not exceeding seven days or may
21 appoint an independent expert examiner as provided in subsection 4.

22 2. a. Evidence of the factors certified under subsection 1 may be presented to the
23 court at an involuntary treatment hearing held pursuant to sections 25-03.1-19
24 and 25-03.1-22, or at a separate hearing after motion and notice. The court in
25 ruling on the requested authorization for involuntary treatment with prescribed
26 medication shall consider all relevant evidence presented at the hearing,
27 including:

- 28 (1) The danger the patient presents to self or others;
- 29 (2) The patient's current condition;
- 30 (3) The patient's treatment history;
- 31 (4) The results of previous medication trials;

- 1 (5) The efficacy of current or past treatment modalities concerning the patient;
- 2 (6) The patient's prognosis; and
- 3 (7) The effect of the patient's mental condition on the patient's capacity to
- 4 consent.
- 5 b. Involuntary treatment with prescribed medication may not be authorized by the
- 6 court solely for the convenience of facility staff or for the purpose of punishment.
- 7 3. If the factors certified under subsection 1 have been demonstrated by clear and
- 8 convincing evidence, the court may include in its involuntary treatment order a
- 9 provision, or it may issue a separate order after notice and hearing, authorizing the
- 10 treating psychiatrist to involuntarily treat the patient with prescribed medication on
- 11 such terms and conditions as are appropriate. The order for involuntary treatment with
- 12 prescribed medication, however, may not be in effect for more than ninety days.
- 13 4. If a patient has requested an examination by an independent expert examiner under
- 14 this chapter, and if the treating psychiatrist has requested authorization for involuntary
- 15 treatment with prescribed medication, only a psychiatrist may independently examine
- 16 the patient as to the issue of involuntary treatment with prescribed medication.

17 **SECTION 11. AMENDMENT.** Section 25-03.1-19 of the North Dakota Century Code is
 18 amended and reenacted as follows:

19 **25-03.1-19. Involuntary treatment hearing.**

20 The involuntary treatment hearing, unless waived by the respondent or the respondent has
 21 been released as a person not requiring treatment, must be held within fourteen days of the
 22 preliminary hearing. If the preliminary hearing is not required, the involuntary treatment hearing
 23 must be held within four days, exclusive of weekends and holidays, of the date the court
 24 received the expert examiner's report, not to exceed fourteen days from the time the petition
 25 was served. The court may extend the time for hearing for good cause. The respondent has the
 26 right to an examination by an independent expert examiner if so requested. If the respondent is
 27 indigent, the county of residence of the respondent shall pay for the cost of the examination and
 28 the respondent may choose an independent expert examiner.

29 The hearing must be held in the county of the respondent's residence or location or the
 30 county where the state hospital or treatment facility treating the respondent is located. At the
 31 hearing, evidence in support of the petition must be presented by the state's attorney, private

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1 counsel, or counsel designated by the court. During the hearing, the petitioner and the
2 respondent must be afforded an opportunity to testify and to present and cross-examine
3 witnesses. The court may receive the testimony of any other interested person. All
4 ~~persons~~individuals not necessary for the conduct of the proceeding must be excluded, except
5 that the court may admit ~~persons~~individuals having a legitimate interest in the proceeding. The
6 hearing must be conducted in as informal a manner as practical, but the issue must be tried as
7 a civil matter. Discovery and the power of subpoena permitted under the North Dakota Rules of
8 Civil Procedure are available to the respondent. The court shall receive all relevant and material
9 evidence ~~which~~that may be offered as governed by the North Dakota Rules of Evidence. There
10 is a presumption in favor of the respondent, and the burden of proof in support of the petition is
11 upon the petitioner.

12 If, upon completion of the hearing, the court finds that the petition has not been sustained
13 by clear and convincing evidence, ~~the court~~ shall deny the petition, terminate the proceeding,
14 and order that the respondent be discharged if the respondent has been hospitalized before the
15 hearing.

16 **SECTION 12. AMENDMENT.** Subsection 3 of section 25-03.1-21 of the North Dakota
17 Century Code is amended and reenacted as follows:

18 3. If a peace officer, physician either in person or directing an emergency medical
19 services professional, psychiatrist, clinical psychologist, advanced practice registered
20 nurse, or any mental health professional reasonably believes that the respondent is
21 not complying with an order for alternative treatment, that the alternative treatment is
22 not sufficient to prevent harm or injuries to the respondent or others, and that
23 considerations of time and safety do not allow intervention by a court, the designated
24 professional may cause the respondent to be taken into custody and detained at a
25 treatment facility as provided in subsection 3 of section 25-03.1-25 and, within
26 twenty-four hours, shall file a notice with the court stating the circumstances and
27 factors of the case. The state hospital or public treatment facility ~~must~~shall
28 immediately accept, if appropriately screened and medically stable, and a private
29 treatment facility may accept, the respondent on a provisional basis. The
30 superintendent or director shall require an immediate examination of the respondent
31 and, within twenty-four hours after admission, shall either release the respondent

1 subject to the conditions of the original order or file a notice with the court stating in
2 detail the circumstances and factors of the case. The court shall, within forty-eight
3 hours of receipt of the notice of the superintendent or director, after a hearing and
4 based on the evidence presented and other available information:

- 5 a. Release the individual from hospitalization and continue the alternative treatment
- 6 order;
- 7 b. Consider other alternatives to hospitalization, modify its original order, and direct
- 8 the individual to undergo another program of alternative treatment for the
- 9 remainder of the commitment period; or
- 10 c. Enter a new order directing that the respondent remain hospitalized until
- 11 discharged from the hospital under section 25-03.1-30.

12 **SECTION 13. AMENDMENT.** Section 25-03.1-23 of the North Dakota Century Code is
13 amended and reenacted as follows:

14 **25-03.1-23. Petition for continuing treatment orders.**

15 A petition for an order authorizing continuing treatment must contain a statement setting
16 forth the reasons for the determination that the patient continues to be a person requiring
17 treatment; a statement describing the treatment program provided to the patient and the results
18 of that treatment; and a clinical estimate as to how long further treatment will be required. The
19 petition must be accompanied by a certificate executed by a physician, psychiatrist,
20 psychologist, advanced practice registered nurse, or licensed addiction counselor, any of whom
21 is practicing within that individual's professional scope of practice.

22 **SECTION 14. AMENDMENT.** Section 25-03.1-25 of the North Dakota Century Code is
23 amended and reenacted as follows:

24 **25-03.1-25. Detention or hospitalization - Emergency procedure.**

- 25 1. When a peace officer, physician either in person or directing an emergency medical
- 26 services professional, psychiatrist, psychologist, advanced practice registered nurse,
- 27 or mental health professional has reasonable cause to believe that an individual is a
- 28 person requiring treatment and there exists a serious risk of harm to that
- 29 ~~person~~individual, ~~other person~~others, or property of an immediate nature that
- 30 considerations of safety do not allow preliminary intervention by a magistrate, the
- 31 peace officer, physician either in person or directing an emergency medical services

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- 1 professional, psychiatrist, psychologist, advanced practice registered nurse, or mental
2 health professional, using the screening process set forth in section 25-03.1-04, may
3 cause the ~~person~~individual to be taken into custody and detained at a treatment facility
4 as provided in subsection 3, and subject to section 25-03.1-26, except that if
5 emergency conditions exist that prevent the immediate conveyance of the individual to
6 a public treatment facility, a private facility that has adequate resources and capacity
7 to hold that individual may hold the individual in anticipation of conveyance to a public
8 treatment facility for up to twenty-three hours:
- 9 a. Without conducting an immediate examination required under section
10 25-03.1-26; and
 - 11 b. Without following notice and hearing requirements for a transfer to another
12 treatment facility required under subsection 3 of section 25-03.1-34.
- 13 2. If a petitioner seeking the involuntary treatment of a respondent requests that the
14 respondent be taken into immediate custody and the magistrate, upon reviewing the
15 petition and accompanying documentation, finds probable cause to believe that the
16 respondent is a person requiring treatment and there exists a serious risk of harm to
17 the respondent, ~~other persons~~others, or property if allowed to remain at liberty, the
18 magistrate may enter a written order directing that the respondent be taken into
19 immediate custody and be detained as provided in subsection 3 until the preliminary or
20 treatment hearing, which must be held no more than seven days after the date of the
21 order.
- 22 3. Detention under this section may be:
- 23 a. In a treatment facility where the director or superintendent must be informed of
24 the reasons why immediate custody has been ordered. The facility may provide
25 treatment that is necessary to preserve the respondent's life or to appropriately
26 control behavior by the respondent which is likely to result in physical injury to
27 self or to others if allowed to continue, but may not otherwise provide treatment to
28 the respondent without the respondent's consent; or
 - 29 b. In a public or private facility in the community which is suitably equipped and
30 staffed for the purpose. Detention in a jail or other correctional facility may not be
31 ordered except in cases of actual emergency when no other secure facility is

- 1 accessible, and then only for a period of not more than twenty-four hours and
2 under close supervision.
- 3 4. Immediately upon being taken into custody, the ~~person~~individual must be advised of
4 the purpose of custody, of the intended uses and possible effects of any evaluation
5 that the ~~person~~individual undergoes, and of the ~~person's~~individual's rights to counsel
6 and to a preliminary or treatment hearing.
- 7 5. Upon arrival at a facility the peace officer, physician, psychiatrist, psychologist,
8 advanced practice registered nurse, or mental health professional who conveyed the
9 ~~person~~individual or who caused the ~~person~~individual to be conveyed shall complete an
10 application for evaluation and shall deliver a detailed written report from the peace
11 officer, physician, psychiatrist, psychologist, advanced practice registered nurse, or the
12 mental health professional who caused the ~~person~~individual to be conveyed. The
13 written report must state the circumstances under which the ~~person~~individual was
14 taken into custody. The report must allege in detail the overt act that constituted the
15 basis for the beliefs that the individual is a person requiring treatment and that,
16 because of that ~~person's~~individual's condition, there exists a serious risk of harm to
17 that ~~person~~individual, ~~another person~~others, or property if the ~~person~~individual is not
18 immediately detained.

19 **SECTION 15. AMENDMENT.** Section 25-03.1-26 of the North Dakota Century Code is
20 amended and reenacted as follows:

21 **25-03.1-26. Emergency procedure - Acceptance of petition and individual - Notice -**
22 **Court hearing set.**

- 23 1. A public treatment facility immediately shall accept and a private treatment facility may
24 accept on a provisional basis the application and the ~~person~~individual admitted under
25 section 25-03.1-25. The superintendent or director shall require an immediate
26 examination of the subject and, within twenty-four hours after admission, shall either
27 release the ~~person~~individual if the superintendent or director finds that the subject
28 does not meet the emergency commitment standards or file a petition if one has not
29 been filed with the court of the ~~person's~~individual's residence or the court which
30 directed immediate custody under subsection 2 of section 25-03.1-25, giving notice to
31 the court and stating in detail the circumstances and facts of the case.

- 1 2. Upon receipt of the petition and notice of the emergency detention, the magistrate
2 shall set a date for a preliminary hearing, if the respondent is alleged to be suffering
3 from mental illness or from a combination of mental illness and chemical dependency,
4 or a treatment hearing, if the respondent is alleged to be suffering from chemical
5 dependency, to be held no later than four days, exclusive of weekends and holidays,
6 after detention unless the person has been released as a person not requiring
7 treatment, has been voluntarily admitted for treatment, has requested or agreed to a
8 continuance, or unless the hearing has been extended by the magistrate for good
9 cause shown. The magistrate shall appoint counsel if one has not been retained by
10 the respondent.

11 **SECTION 16. AMENDMENT.** Section 25-03.1-27 of the North Dakota Century Code is
12 amended and reenacted as follows:

13 **25-03.1-27. Notice and statement of rights.**

- 14 1. ~~Whenever any person~~When an individual is detained for emergency evaluation and
15 treatment under this chapter, the superintendent or director shall cause both the
16 patient and, if possible, a responsible member of the patient's immediate family, a
17 guardian, or a friend, if any, to receive:
- 18 a. A copy of the petition which asserted that the individual is a person requiring
19 treatment.
 - 20 b. A written statement explaining that the individual will be examined by an expert
21 examiner within twenty-four hours of hospitalization, excluding holidays.
 - 22 c. A written statement in simple terms explaining the rights of the individual alleged
23 to be suffering from mental illness or from a combination of mental illness and
24 chemical dependency to a preliminary hearing, to be present at the hearing, and
25 to be represented by legal counsel, if the individual is certified by an expert
26 examiner or examiners as a person requiring treatment.
 - 27 d. A written statement in simple terms explaining the rights of the individual to a
28 treatment hearing, to be present at the hearing, to be represented by legal
29 counsel, and the right to an independent medical evaluation.
- 30 2. If the individual is unable to read or understand the written materials, every reasonable
31 effort must be made to explain ~~them~~the written material in a language the individual

1 understands, and a note of the explanation and by whom made must be entered into
2 the patient record.

3 **SECTION 17. AMENDMENT.** Section 25-03.1-41 of the North Dakota Century Code is
4 amended and reenacted as follows:

5 **25-03.1-41. Limitations and restrictions of patient's rights.**

6 The rights enumerated in subsections 5, 6, 7, and 8 of section 25-03.1-40 may be limited or
7 restricted by the treating physician, psychiatrist, advanced practice registered nurse, or
8 psychologist trained in a clinical program, if in that ~~person's~~individual's professional judgment to
9 do so would be in the best interests of the patient and the rights are restricted or limited in the
10 manner authorized by the rules adopted pursuant to section 25-03.1-46. ~~Whenever~~When a
11 physician, psychiatrist, advanced practice registered nurse, or psychologist trained in a clinical
12 program responsible for treatment of a particular patient imposes a special restriction on the
13 rights of the patient as authorized by the rules, a written order specifying the restriction and the
14 reasons for the restriction must be signed by the physician, psychiatrist, advanced practice
15 registered nurse, or psychologist trained in a clinical program and attached to the patient's
16 chart. These restrictions must be reviewed at intervals of not more than fourteen days and may
17 be renewed by following the procedure set out in this section.

18 **SECTION 18. AMENDMENT.** Section 25-03.1-42 of the North Dakota Century Code is
19 amended and reenacted as follows:

20 **25-03.1-42. Limitation of liability - Penalty for false petition.**

- 21 1. A person acting in good faith upon either actual knowledge or reliable information
22 ~~whewhich~~ makes the petition for involuntary treatment of ~~another person~~an individual
23 under this chapter is not subject to civil or criminal liability.
- 24 2. A physician, psychiatrist, psychologist, advanced practice registered nurse, mental
25 health professional, employee of a treatment facility, state's attorney, or peace officer
26 who in good faith exercises professional judgment in fulfilling an obligation or
27 discretionary responsibility under this chapter is not subject to civil or criminal liability
28 for acting unless it can be shown that it was done in a negligent manner.
- 29 3. A person ~~whethat~~ makes a petition for involuntary treatment of ~~another person~~an
30 individual without having good cause to believe that the ~~other person~~individual is

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- 1 suffering from mental illness or chemical dependency and as a result is likely to cause
- 2 serious harm to self or others is guilty of a class A misdemeanor.

BEHAVIORAL HEALTH TALKING POINTS

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2) SB 2045 - INCREASE SUBSTANCE ABUSE SERVICES THROUGH A VOUCHER PROGRAM

Human Services Committee

Second Draft

PURPOSE: To increase access to addiction treatment services.

BACKGROUND: This bill came about as the result of the Schulte report and the Stakeholder's report. Currently private providers have limited access to the funds from DHS which are designated for addiction treatment services.

A. Section One - Appropriates \$2 million for the establishing and administering a voucher system to assist in the payment of addiction treatment services provided by private providers.

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SENATE BILL NO. 2045

Introduced by

Legislative Management

(Human Services Committee)

1 A BILL for an Act to provide an appropriation to the department of human services for a voucher
2 system for addiction treatment services.

3 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

4 **SECTION 1. APPROPRIATION.** There is appropriated out of any moneys in the general
5 fund in the state treasury, not otherwise appropriated, the sum of \$2,000,000, or so much of the
6 sum as may be necessary, to the department of human services for the purpose of establishing
7 and administering a voucher system to assist in the payment of addiction treatment services
8 provided by private providers, for the biennium beginning July 1, 2015, and ending June 30,
9 2017. Services eligible for the voucher program include only those services recognized as
10 effective by the American society of addiction medicine.

BEHAVIORAL HEALTH TALKING POINTS

1/9/2015

3) SB 2046 - EXPANDING SERVICES

Human Services Committee
Third Draft

Purpose: To increase access for adult and youth behavioral health services, including detoxification.

BACKGROUND: This bill came about as the result of the Schulte report and input from the Stakeholder's report which identified the lack of available resources for substance abuse services within North Dakota.

NOTE: In an effort to include all the areas of behavioral health, the stakeholders broke the services delivery system into three components.

1. Adult Behavioral Health
2. Children and Youth Behavioral Health
3. Substance Abuse

Therefore, you will see various bills being introduced that address these specific areas.

- A. Section One - Requires DHS to adopt rules allowing licensed and marriage family therapists and licensed professional clinical counselors to receive payment for behavioral health services provided to recipients of medical assistance.
- B. Section Two - Requires DHS to develop a client based outcome data system for behavioral health services.
- C. Section Three - Appropriates \$3,000,000 to DHS for the purpose of expanding adult and youth substance abuse services.

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BEHAVIORAL HEALTH TALKING POINTS

- D. Section Four - Appropriates \$25,000 to the highway patrol for the purpose of providing Mental Health First Aid training for state and local law enforcement personnel.

- E. Section Five - Requires Legislative Management to study the structure and services of the department of human services during the 2015-16 interim.

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of North Dakota

SENATE BILL NO. 2046

Introduced by

Legislative Management

(Human Services Committee)

1 A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota
2 century code, relating to medical assistance coverage for certain behavioral health services; to
3 provide for the development of an outcomes-based data system for behavioral health services;
4 to provide an appropriation to the department of human services for substance abuse treatment
5 services; to provide an appropriation to highway patrol for law enforcement training; and to
6 provide for a legislative management study.

7 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

8 **SECTION 1.** A new section to chapter 50-24.1 of the North Dakota Century Code is created
9 and enacted as follows:

10 **Behavioral health services - Licensed marriage and family therapists.**

11 The department of human services shall adopt rules entitling licensed professional clinical
12 counselors and licensed marriage and family therapists to payment for behavioral health
13 services provided to recipients of medical assistance, subject to limitations and exclusions the
14 department determines necessary based on federal laws and regulations.

15 **SECTION 2. DEPARTMENT OF HUMAN SERVICES - OUTCOMES-BASED DATA**

16 **SYSTEM - REPORTS TO LEGISLATIVE MANAGEMENT.** The department of human services
17 shall develop an outcomes-based data system for behavioral health services during the
18 biennium beginning July 1, 2015, and ending June 30, 2017. The department of human
19 services shall report periodically to the legislative management during the 2015-16 interim on
20 the development of the outcomes-based data system.

21 **SECTION 3. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES - SUBSTANCE**
22 **ABUSE TREATMENT SERVICES - REPORTS TO THE LEGISLATIVE MANAGEMENT.** There

23 is appropriated out of any moneys in the general fund in the state treasury, not otherwise
24 appropriated, the sum of \$3,000,000, or so much of the sum as may be necessary, to the

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1 department of human services for the purpose of expanding adult and youth substance abuse
2 treatment services, including detoxification services, for the biennium beginning July 1, 2015,
3 and ending June 30, 2017. The department of human services shall report to the legislative
4 management on the use of these funds by July 1, 2016.

5 **SECTION 4. APPROPRIATION - HIGHWAY PATROL - TRAINING.** There is appropriated
6 out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum
7 of \$25,000, or so much of the sum as may be necessary, to the highway patrol for the purpose
8 of providing mental health first aid training for state and local law enforcement personnel, for the
9 biennium beginning July 1, 2015, and ending June 30, 2017.

10 **SECTION 5. LEGISLATIVE MANAGEMENT STUDY - DEPARTMENT OF HUMAN**
11 **SERVICES STRUCTURE.** During the 2015-16 interim, the legislative management shall
12 consider studying the structure and services of the department of human services. If conducted,
13 the study must identify core services provided by the department of human services, services
14 which may be provided by private providers rather than the department of human services, and
15 whether it is appropriate for the department of human services to provide services it also
16 regulates. The legislative management shall report its findings and recommendations, along
17 with any legislation required to implement the recommendations, to the sixty-fifth legislative
18 assembly.

BEHAVIORAL HEALTH TALKING POINTS

1/9/2015

4) HB 1048 - UNIFORM LICENSING

Human Services Committee

Second Draft

PURPOSE: To develop uniform licensing and reciprocity standards in an effort to increase the workforce in behavioral health.

BACKGROUND: This bill came about as the result of the Schulte report and the Stakeholder's report. During the numerous meetings, phone calls and visits with behavioral health providers, a consistent theme from the providers was the difficulty in getting employees licensed in North Dakota.

- A. Section One - Requires the Department of Health oversight and administration to develop a uniform licensing and reciprocity standard for licensees of the Board of Addiction Counseling Examiners, Board of Counselor Examiners, North Dakota Board of Social Work Examiners, State Board of Psychologist Examiners, State Board of Medical Examiners and North Dakota Marriage and Family Therapy Licensure Board. The plan must include a standard for issuance of licenses to qualified applicants within 30 days of application.
- B. Sections Two through Seven - Requires the various boards to participate with and respond to requests from the health council relating to administration and implementation of uniform licensing and reciprocity standards.

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of North Dakota

HOUSE BILL NO. 1048

Introduced by

Legislative Management

(Human Services Committee)

1 A BILL for an Act to create and enact subsection 6 to section 23-01-03, sections 43-17-44 and
2 43-32-35, subsection 11 to section 43-41-09, subdivision k to subsection 1 of section 43-45-04,
3 subsection 8 to section 43-47-03, and subsection 8 to section 43-53-05 of the North Dakota
4 Century Code, relating to state department of health oversight and administration of the
5 development of uniform licensing and reciprocity standards for licensees of the board of
6 addiction counseling examiners, board of counselor examiners, North Dakota board of social
7 work examiners, state board of psychologist examiners, state board of medical examiners, and
8 North Dakota marriage and family therapy licensure board.

9 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

10 **SECTION 1.** Subsection 6 to section 23-01-03 of the North Dakota Century Code is created
11 and enacted as follows:

12 6. Develop a plan, during the 2015-16 interim, for the administration and implementation
13 of uniform licensing and reciprocity standards for licensees of the board of addiction
14 counseling examiners, board of counselor examiners, North Dakota board of social
15 work examiners, state board of psychologist examiners, state board of medical
16 examiners, and North Dakota marriage and family therapy licensure board. The plan
17 must include a standard for issuance of licenses to qualified applicants within 30 days
18 of application. The health council shall evaluate whether regional, national, and
19 international licensing and reciprocity standards are adequate for licensure in the
20 state. Before July 1, 2016, the health council shall present its findings, the proposed
21 plan, and any legislative changes necessary to implement that plan, to an interim
22 committee designated by the legislative management.

23 **SECTION 2.** Section 43-17-44 of the North Dakota Century Code is created and enacted as
24 follows:

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1 **43-17-44. Licensing and reciprocity standards uniformity.**

2 The board shall participate with and respond to requests from the health council relating to
3 administration and implementation of uniform licensing and reciprocity standards for licensees
4 of the board.

5 **SECTION 3.** Section 43-32-35 of the North Dakota Century Code is created and enacted as
6 follows:

7 **43-32-35. Licensing and reciprocity standards uniformity.**

8 The board shall participate with and respond to requests from the health council relating to
9 administration and implementation of uniform licensing and reciprocity standards for licensees
10 of the board.

11 **SECTION 4.** Subsection 11 to section 43-41-09 of the North Dakota Century Code is
12 created and enacted as follows:

13 11. Participate with and respond to requests from the health council relating to
14 administration and implementation of uniform licensing and reciprocity standards for
15 licensees of the board.

16 **SECTION 5.** Subdivision k to subsection 1 of section 43-45-04 the North Dakota Century
17 Code is created and enacted as follows:

18 k. Participate with and respond to requests from the health council relating to
19 administration and implementation of uniform licensing and reciprocity standards
20 for licensees of the board.

21 **SECTION 6.** Subsection 8 to section 43-47-03 of the North Dakota Century Code is created
22 and enacted as follows:

23 8. Participate with and respond to requests from the health council relating to
24 administration and implementation of uniform licensing and reciprocity standards for
25 licensees of the board.

26 **SECTION 7.** Subsection 8 to section 43-53-05 of the North Dakota Century Code is created
27 and enacted as follows:

28 8. The board shall participate with and respond to requests from the health council
29 relating to administration and implementation of uniform licensing and reciprocity
30 standards for licensees of the board.

BEHAVIORAL HEALTH TALKING POINTS

1/9/2015

5) SB 2047 - ADDITIONAL COMMITMENT PROFESSIONALS

Human Services Committee

Third Draft

PURPOSE: This bill is another workforce enhancement bill which increases the number of qualified behavioral health professionals who can do commitments.

BACKGROUND: This bill came about as the result of the Stakeholder's report. This bill is intended to expand community resources in an effort to improve access and availability to behavioral health services.

- A. Section One - Amends subsection 8 of section 25-03.2-01. Chapter 25.03 is the Commitment Procedures chapter. This bill amends the definition of a "qualified mental health professional" to include licensed marriage and family therapist.

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of North Dakota

SENATE BILL NO. 2047

Introduced by

Legislative Management

(Human Services Committee)

1 A BILL for an Act to amend and reenact subsection 8 of section 25-03.2-01 of the North Dakota
2 Century Code, relating to the definition of a qualified mental health professional.

3 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

4 **SECTION 1. AMENDMENT.** Subsection 8 of section 25-03.2-01 of the North Dakota
5 Century Code is amended and reenacted as follows:

6 8. "Qualified mental health professional" means ~~a licensed physician who is a~~
7 ~~psychiatrist, a licensed clinical psychologist who is qualified for listing on the national~~
8 ~~register of health service providers in psychology, a licensed certified social worker~~
9 ~~who is a board-certified diplomate in clinical social work, or a nurse who holds~~
10 ~~advanced licensure in psychiatric nursing;~~

11 a. An individual who holds a state license if practicing in a field covered by a state
12 licensure law and is a psychiatrist; an advanced practice registered nurse who
13 holds a national certification in psychiatric mental health care registered by the
14 board of nursing; a physician assistant with a mental health certification
15 practicing under the supervision of a psychiatrist; a licensed marriage and family
16 therapist; or an individual who holds a doctorate degree in psychology and is
17 licensed by the board of psychologist examiners; or

18 b. An individual:
19 (1) Who holds at least a master's degree in a mental health field, including
20 psychology, counseling and guidance, nursing, or social work, or who is an
21 advanced practice registered nurse, a physician assistant with a mental
22 health certification, or a physician;

23 (2) Who holds a state license if practicing in a field covered by a state licensure
24 law; and

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- 1 (3) Who has at least two years of post-degree clinical experience, supervised
- 2 by another mental health professional, in assessing mental health needs
- 3 and problems and in providing appropriate mental health services.

BEHAVIORAL HEALTH TALKING POINTS

1/9/2015

6) SB 2048 - OMNIBUS
Human Services Committee
First Draft

PURPOSE: To enhance behavioral health services by establishing a consistent and common methodology of assessing/diagnosing those in need. It is also addressing the need for crisis intervention in our rural communities by providing training to the Critical Access Hospitals.

BACKGROUND: This bill came about as the result of the Schulte report and the Stakeholder's report.

- A. Section One - Appropriates \$6,000,000 for the purpose of establishing an adult and youth mental health assessment network.
 - a. Establishes Private/Public Adult and Youth Mental Health Assessment Networks throughout North Dakota to determine the most appropriate level of service needed.
 - b. Train Critical Access Hospitals to triage behavioral health issues including access to telemedicine to Mental Health Assessment Networks.
 - c. Establish a model for adult crisis intervention.

- B. Section Two - Appropriates \$175,000 to the department of human services for the purpose of establishing a pilot project involving law enforcement, health care providers, and other related organizations in one region to develop planning protocols for discharge or release of individuals with behavioral health issues.
 - a. Establishes a one year pilot project in one region to develop discharge planning protocols, including the establishment of outcome measures.
 - b. Includes law enforcement, health care providers and private partners.

BEHAVIORAL HEALTH TALKING POINTS

- C. Section Three - Appropriates \$50,000 for mental health training for teachers and child care providers.
 - a. Provides basic training in schools on behavioral health issues for teachers, child care providers using the Mental Health First Aid model.

- D. Section Four - Requires a legislative management study of screening and assessment programs for children during the 2015-16 interim.
 - a. Evaluate outcome data on behavioral health screening tools done with Health Tracks & Health Steps.
 - b. Monitor referral patterns and unmet needs.
 - c. Prepare recommendations to establish routine standardized screening using evidence based practice throughout the state to routinely screen all 2, 3, and 4 year olds.

- E. Section Five - Requires the continuation of the current study on the behavioral health needs of Youth and Adults during the 2015-16 interim.
 - a. Study must include consideration of behavioral health needs of youth and adults and access, availability and delivery of services.
 - b. Study must include input from stakeholders, including representatives of law enforcement, social and clinical services providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions.
 - c. The study must include monitoring and reviewing the strategies to improve behavioral health services implemented pursuant to legislation enacted by the sixty-fourth legislative assembly and other behavioral health - related recommendations presented to the 2013-14 interim human services committee.
 - d. Report findings and recommendations, along with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.

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of North Dakota

SENATE BILL NO. 2048

Introduced by

Legislative Management
(Human Services Committee)

1 A BILL for an Act to provide appropriations to the department of human services for improving
2 behavioral health services; to provide an appropriation to the department of public instruction for
3 teacher and child care provider training; and to provide for legislative management studies.

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

5 **SECTION 1. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES - MENTAL**
6 **HEALTH ASSESSMENT NETWORK.** There is appropriated out of any moneys in the general
7 fund in the state treasury, not otherwise appropriated, the sum of \$6,000,000, or so much of the
8 sum as may be necessary, to the department of human services for the purpose of establishing
9 an adult and youth mental health assessment network, for the biennium beginning July 1, 2015,
10 and ending June 30, 2017.

11 **SECTION 2. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES - PILOT**
12 **PROJECT - DISCHARGE PLANNING PROTOCOLS.** There is appropriated out of any moneys
13 in the general fund in the state treasury, not otherwise appropriated, the sum of \$175,000, or so
14 much of the sum as may be necessary, to the department of human services for the purpose of
15 establishing a pilot project involving law enforcement, health care providers, and other related
16 organizations in one region to develop planning protocols for discharge or release of individuals
17 with behavioral health issues, for the biennium beginning July 1, 2015, and ending June 30,
18 2017. The protocols must include outcome measures.

19 **SECTION 3. APPROPRIATION - DEPARTMENT OF PUBLIC INSTRUCTION - TRAINING.**
20 There is appropriated out of any moneys in the general fund in the state treasury, not otherwise
21 appropriated, the sum of \$50,000, or so much of the sum as may be necessary, to the
22 department of public instruction for the purpose of providing mental health first-aid training for
23 teachers and child care providers, for the biennium beginning July 1, 2015, and ending June 30,
24 2017.

1 **SECTION 4. LEGISLATIVE MANAGEMENT STUDY - MENTAL HEALTH SCREENING**

2 **AND ASSESSMENT FOR CHILDREN.** During the 2015-16 interim, the legislative management
3 shall consider studying mental health screening and assessment programs for children. If
4 conducted, the study must identify a potential standardized screening process using evidence-
5 based practices to routinely screen all children ages two through four at primary health care
6 sites. The study must also review the feasibility and desirability of implementing a visiting
7 nurses program for children ages zero through five. The legislative management shall report its
8 findings and recommendations, along with any legislation required to implement the
9 recommendations, to the sixty-fifth legislative assembly.

10 **SECTION 5. LEGISLATIVE MANAGEMENT STUDY - BEHAVIORAL HEALTH NEEDS OF**

11 **YOUTH AND ADULTS.** During the 2015-16 interim, the legislative management shall consider
12 studying behavioral health needs. The study must include consideration of behavioral health
13 needs of youth and adults and access, availability, and delivery of services. The study must
14 include input from stakeholders, including representatives of law enforcement, social and
15 clinical service providers, education, medical providers, mental health advocacy organizations,
16 emergency medical service providers, juvenile court, tribal government, and state and local
17 agencies and institutions. The study must also include monitoring and reviewing the strategies
18 to improve behavioral health services implemented pursuant to legislation enacted by the
19 sixty-fourth legislative assembly and other behavioral health-related recommendations
20 presented to the 2013-14 interim human services committee. The legislative management shall
21 report its findings and recommendations, along with any legislation required to implement the
22 recommendations, to the sixty-fifth legislative assembly.

BEHAVIORAL HEALTH TALKING POINTS

1/9/2015

7) SB 1049 - WORKFORCE ENHANCEMENT

Human Services Committee

Second Draft

PURPOSE: This is one of several workforce enhancement bills.

BACKGROUND: This bill came about as the result of the Schulte report and the Stakeholder’s report. Due to the severe shortage of behavioral health professionals, several sections of this bill establish a revolving loan fund through the Bank of North Dakota to encourage more individuals to enter professions within the behavioral health field.

Currently, licensed addiction counselors have to complete a 1400 hour unpaid internship. They do not qualify for student loans during this period. Currently, the Department of Human Services receives reimbursement for providing clinical training for individuals pursuing licensure as addiction counselors. Private providers do not receive compensation for providing clinical training experiences for individuals pursuing licensure as addiction counselors. Sections two, four and five address these issues.

- A. Section One - Establishes a student loan repayment grant program for behavioral health professionals.
 - a. Board of higher education shall administer a grant program to assist repayment of loans incurred by behavioral health professionals.
 - b. Applicant must:
 - i. Be employed as a behavioral health professional in a clinical setting in North Dakota.
 - ii. Have a student loan with the Bank of North Dakota or other participating lender
 - c. Maximum grant amount is \$1,500 per year with a maximum of \$6,000.

BEHAVIORAL HEALTH TALKING POINTS

- d. Section one, item six defines “behavioral health professional” and includes licensed marriage and family therapist and physician assistants with mental health certification.

- B. Section Two - Establishes a loan program for individuals participating in an unpaid internship at a licensed addiction treatment facility.
 - a. Bank of North Dakota shall develop and implement a program which loans may be provided to qualified individuals participating at a licensed addiction treatment facility in North Dakota.
 - b. Bank of ND forgives 25% of total amount loaned for each 12 month period that the individual serves as a licensed addiction counselor in North Dakota.
 - c. Maximum loan is \$25,000.
 - d. Only applicable to individuals beginning an unpaid internship after June 30, 2015.
 - e. Bank of North Dakota shall maintain a revolving loan fund for the purpose of making loans under this section.

- C. Section Three – Appropriates \$180,000 to the state board of higher education for administering a grant program to assist with repayment of student loans incurred by behavioral health professionals

- D. Section Four – Appropriates \$1,000,000 to the Bank of North Dakota to establish a revolving loan program for addiction counselor internships.

- E. Section Five – Appropriates \$200,000 to the Department of Human Services for grants to private entities that provide clinical training for individuals pursuing licensure as addiction counselors. Must complete 700 hours of clinical training toward obtaining licensure as an addiction counselor.

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Sixty-fourth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1049

Introduced by

Legislative Management

(Human Services Committee)

1 A BILL for an Act to create and enact a new section to chapter 15-10 and a new section to
2 chapter 43-45 of the North Dakota Century Code, relating to loans and grants for certain
3 behavioral health professionals; to provide for a transfer; and to provide for an appropriation.

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

5 **SECTION 1.** A new section to chapter 15-10 of the North Dakota Century Code is created
6 and enacted as follows:

7 **Student loan repayment grants - Behavioral health professionals.**

- 8 1. The state board of higher education shall administer a grant program to assist with the
9 repayment of student loans incurred by behavioral health professionals.
- 10 2. To be eligible for a student loan repayment grant under this section, an applicant must:
 - 11 a. Be employed as a behavioral health professional in a clinical setting in this state;
12 and
 - 13 b. Have a student loan with the Bank of North Dakota or other participating lender.
- 14 3. The state board of higher education shall distribute grants awarded under this section
15 directly to the Bank of North Dakota or to another participating lender to assist in the
16 repayment of the applicant's outstanding student loan principal balance.
- 17 4. The maximum grant for which an applicant may qualify is one thousand five hundred
18 dollars per year and an applicant may not receive more than six thousand dollars in
19 grants under this section.
- 20 5. If in any year the grant applications exceed the amount appropriated for this program,
21 the state board of higher education shall prorate the grants among all eligible
22 applicants.
- 23 6. For purposes of this section, a "behavioral health professional" means any of the
24 following:

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- 1 a. A psychologist who has at least a master's degree and is licensed by or approved
- 2 for exemption by the state board of psychologist examiners.
- 3 b. A social worker who has at least a master's degree in social work from an
- 4 accredited program and who is licensed in accordance with chapter 43-41.
- 5 c. A registered nurse who has at least:
- 6 (1) A master's degree in psychiatric and mental health nursing from an
- 7 accredited program;
- 8 (2) Two years of psychiatric clinical experience under the supervision of a
- 9 registered nurse meeting the requirements of paragraph 1; or
- 10 (3) Two years of psychiatric clinical experience under the supervision of a:
- 11 (a) Physician;
- 12 (b) Psychiatrist;
- 13 (c) Psychologist trained in a clinical program; or
- 14 (d) Licensed addiction counselor.
- 15 d. A licensed addiction counselor.
- 16 e. A licensed marriage and family therapist.
- 17 f. A licensed professional counselor with at least a master's degree in counseling
- 18 from an accredited program who has:
- 19 (1) Completed training beyond the master's level, as required by the national
- 20 academy of mental health counselors; or
- 21 (2) At least two years of clinical experience in a mental health agency or setting
- 22 under the supervision of a psychiatrist or psychologist.
- 23 g. A physician assistant with a mental health certification.

24 **SECTION 2.** A new section to chapter 43-45 of the North Dakota Century Code is created
25 and enacted as follows:

26 **Addiction counseling internship - Loan program - Revolving fund - Continuing**
27 **appropriation.**

- 28 1. a. The Bank of North Dakota shall develop and implement a program under which
- 29 loans may be provided to qualified individuals participating in an unpaid
- 30 internship at a licensed substance abuse treatment facility in this state, in order to
- 31 obtain licensure as an addiction counselor.

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1 **SECTION 5. APPROPRIATION.** There is appropriated out of any moneys in the general
2 fund in the state treasury, not otherwise appropriated, the sum of \$200,000, or so much of the
3 sum as may be necessary, to the department of human services for the purpose of providing
4 annual grants to private entities that provide clinical training experiences for individuals pursuing
5 licensure as addiction counselors, for the biennium beginning July 1, 2015, and ending June 30,
6 2017.

- 7 1. The department of human services shall consider applications for grants under this
8 section each year in chronological order.
- 9 2. Grants awarded to an entity under this section must be in the amount of \$5,000 for
10 each individual enrolled in a clinical training program and completing at least
11 700 hours of clinical training eligible toward obtaining licensure as an addiction
12 counselor.
- 13 3. The department of human services may not expend more than fifty percent of the
14 amount appropriated for purposes of this section during the first year of the biennium.

BEHAVIORAL HEALTH TALKING POINTS

1/9/2015

8) SB 2049 - BEHAVIORAL HEALTH PROFESSIONAL ROLE CLARIFICATION
Human Services Committee
First Draft

PURPOSE: This bill is another one of several workforce enhancement bills.

BACKGROUND: This bill came about as the result of the Stakeholder's report. The purpose behind this bill to expand community resources in an effort to improve access and availability to behavioral health services.

- A. Section One - Amends the current statute (Subsection 10 of section 25-03.1-02). Chapter 25-03.1 is the Commitment Procedures chapter. Section 25-03.1-02 provides the definitions. This bill adds licensed marriage and family therapist to the current definition of a "mental health professional" under subsection 10.

- B. Section Two - Amends section 32-03-48. Chapter 32-03 is the Damages and Compensatory Relief chapter. Item 5 of section two of this bill adds licensed marriage and family therapist to the definition of "mental health personnel."

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Sixty-fourth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2049

Introduced by

Legislative Management

(Human Services Committee)

1 A BILL for an Act to amend and reenact subsection 10 of section 25-03.1-02 and section
2 32-03-48 of the North Dakota Century Code, relating to inclusion of marriage and family
3 therapists in definitions of mental health professionals.

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

5 **SECTION 1. AMENDMENT.** Subsection 10 of section 25-03.1-02 of the North Dakota
6 Century Code is amended and reenacted as follows:

7 10. "Mental health professional" means:

- 8 a. A psychologist with at least a master's degree who has been either licensed or
9 approved for exemption by the North Dakota board of psychology examiners.
- 10 b. A social worker with a master's degree in social work from an accredited
11 program.
- 12 c. A registered nurse with a master's degree in psychiatric and mental health
13 nursing from an accredited program.
- 14 d. A registered nurse with a minimum of two years of psychiatric clinical experience
15 under the supervision of a registered nurse as defined by subdivision c or of an
16 expert examiner.
- 17 e. A licensed addiction counselor.
- 18 f. A licensed professional counselor with a master's degree in counseling from an
19 accredited program who has either successfully completed the advanced training
20 beyond the master's degree as required by the national academy of mental
21 health counselors or a minimum of two years of clinical experience in a mental
22 health agency or setting under the supervision of a psychiatrist or psychologist.
- 23 g. A licensed marriage and family therapist.

1 **SECTION 2. AMENDMENT.** Section 32-03-48 of the North Dakota Century Code is
2 amended and reenacted as follows:

3 **32-03-48. Definitions.**

4 As used in sections 32-03-48 through 32-03-50, unless the context otherwise requires:

- 5 1. "Critical incident" means any event encountered by emergency service personnel
6 within the scope of their employment which causes them to experience unusually
7 strong emotional reactions that have the potential to interfere with their ability to
8 perform their jobs or that may interfere with their personal lives.
- 9 2. "Critical incident stress debriefing" means the process of resolving the effects of
10 critical incidents on emergency service personnel through a structured meeting with
11 both psychological and educational components according to the model approved by
12 the state department of health.
- 13 3. "Critical incident stress management team" means those volunteers who are
14 recognized by the state department of health as members of an organized group that
15 provides critical incident stress debriefing services on behalf of the state.
- 16 4. "Emergency service personnel" means individuals who provide emergency services to
17 persons requiring medical aid, firefighting services, law enforcement assistance, or
18 other emergency assistance. The term includes law enforcement officers, firefighters,
19 rescue personnel, ambulance personnel, quick response personnel, emergency
20 service dispatchers, nurses, physicians, and other emergency care providers.
- 21 5. "Mental health personnel" means psychiatrists, licensed psychologists, licensed social
22 workers, licensed mental health counselors, nurses, members of the clergy, licensed
23 marriage and family therapists, and other individuals approved by the state
24 department of health to function as members of a critical incident stress management
25 team, who have completed appropriate training as approved by the department.
- 26 6. "Peer support personnel" means those members of a critical incident stress
27 management team who are emergency service personnel and who have completed
28 appropriate training approved by the state department of health.

Attach #9
 SB 2046
 01/14/15
 J# 21959
 Section 0

North Dakota Legislative Branch

Legislative Bill Tracking - Sixty-fourth Assembly (2015) - Committee Hearings

[Tracking Lists](#) | [Today's Calendar](#) | [Committee Hearings](#) | [Conference Committee Hearings](#) | [Bill Status](#) | [Bills Introduced Since 01/08/2015](#)

Date and Time	Bill Number	Short Title	Committee	Room	List Name	Description	Comment
01/12/2015 09:00 AM	HB 1036	A BILL for an Act to provide for the state department of health to study health professional assistance programs and report to the legislative management.	House Human Services	Fort Union	Behavioral Health		
01/12/2015 10:00 AM	HB 1049	Relating to loans and grants for certain behavioral health professionals; to provide for a transfer; and to provide for an appropriation.	House Human Services	Fort Union	Behavioral Health		
01/12/2015 10:30 AM	HB 1115	Relating to a state behavioral health professional loan repayment program.	House Human Services	Fort Union	Behavioral Health		
01/13/2015 09:30 AM	HB 1039	Relating to health insurance coverage of substance abuse treatment; to repeal section 26 1-36-08.1 of the North Dakota Century Code, relating to alternative health insurance coverage of substance abuse treatment; and to provide for application.	House Human Services	Fort Union	Behavioral Health		
01/13/2015 09:40 AM	HB 1040	Relating to scope of practice in involuntary commitment proceedings; and to provide a penalty.	House Judiciary	Prairie	Behavioral Health		
01/13/2015 10:00 AM	SB 2049	Relating to inclusion of marriage and family therapists in definitions of mental health professionals.	Senate Human Services	Red River	Behavioral Health		
01/14/2015 09:00 AM	HB 1048	Relating to state department of health oversight and administration of the development of uniform licensing and reciprocity standards for licensees of the board of addiction counseling examiners, board of counselor examiners, North Dakota board of social work examiners, state board of psychologist examiners, state board of medical examiners, and North Dakota marriage and family therapy licensure board.	House Human Services	Fort Union	Behavioral Health		
01/14/2015 09:00 AM	SB 2045	A BILL for an Act to provide an appropriation to the department of human services for a voucher system for addiction treatment services.	Senate Human Services	Red River	Behavioral Health		
01/14/2015 09:30 AM	SB 2046	Relating to medical assistance coverage for certain behavioral health services; to provide for the development of an outcomes-based data system for behavioral health services; to provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to provide for a legislative management study.	Senate Human Services	Red River	Behavioral Health		
01/14/2015 10:45 AM	SB 2048	A BILL for an Act to provide appropriations to the department of human services for improving behavioral health services; to provide an appropriation to the department of public instruction for teacher and child care provider training; and to provide for legislative management studies.	Senate Human Services	Red River	Behavioral Health		
01/16/2015 09:00 AM	HB 1048	Relating to state department of health oversight and administration of the development of uniform licensing and reciprocity standards for licensees of the board of addiction counseling examiners, board of counselor examiners, North Dakota board of social work examiners, state board of psychologist examiners, state board of medical examiners, and North Dakota marriage and family therapy licensure board.	House Energy and Natural Resources	Pioneer	Behavioral Health		

PROPOSED AMENDMENTS TO SENATE BILL NO. 2046

Attach #1
01/21/15
SB2046
J# 22664

Page 1, line 5, after "services" insert "and for coverage of licensed marriage and family therapists as medicaid providers"

Page 1, line 11, replace "The" with "Beginning January 1, 2016, the"

Page 1, line 11, remove "adopt rules entitling licensed professional clinical"

Page 1, line 12, replace "counselors and" with "allow"

Page 1, line 12, after "to" insert "enroll and be eligible for"

Page 1, line 14, remove "based on federal laws and regulations"

Page 2, line 1, replace "expanding adult and youth" with "addressing gaps in the state's"

Page 2, line 2, replace "treatment services" with "system"

Page 2, line 2, after "including" insert "intervention,"

Page 2, line 2, after "detoxification" insert ", and recovery"

Page 2, line 2, replace "biennium" with "period"

Page 2, line 2, replace "2015" with "2016"

Page 2, line 3, after "2017" insert ". The department of human services shall ensure recipients of funding under this section collect and report process and outcome measures. Recipients of funding under this section shall implement research-based programs. The department of human services shall require recipients of funding under this section to develop sustainability plans and participate in training and technical assistance"

Page 2, after line 9 insert:

"SECTION 5. APPROPRIATION – DEPARTMENT OF HUMAN SERVICES – LICENSED MARRIAGE AND FAMILY THERAPISTS. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from special funds derived from federal funds, the sum of \$249,773, or so much of the sum as may be necessary, to the department of human services for the purpose of providing payment to licensed marriage and family therapists who enroll as providers in the medicaid program on or after January 1, 2016."

1.2.

Page 2, line 10, replace "5." with "6."

Renumber accordingly

Attach #2

01/27/15

SB20 46

J# 22664

WITHDRAWAL MANAGEMENT NORTH DAKOTA, REGION 7

Discovery Process



BACKGROUND

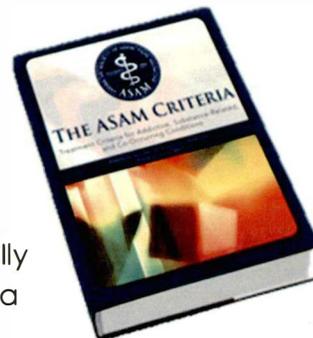
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- Level 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring
- Level 2-WM: Ambulatory Withdrawal Management with Extended On-Site Monitoring
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The widely used general term of "detoxification" can involve management of intoxication episodes and withdrawal episodes. Adults, at various points in time, may be in need of intoxication management and may be in need of withdrawal management, in addition to management of their substance use disorder. Adolescents are more frequently in need of management for intoxication episodes than management for withdrawal symptoms.

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seizures, but their withdrawal syndrome was not managed as it could have been by using the full range of five levels of withdrawal management that are in the adult criteria. By managing withdrawal in a continuum of WM services, a person could get two weeks of support for what is now spent in three or four days in the most intensive and expensive levels of WM (e.g., Level 3.2-WM may cost \$100-200/day, which could give a person three or four days in twenty-four-hour support for every one day that Level 4-WM costs). Thus, without spending more resources and maybe even less than what is spent for a few days of the most intensive and expensive levels of WM, the patient could receive much longer lengths of withdrawal management in the five levels of WM.

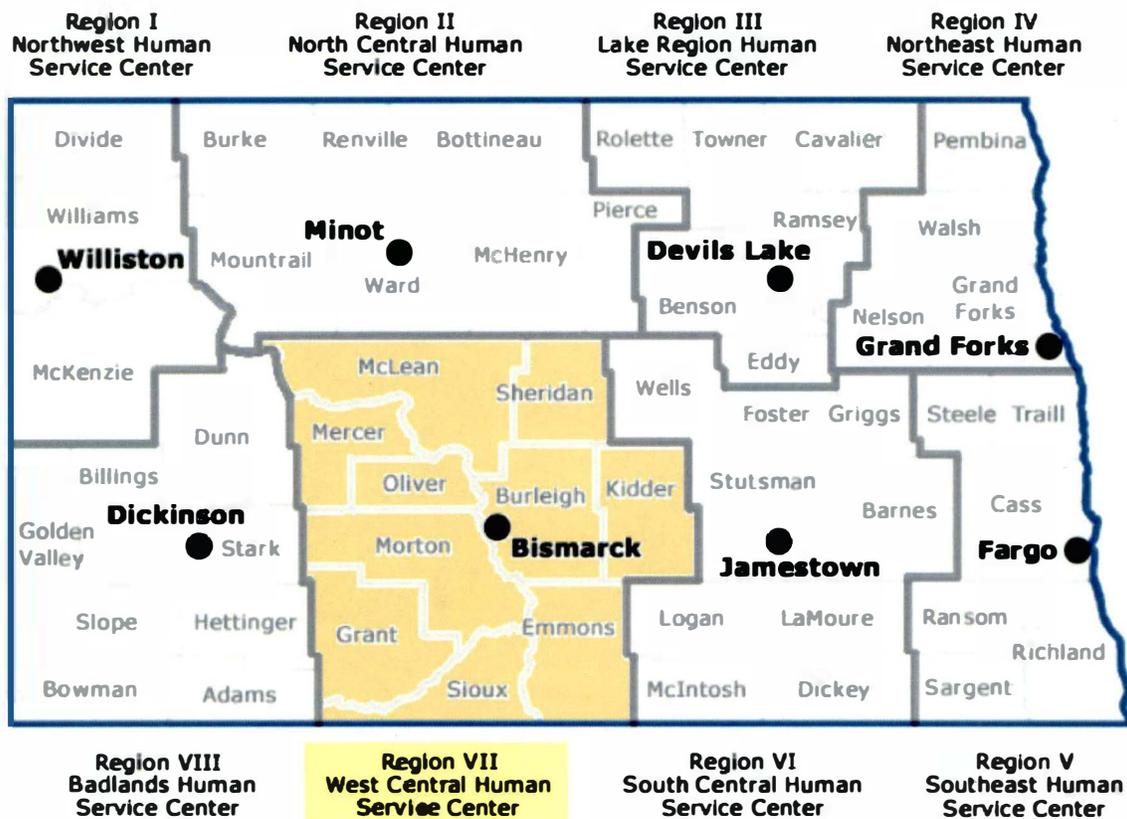
Mee-Lee D, Shulman GD, Fishman MF, Gastfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Cnage Companies®; 2013.

http://www.counselormagazine.com/2013/Nov-Dec/ASAM_Criteria/

4

METHODS

Information was collected from Region 7 service providers, law enforcement, partners and state agencies in order to paint a clearer picture of what the withdrawal management needs are in the region.



DISCOVERY

CURRENT SYSTEM OVERVIEW

Substance use disorder treatment providers in North Dakota are required to be licensed by the Department of Human Services' Mental Health and Substance Abuse Division. Of the 35 licensed treatment providers in Region 7, there are two programs providing social detoxification services. West Central Human Service Center (WCHSC) and Heartview Foundation provide social detox services; however, both agencies report with the intent of engaging people into treatment and not as a lone service (detox only).



Division of Mental Health & Substance Abuse
1237 West Divide Avenue Suite 1C - Bismarck, ND 58501-1208
(701) 328-8920/1-800-755-2719
Fax: (701) 328-8989
www.nd.gov/dhs

Social Detoxification ASAM Level 3.2-D: "Detoxification" means the process of interrupting the momentum of compulsive use in an individual diagnosed with substance dependence and the condition of recovery from the effects of alcohol or another drug, the treatment required to manage withdrawal symptoms from alcohol or another drug, and the promotion of recovery from its effects. "Social detoxification" means detoxification in an organized residential, nonmedical setting delivered by appropriately trained staff who provide safe, 24-hour monitoring, observation, and support in a supervised environment for a client to achieve initial recovery from the effects of alcohol or another drug.

City	Program	Phone
Bismarck	Heartview Foundation	(701) 222-0386/1-800-337-3160
Bismarck	West Central Human Service Center - Bismarck	(701) 328-8888/1-888-328-2662/24-Hour Crisis Lines: (701) 328-8899/1-888-328-2112
Devils Lake	Lake Region Human Service Center - Devils Lake	(701) 665-2200/1-888-607-8610/Crisis Line: (701) 662-5050 (collect calls accepted)
Dickinson	Badlands Human Service Center	(701) 227-7500/1-888-227-7525/Crisis Lines: 8 a.m. - 5 p.m.: (701) 225-7500/After 5 p.m.: (701) 290-5719
Fargo	City of Fargo dba Fargo Cass Public Health	(701) 364-0116
Fargo	Dacotah Foundation - Dakotah Pioneer	(701) 223-4517
Fargo	ShareHouse, Inc.	(701) 282-6561/1-877-294-6561
Jamestown	South Central Human Service Center	(701) 253-6300/1-800-260-1310/Crisis Line: (701) 253-6304
Minot	North Central Human Service Center	(701) 857-8500/1-888-470-6968
Minot	Trinity Hospitals	(701) 857-2480/1-800-247-1316
Rolla	Lake Region Human Service Center - Rolla Outreach	(701) 477-8272

March 2014

West Central Human Service Center (WCHSC): WCHSC contracts with a local medical provider to provide medical detox services in Region 7. WCHSC also has a 10 bed facility, but is not actively detoxing more than two or three persons at a time depending on bed availability and the client's number of days in treatment. WCHSC frequently has a full waiting list for residential services. It was reported that detox protocols can begin on the inpatient units or clients are given preliminary treatment in an ER prior to admission. Clients may be given scheduled medication if prescribed by a primary care doctor.

Heartview Foundation: Heartview has a 12 bed facility. It was reported that Heartview functions similarly regarding their social detox services. Detox-only admissions do not occur at Heartview.

6

Based on the state's public intoxication law, peace officers have a responsibility to take an apparently intoxicated person to their home, the hospital, a detox center, or jail for the purposes of detoxification.

5-01-05.1. Public intoxication - Assistance - Medical care.

A peace officer has authority to take any apparently intoxicated person to the person's home, to a local hospital, to a detoxification center, or, whenever that person constitutes a danger to that person or others, to a jail for purposes of detoxification. A duly licensed physician of a local hospital or a licensed addiction counselor of a detoxification center has authority to hold that person for treatment up to seventy-two hours. That intoxicated person may not be held in jail because of intoxication more than twenty-four hours. An intoxicated person may not be placed in a jail unless a jailer is constantly present within hearing distance and medical services are provided when the need is indicated. Upon placing that person in jail, or if the person is admitted into a hospital or detoxification center, upon admission, the peace officer shall make a reasonable effort to notify the intoxicated person's family as soon as possible. Any additional costs incurred by the city, county, ambulance service, or medical service provider on account of an intoxicated person shall be recoverable from that person.

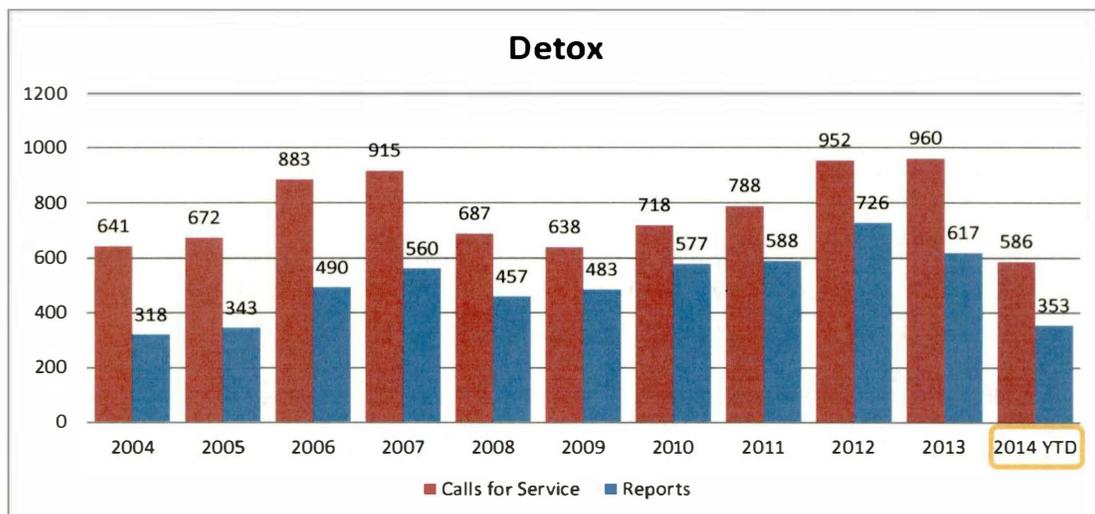
5-01-05.2. No prosecution for intoxication.

No person may be prosecuted in any court solely for public intoxication. Law enforcement officers may utilize standard identification procedures on all persons given assistance because of apparent intoxication.

With the limited number of social/medical detox providers in the region (and the entire state), other systems/providers (jails and hospitals) are often left responsible but are not licensed or trained to provide the level of care required.

LAW ENFORCEMENT

Below is data from the Bismarck Police Department (Detox related calls and reports for years 2004 through July 2014). The "Calls for Services" are the actual calls/encounters with people with a detox issue. The "Reports" number accounts for individuals that had to go to jail, or at least the vast majority for sure, due to the officer being unable to locate anyone to take care of them.



LEGISLATIVE

The recent legislative interim committee Study of Behavioral Health Needs of Youth and Adults has provided some information and guidance for next steps regarding the lack of services in this area.

*"The number one concern across the state can be summed up in one phrase: "Not enough services." The statement includes services at all levels from preventative services, case management, substance abuse services including residential, **DETOX**, psychiatric services, lack of stat children's residential services, etc."*

A strategy that is suggested is to "Increase substance abuse services including detox."

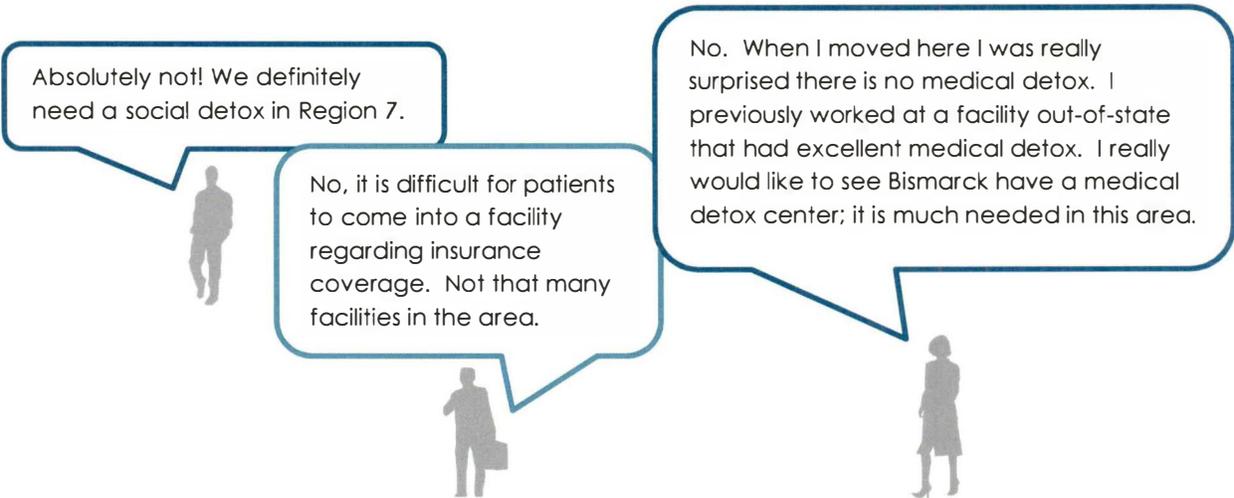
- Excerpts from "Behavioral Health Planning Draft Final Report" 6/19/14. Schulte Consulting"

A Goal developed by the Behavioral Health Stakeholders Group project is: "Substance Abuse Goal 1.2: Expand Medical and Social detoxification resources" with the action steps being, (1) Assess current services and develop a plan to assure services in all regions. Support local efforts to build comprehensive detox structure; (2) Expand the behavioral health training model first responders used in Cass County to the whole state and integrate into Post Training standards.

- Excerpts from "Building Stronger Behavioral Health Services in North Dakota: Framing Key Issues and Answers" 7/18/14. Behavioral Health Stakeholders Group

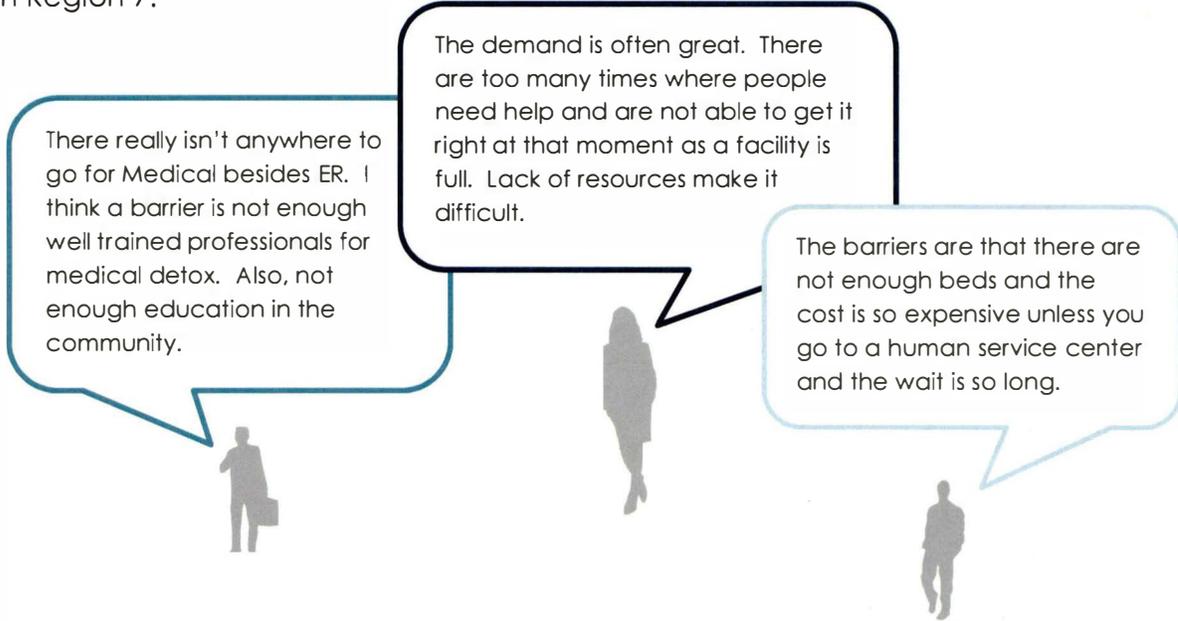
INFORMATION IDENTIFIED IN REGION 7

Behavioral health provider feedback regarding whether or not there is **sufficient access** to social and/or medical detox in Region 7:



4

Behavioral health provider feedback regarding **barriers** to accessing social and/or medical detox in Region 7:



Youth-specific concerns from behavioral health providers:

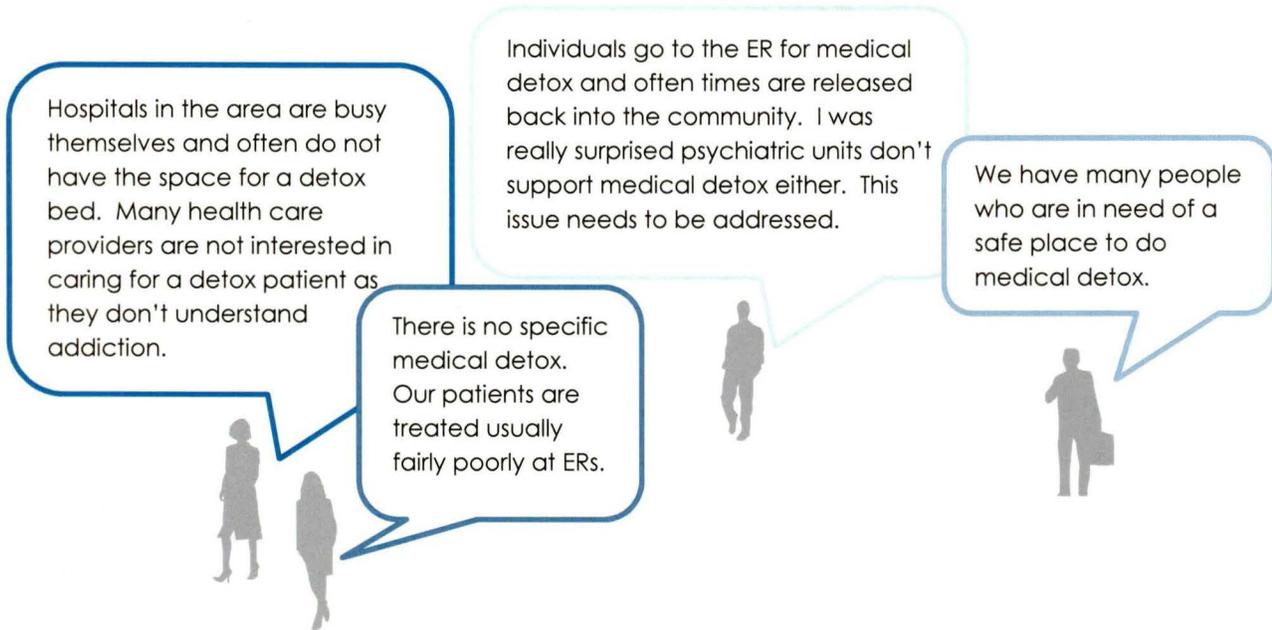


The current capacity in the region (and entire state) is limited in terms of the number of facilities/providers. Another identified concern is the knowledge and skill of providers.

Unmet needs regarding **social detox** (Region 7 Behavioral Health Provider feedback):



Unmet needs regarding **medical detox** (Region 7 Behavioral Health Provider feedback):



The capacity of these services is currently limited, however, the ever increasing need for a changing state landscape (ex - population and narcotic usage) only draws attention to this gap in the state's substance use disorder system.

The current system also does little to address the "revolving door" - where there are repeat admissions and limited engagement strategies. When looking to solutions this should be considered.

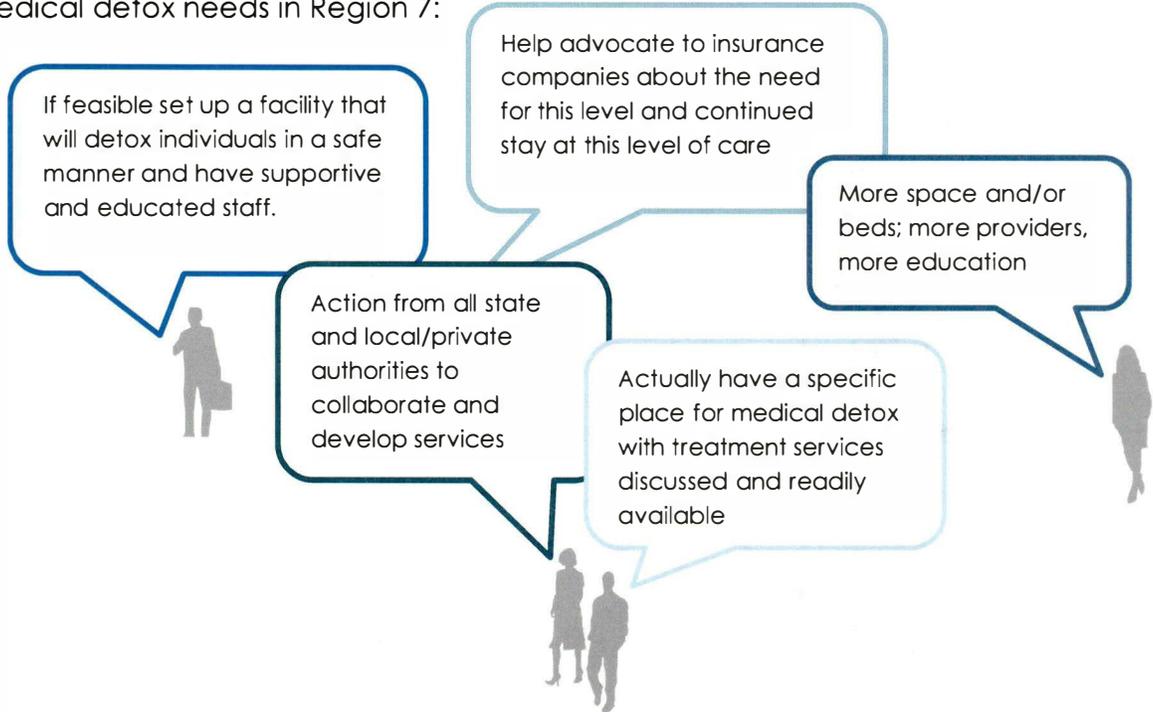
NORTH DAKOTA WITHDRAWAL MANAGEMENT LOGIC MODEL

PROBLEM	WHY?	STRATEGES	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
<p>Police Responsibility (Public intoxication law)</p> <p>Limited capacity for social detox (facilities and skills)</p> <p>Facilities (Jail) not licensed for "detox" but left responsible</p> <p>Limited or no capacity for medical detox (no facilities, risky placements, oversight?, finding?)</p> <p>Increased needs (population & narcotics)</p> <p>"Revolving door" (limited engagement, repeat admissions)</p>	<p>Public Intoxication law issues</p> <p>Lack of service providers</p> <p>Limited skills in managing withdrawal and intoxication.</p> <p>Jail only option but not qualified or licensed.</p> <p>Hospitals not providing medical detox (limited)</p> <p>Fort Yates transfers to hospital – then out to Bismarck PD.</p> <p>Lack of collaboration among parties/providers</p>	<p>Revise public intoxication law with current language.</p> <p>Public intoxication becomes a misdemeanor</p> <p>Training and technical assistance needed to develop and enhance skills regarding wm & im.</p> <p>Increase capacity for medical detox (wm)</p> <p>Increase capacity for social detox (wm)</p> <p>Identify process for intoxication management</p> <p>Update Administrative Rule with current ASAM (wm & im)</p> <p>Identify oversight agency for medical detox (im)</p> <p>Ensure engagement strategies in social and medical detox settings.</p>	<p>Capacity</p> <ul style="list-style-type: none"> • increased skills • increased facilities (social & medical) <p>Increased Coordination</p> <p>Increased Engagement</p>	<p>Decreased community problems</p> <p>Decreased law enforcement involvement</p> <p>Better care for consumers across the continuum of care</p> <p>Improved wellness for consumers</p> <p>Decrease in "revolving door"</p>

10

STRATEGIES

Behavioral health provider feedback regarding **what can be done to improve** social and medical detox needs in Region 7:

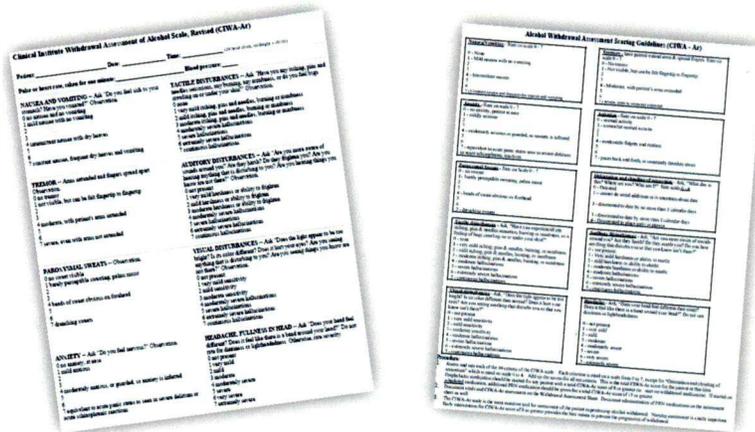


Training

- Training and technical assistance may be needed to develop and enhance skills regarding withdrawal and intoxication management.
- Increase capacity for medical and social detox for withdrawal management with many audiences.

Universal use of screening/assessment tools (CIWA-AR)

- Required in North Dakota Administrative Code relating to Substance Abuse Treatment licensing.



12

Funding

- Identify available funding to support withdrawal management needs in the community

Reimbursement

- Increase insurance coverage for withdrawal and intoxication management services.

Policy

- Revise public intoxication law with current language
- Update Administrative Rule with current ASAM for withdrawal and intoxication management
- New (sub-acute) level of care

Oversight

- Identify oversight agency for medical detox
- Identify process for intoxication management

Engagement

- Ensure engagement strategies in social and medical detox settings to decrease “revolving door”.

KEY PARTNERS



SB2046
 Attach#1 J# 22756
 01/28/15

Increase in Behavioral Health Services Contained in Various Bills

Prepared by the Department of Human Services - January 28, 2015

Amounts reflected are the appropriation contained in each Bill; if fiscal note is different, the fiscal note amount is highlighted below.

	Department of Human Services		Department of Health		Department of Public Instruction		Highway Patrol		OMB/Bank of ND		State Board of Higher Education		Total	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
SB 2012-Department of Human Services														
Additional funding for extended services slots, prevocational skills slots, 10 bed crisis residential/transitional, 4 bed alternative care residential, IDDT programming, 10 bed residential addiction, 15 bed expansion for Tompkins Rehabilitation, trauma-informed system of care, ND Cares, and mobile crisis on-call services	6,001,660	276,588											6,001,660	276,588
Traumatic Brain Injury														
HB 1046 Relating to a traumatic brain injury registry, traumatic brain injury regional resource facilitation, and expanded traumatic brain injury programming	1,975,000 2,536,092		251,083										2,226,083	-
SB 2044 TBI Flex Fund Program	250,000 416,092												250,000	-
Workforce														
HB 1004 - Department of Health Provides for the Behavioral Health Professionals Loan Program appropriation			495,000										495,000	-
HB 1048 Board Licensing Requirements			108,900										-	-
HB 1049 Relating to loans and grants for certain behavioral health professionals	200,000								1,000,000		180,000		1,380,000	-
HB 1115 Relating to a state behavioral health professional loan repayment program													-	-
SB 2162 Relating to loan repayment programs for social workers and addiction counselors; and to provide an appropriation.			360,000										360,000	-
Youth														
HB 1350 To provide for a shelter and assessment pilot project for at-risk youth; to provide an appropriation; and to provide for a report to the legislative management.	750,000												750,000	-
Substance Abuse Services														
SB 2045 Provides for a voucher system for addiction treatment services.	2,000,000 2,166,092												2,000,000	-
Mixed														
SB 2046 Medical assistance coverage for certain behavioral health services; an outcomes-based data system for behavioral health services; DHS for substance abuse treatment services; Highway Patrol for law enforcement training	3,000,000 3,290,979	- 124,886						25,000					3,025,000	-
SB 2048 DHS for mental health assessment network, discharge planning protocols pilot, DPI training, mental health screening for children and a study.	6,175,000 6,341,092					50,000 990,000							6,225,000	-
Totals	20,351,660	276,588	1,106,083	-	50,000	-	25,000	-	1,000,000	-	180,000	-	22,712,743	276,588

HB 1280 provides for a study of the feasibility and desirability of reorganizing and restructuring the Department of Human Services. HCR 3005 provides for a study for the system of care for individuals with brain injury and SCR 4005 provides for a study for judicial issues related to behavioral health, including 24-hour hold, termination of parent rights, and court committals.

SB2046
02/04/15 Committee
Attach #1
JH 23250

SB 2046 DRAFT AMENDMENT

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota

century code, relating to medical assistance coverage for certain behavioral health services; to ~~provide for the development of an outcomes-based data system for behavioral health services; to~~ provide an appropriation to the department of human services for substance abuse treatment services; to provide an appropriation to highway patrol for law enforcement training; and to ~~provide for a legislative management study~~ an appropriation to the department of human services for providing payment to licensed marriage and family therapists.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Behavioral health services - Licensed marriage and family therapists.

~~The Beginning~~ January 1, 2016, the department of human services shall adopt rules entitling ~~licensed professional clinical counselors and~~ allow licensed marriage and family therapists to enroll and be eligible for payment for behavioral health services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary ~~based on federal laws and regulations.~~

~~SECTION 2. DEPARTMENT OF HUMAN SERVICES - OUTCOMES-BASED DATA SYSTEM - REPORTS TO LEGISLATIVE MANAGEMENT.~~

~~The department of human services shall develop an outcomes-based data system for behavioral health services during the biennium beginning July 1, 2015, and ending June 30, 2017. The department of human services shall report periodically to the legislative management during the 2015-16 interim on the development of the outcomes-based data system.~~

**SECTION 32. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES -
~~SUBSTANCE ABUSE TREATMENT SERVICES~~ ^{SYSTEM} - REPORTS TO THE LEGISLATIVE
MANAGEMENT.**

There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$3,000,000, or so much of the sum as may be necessary, to the department of human services for the purpose of ~~expanding adult and youth~~ addressing gaps in the state's substance abuse treatment services system, including intervention, detoxification and recovery services, for the ~~biennium period~~ beginning July 1, 2015 2016, and ending June 30, 2017. The department of human services shall ensure recipients of funding under this section collect and report process and outcome measures. Recipients of funding under this section shall implement research-based programs. The department of human services shall require recipients of funding under this section to develop sustainability plans and participate in training and technical assistance. The department of human services shall report to the legislative management on the use of these funds by July 1, 2016.

SECTION 43. APPROPRIATION - HIGHWAY PATROL - TRAINING.

There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$25,000, or so much of the sum as may be necessary, to the highway patrol for the purpose of providing mental health first aid training for state and local law enforcement personnel, for the biennium beginning July 1, 2015, and ending June 30, 2017.

**~~SECTION 5. LEGISLATIVE MANAGEMENT STUDY - DEPARTMENT OF
HUMAN SERVICES STRUCTURE.~~**

~~During the 2015-16 interim, the legislative management shall consider studying the structure and services of the department of human services. If conducted, the study must identify core services~~

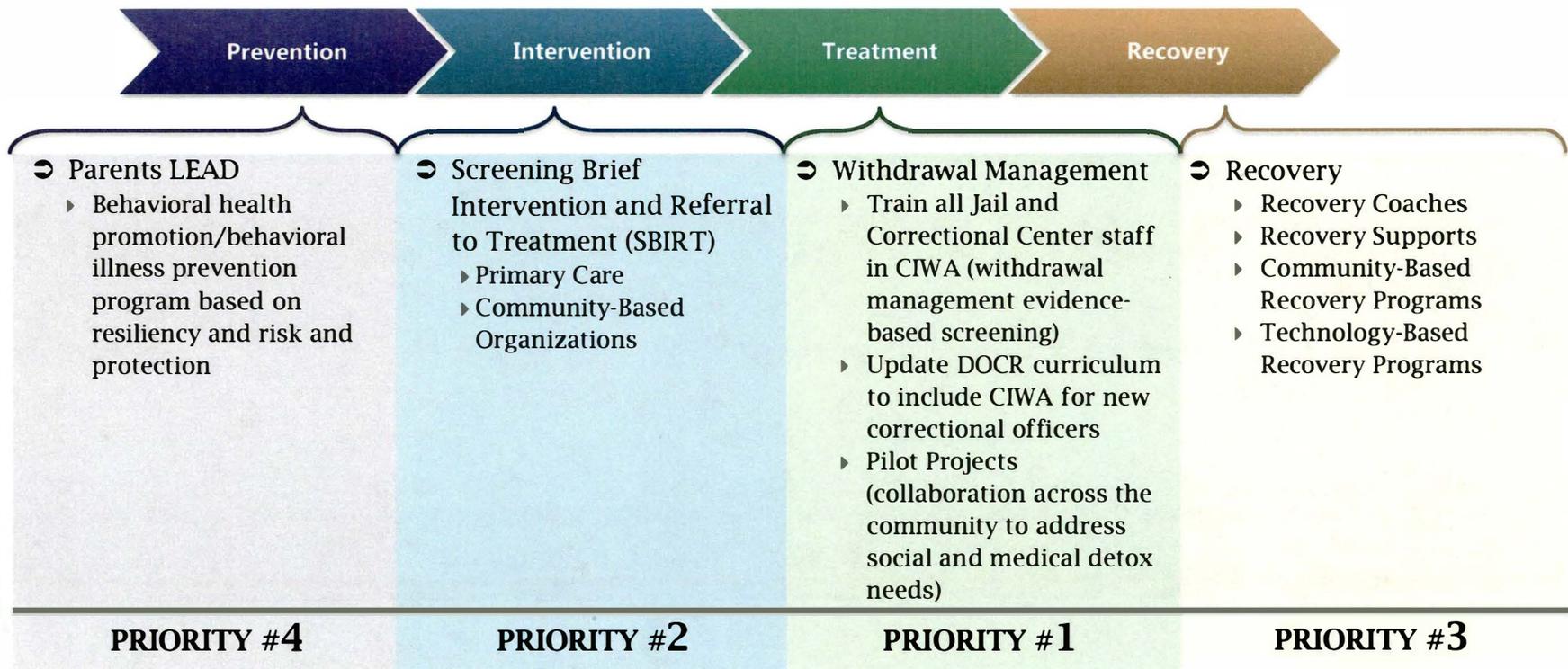
~~provided by the department of human services, services which may be provided by private providers rather than the department of human services, and whether it is appropriate for the department of human services to provide services it also regulates. The legislative management shall report its findings and recommendations, along with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.~~

"SECTION 4. APPROPRIATION – DEPARTMENT OF HUMAN SERVICES – LICENSED MARRIAGE AND FAMILY THERAPISTS. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from special funds derived from federal funds, the sum of \$^{124,886}~~249,773~~, or so much of the sum as may be necessary, to the department of human services for the purpose of providing payment to licensed marriage and family therapists who enroll as providers in the medicaid program on or after January 1, 2016."

↓
the sum of \$124,886,
or so much of
the sum as may be
necessary

SB 2046: Enhance Substance Use Disorder (SUD) System

Grant program to address the gaps in the SUD System



In order to qualify, all programs must collect and report both process and outcome measures, and be research based. Other requirements include sustainability planning, training and technical assistance, reporting, and collaboration.

1.1

SB 2046
2-12-15
#1

SB 2046
2-12-15
2

WITHDRAWAL MANAGEMENT NORTH DAKOTA, REGION 7

Discovery Process



2.1

BACKGROUND

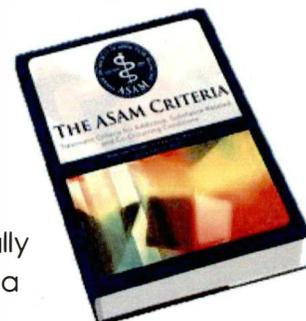
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The ASAM Criteria describes various levels of care for withdrawal management for adults as if these services were offered separately from the services a patient may need to manage their addiction (substance use disorder). In many cases, services for withdrawal management and services for addiction management are offered concurrently, by the same staff, in the same treatment setting, in an integrated manner. But in making decisions about the clinical necessity of offering specific interventions to address intoxication or withdrawal, The ASAM Criteria "unbundles" services (at least conceptually) and examines the features of a patient's clinical presentation which may indicate specific interventions for "detoxification" – now termed "withdrawal management"

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The clinical implication of the change to "withdrawal management" is that a patient is often admitted to a Level 3.7-Withdrawal Management (WM) or 4-WM at \$600-800/day for a few days to prevent withdrawal seizures and then is discharged. Within a week a person may start using substances again, which is seen as noncompliance because they have already been detoxified. However, they were actually treated for a few days to prevent

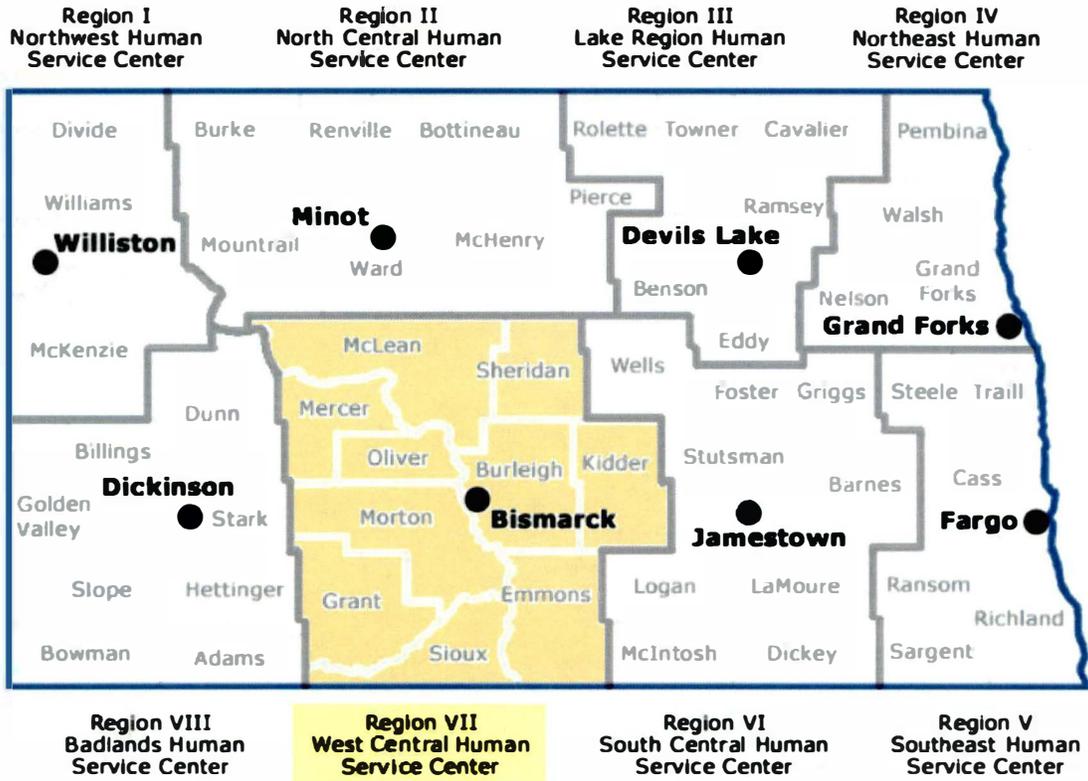
seizures, but their withdrawal syndrome was not managed as it could have been by using the full range of five levels of withdrawal management that are in the adult criteria. By managing withdrawal in a continuum of WM services, a person could get two weeks of support for what is now spent in three or four days in the most intensive and expensive levels of WM (e.g., Level 3.2-WM may cost \$100-200/day, which could give a person three or four days in twenty-four-hour support for every one day that Level 4-WM costs). Thus, without spending more resources and maybe even less than what is spent for a few days of the most intensive and expensive levels of WM, the patient could receive much longer lengths of withdrawal management in the five levels of WM.

Mee-Lee D, Shulman GD, Fishman MF, Gastfriend DR, Miller MM, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Cnage Companies®; 2013.

http://www.counselormagazine.com/2013/Nov-Dec/ASAM_Criteria/

METHODS

Information was collected from Region 7 service providers, law enforcement, partners and state agencies in order to paint a clearer picture of what the withdrawal management needs are in the region.



DISCOVERY

CURRENT SYSTEM OVERVIEW

Substance use disorder treatment providers in North Dakota are required to be licensed by the Department of Human Services' Mental Health and Substance Abuse Division. Of the 35 licensed treatment providers in Region 7, there are two programs providing social detoxification services. West Central Human Service Center (WCHSC) and Heartview Foundation provide social detox services; however, both agencies report with the intent of engaging people into treatment and not as a lone service (detox only).



Division of Mental Health & Substance Abuse

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www.nd.gov/dhs

Social Detoxification ASAM Level 3.2-D. "Detoxification" means the process of interrupting the momentum of compulsive use in an individual diagnosed with substance dependence and the condition of recovery from the effects of alcohol or another drug, the treatment required to manage withdrawal symptoms from alcohol or another drug, and the promotion of recovery from its effects. "Social detoxification" means detoxification in an organized residential, nonmedical setting delivered by appropriately trained staff who provide safe, 24-hour monitoring, observation, and support in a supervised environment for a client to achieve initial recovery from the effects of alcohol or another drug.

City	Program	Phone
Bismarck	Heartview Foundation	(701) 222-0386/1-800-337-3160
Bismarck	West Central Human Service Center - Bismarck	(701) 328-8888/1-888-328-2662/24-Hour Crisis Lines: (701) 328-8899/1-888-328-2112
Devils Lake	Lake Region Human Service Center - Devils Lake	(701) 665-2200/1-888-607-8610/Crisis Line: (701) 662-5050 (collect calls accepted)
Dickinson	Badlands Human Service Center	(701) 227-7500/1-888-227-7525/Crisis Lines: 8 a.m. - 5 p.m.:
Fargo	City of Fargo dba Fargo Cass Public Health	(701) 225-7500/After 5 p.m.: (701) 290-5719
Fargo	Dacotah Foundation - Dakotah Pioneer	(701) 364-0116
Fargo	ShareHouse, Inc.	(701) 223-4517
Fargo	ShareHouse, Inc.	(701) 282-6561/1-877-294-6561
Jamestown	South Central Human Service Center	(701) 253-6300/1-800-260-1310/Crisis Line: (701) 253-6304
Minot	North Central Human Service Center	(701) 857-8500/1-888-470-6968
Minot	Trinity Hospitals	(701) 857-2480/1-800-247-1316
Rolla	Lake Region Human Service Center - Rolla Outreach	(701) 477-8272

March 2014

West Central Human Service Center (WCHSC): WCHSC contracts with a local medical provider to provide medical detox services in Region 7. WCHSC also has a 10 bed facility, but is not actively detoxing more than two or three persons at a time depending on bed availability and the client's number of days in treatment. WCHSC frequently has a full waiting list for residential services. It was reported that detox protocols can begin on the inpatient units or clients are given preliminary treatment in an ER prior to admission. Clients may be given scheduled medication if prescribed by a primary care doctor.

Heartview Foundation: Heartview has a 12 bed facility. It was reported that Heartview functions similarly regarding their social detox services. Detox-only admissions do not occur at Heartview.

2.5

Based on the state's public intoxication law, peace officers have a responsibility to take an apparently intoxicated person to their home, the hospital, a detox center, or jail for the purposes of detoxification.

5-01-05.1. Public intoxication - Assistance - Medical care.

A peace officer has authority to take any apparently intoxicated person to the person's home, to a local hospital, to a detoxification center, or, whenever that person constitutes a danger to that person or others, to a jail for purposes of detoxification. A duly licensed physician of a local hospital or a licensed addiction counselor of a detoxification center has authority to hold that person for treatment up to seventy-two hours. That intoxicated person may not be held in jail because of intoxication more than twenty-four hours. An intoxicated person may not be placed in a jail unless a jailer is constantly present within hearing distance and medical services are provided when the need is indicated. Upon placing that person in jail, or if the person is admitted into a hospital or detoxification center, upon admission, the peace officer shall make a reasonable effort to notify the intoxicated person's family as soon as possible. Any additional costs incurred by the city, county, ambulance service, or medical service provider on account of an intoxicated person shall be recoverable from that person.

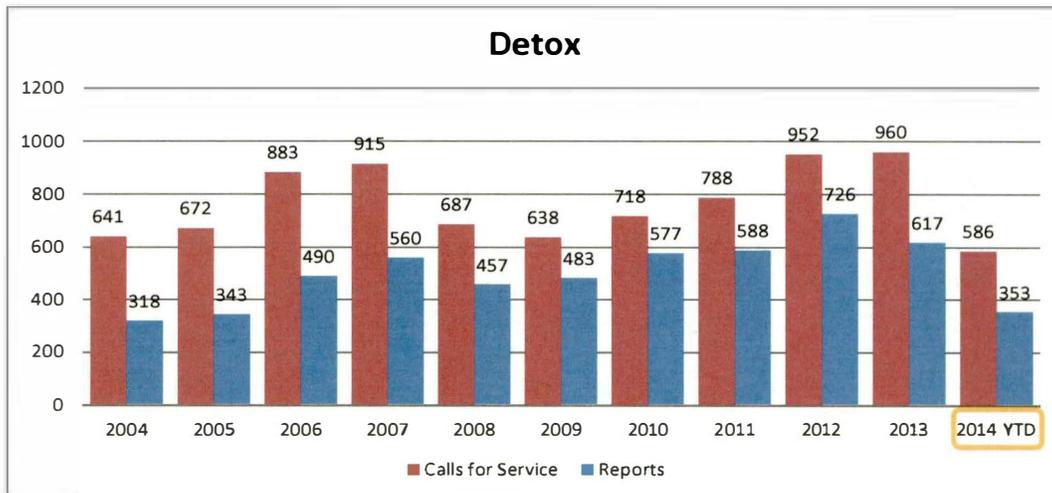
5-01-05.2. No prosecution for intoxication.

No person may be prosecuted in any court solely for public intoxication. Law enforcement officers may utilize standard identification procedures on all persons given assistance because of apparent intoxication.

With the limited number of social/medical detox providers in the region (and the entire state), other systems/providers (jails and hospitals) are often left responsible but are not licensed or trained to provide the level of care required.

LAW ENFORCEMENT

Below is data from the Bismarck Police Department (Detox related calls and reports for years 2004 through July 2014). The "Calls for Services" are the actual calls/encounters with people with a detox issue. The "Reports" number accounts for individuals that had to go to jail, or at least the vast majority for sure, due to the officer being unable to locate anyone to take care of them.



2.6

LEGISLATIVE

The recent legislative interim committee Study of Behavioral Health Needs of Youth and Adults has provided some information and guidance for next steps regarding the lack of services in this area.

*"The number one concern across the state can be summed up in one phrase: "Not enough services." The statement includes services at all levels from preventative services, case management, substance abuse services including residential, **DETOX**, psychiatric services, lack of stat children's residential services, etc."*

A strategy that is suggested is to "Increase substance abuse services including detox."

- Excerpts from "Behavioral Health Planning Draft Final Report" 6/19/14. Schulte Consulting"

A Goal developed by the Behavioral Health Stakeholders Group project is: "Substance Abuse Goal 1.2: Expand Medical and Social detoxification resources" with the action steps being, (1) Assess current services and develop a plan to assure services in all regions. Support local efforts to build comprehensive detox structure; (2) Expand the behavioral health training model first responders used in Cass County to the whole state and integrate into Post Training standards.

- Excerpts from "Building Stronger Behavioral Health Services in North Dakota: Framing Key Issues and Answers" 7/18/14. Behavioral Health Stakeholders Group

INFORMATION IDENTIFIED IN REGION 7

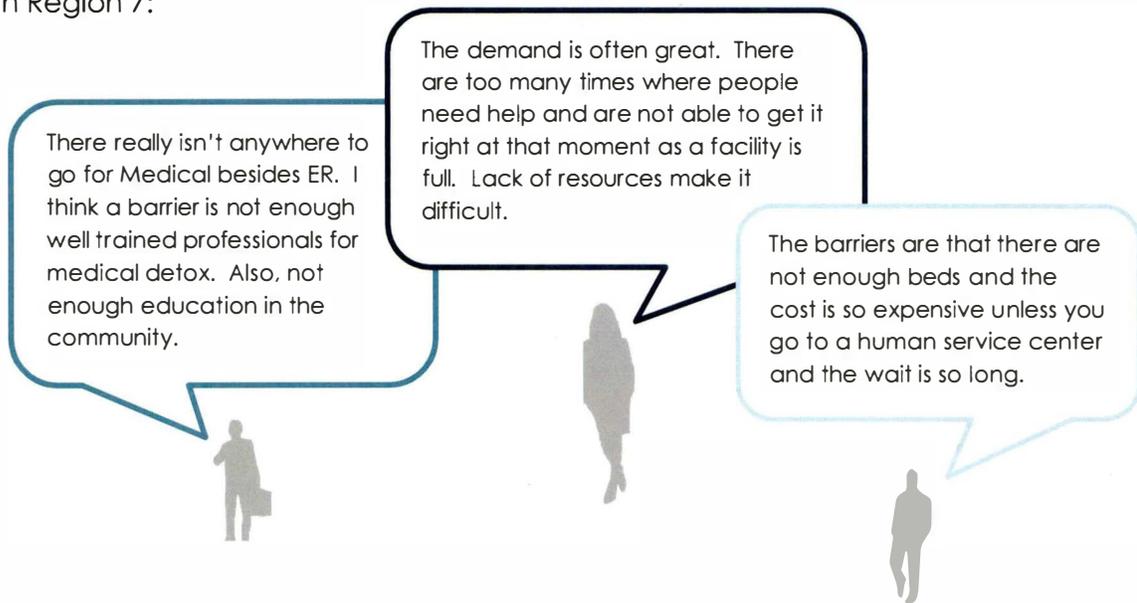
Behavioral health provider feedback regarding whether or not there is **sufficient access** to social and/or medical detox in Region 7:

Absolutely not! We definitely need a social detox in Region 7.

No, it is difficult for patients to come into a facility regarding insurance coverage. Not that many facilities in the area.

No. When I moved here I was really surprised there is no medical detox. I previously worked at a facility out-of-state that had excellent medical detox. I really would like to see Bismarck have a medical detox center; it is much needed in this area.

Behavioral health provider feedback regarding **barriers** to accessing social and/or medical detox in Region 7:



Youth-specific concerns from behavioral health providers:



The current capacity in the region (and entire state) is limited in terms of the number of facilities/providers. Another identified concern is the knowledge and skill of providers.

Unmet needs regarding **social detox** (Region 7 Behavioral Health Provider feedback):



Unmet needs regarding medical detox (Region 7 Behavioral Health Provider feedback):

Hospitals in the area are busy themselves and often do not have the space for a detox bed. Many health care providers are not interested in caring for a detox patient as they don't understand addiction.

There is no specific medical detox. Our patients are treated usually fairly poorly at ERs.

Individuals go to the ER for medical detox and often times are released back into the community. I was really surprised psychiatric units don't support medical detox either. This issue needs to be addressed.

We have many people who are in need of a safe place to do medical detox.



The capacity of these services is currently limited, however, the ever increasing need for a changing state landscape (ex - population and narcotic usage) only draws attention to this gap in the state's substance use disorder system.

The current system also does little to address the "revolving door" - where there are repeat admissions and limited engagement strategies. When looking to solutions this should be considered.

2.9

NORTH DAKOTA WITHDRAWAL MANAGEMENT LOGIC MODEL

PROBLEM	WHY?	STRATEGES	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Police Responsibility (Public intoxication law)	Public Intoxication law issues	Revise public intoxication law with current language.		
Limited capacity for social detox (facilities and skills)	Lack of service providers	Public intoxication becomes a misdemeanor		
Facilities (Jail) not licensed for "detox" but left responsible	Limited skills in managing withdrawal and intoxication.	Training and technical assistance needed to develop and enhance skills regarding wm & im.		
Limited or no capacity for medical detox (no facilities, risky placements, oversight?, finding?)	Jail only option but not qualified or licensed.	Increase capacity for medical detox (wm)	Capacity <ul style="list-style-type: none"> • increased skills • increased facilities (social & medical) 	Decreased community problems
Increased needs (population & narcotics)	Hospitals not providing medical detox (limited)	Increase capacity for social detox (wm)	Increased Coordination	Decreased law enforcement involvement
"Revolving door" (limited engagement, repeat admissions)	Fort Yates transfers to hospital – then out to Bismarck PD.	Identify process for intoxication management	Increased Engagement	Better care for consumers across the continuum of care
	Lack of collaboration among parties/providers	Update Administrative Rule with current ASAM (wm & im)		Improved wellness for consumers
		Identify oversight agency for medical detox (im)		Decrease in "revolving door"
		Ensure engagement strategies in social and medical detox settings.		

2.10

STRATEGIES

Behavioral health provider feedback regarding **what can be done to improve** social and medical detox needs in Region 7:

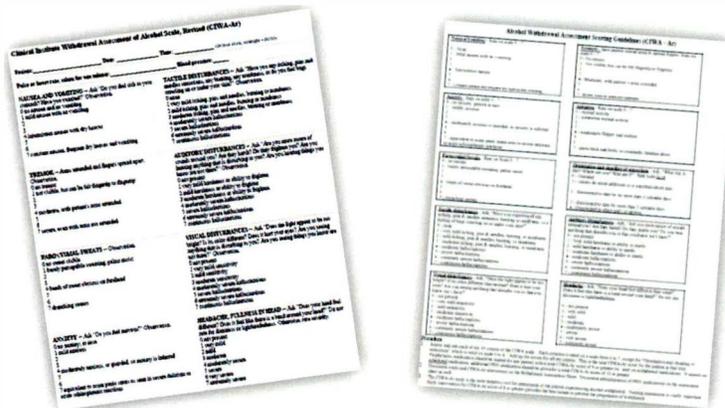


Training

- Training and technical assistance may be needed to develop and enhance skills regarding withdrawal and intoxication management.
- Increase capacity for medical and social detox for withdrawal management with many audiences.

Universal use of screening/assessment tools (CIWA-AR)

- Required in North Dakota Administrative Code relating to Substance Abuse Treatment licensing.



Funding

- Identify available funding to support withdrawal management needs in the community

Reimbursement

- Increase insurance coverage for withdrawal and intoxication management services.

Policy

- Revise public intoxication law with current language
- Update Administrative Rule with current ASAM for withdrawal and intoxication management
- New (sub-acute) level of care

Oversight

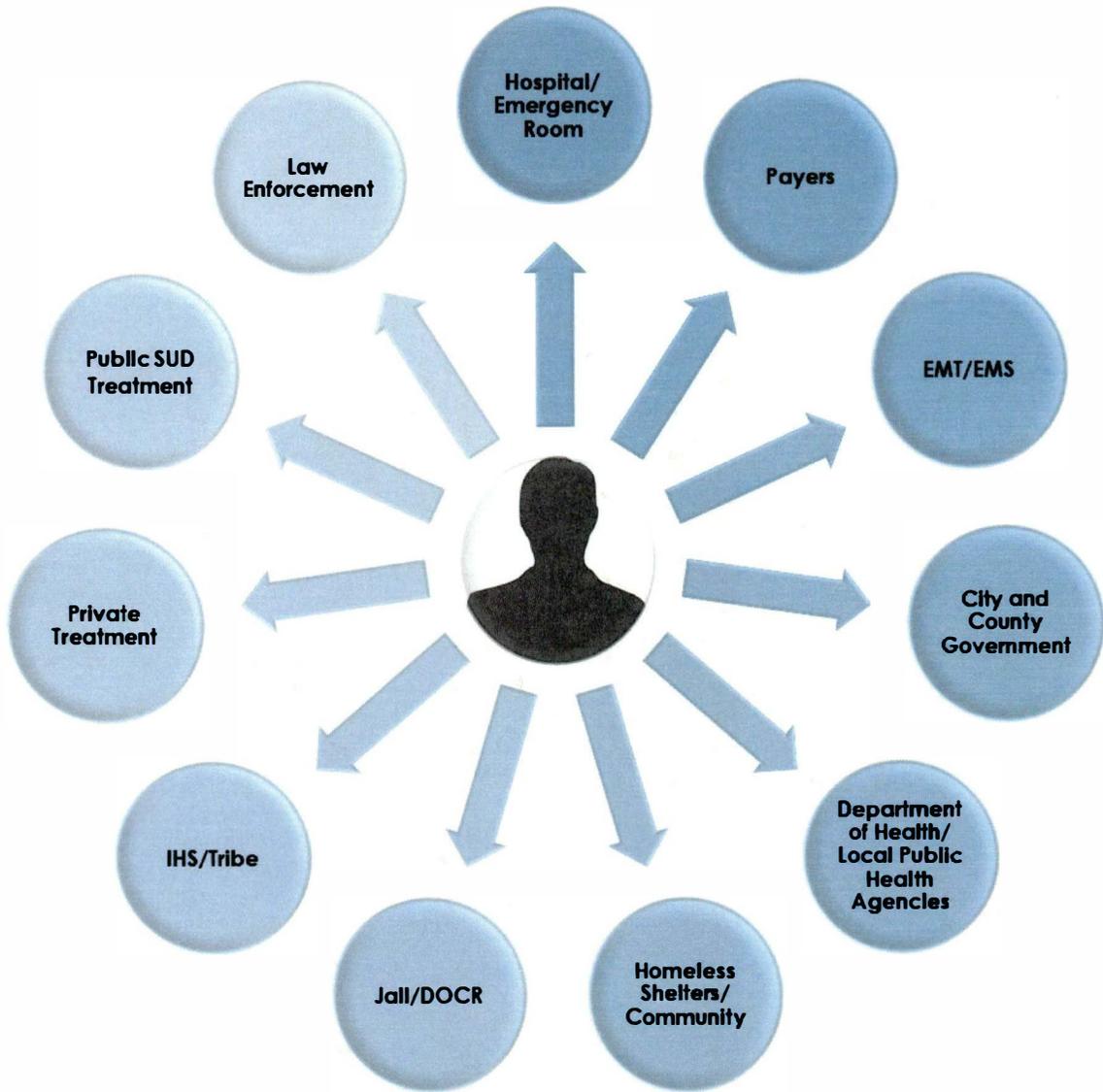
- Identify oversight agency for medical detox
- Identify process for intoxication management

Engagement

- Ensure engagement strategies in social and medical detox settings to decrease "revolving door".

2.12

KEY PARTNERS



February 18, 2015

1
2046
2-18-15

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2046

Page 1, line 2, remove "; to"

Page 1, line 3, remove "provide for reports to the legislative management"

Page 1, line 3, replace "appropriations" with "an appropriation"

Page 1, remove lines 12 through 23

Page 2, remove lines 8 through 12

Re-number accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment removes sections 2 and 4 of the engrossed bill which would have provided a \$3 million general fund appropriation to the Department of Human Services for substance abuse treatment services and a \$25,000 general fund appropriation to the Highway Patrol for mental health first-aid training for state and local law enforcement personnel.

**Testimony of Kristen E. Benson, Ph.D. before the House Human Services Committee
Monday, March 9, 2015**

Hello Chairperson Weisz and members of the House Human Services Committee. I am here today as a member of the North Dakota Division of the American Association for Licensed Marriage and Family Therapy, and to provide testimony in support of Senate Bill 2046 which will classify Licensed Marriage and Family Therapists (LMFT) as advanced mental health professionals who are able to provide diagnosis, evaluation, and treatment services covered by Medical Assistance. I have held an LMFT in 2 states since 2007, and am designated as a Clinical Fellow and an Approved Supervisor by the American Association for Marriage and Family Therapy (AAMFT). I would like to address Marriage and Family Therapy (MFT) scope of practice, training standards and preparation, and current federal coverage.

The current North Dakota Century Code (43-53-01) ascertains that licensed Marriage and Family Therapists are qualified to diagnose, assess, and treat all mental health disorders by stating, "*Marriage and family therapy means the **diagnosis and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Marriage and family therapy involves the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.***" The current ND Administrative Rules (111 2.a) specify that in order to qualify for state licensure, MFTs must demonstrate that they have completed course work specifically related to diagnosis and assessment of mental health disorders which includes, "*psychopathology including the diagnosis of mental illness, and behavior pathology*". Competence to diagnose, assess, and treat all mental health disorders is regulated by the North Dakota Board of Marriage and Family Therapy as outlined in the ND Century Code. Finally, MFTs are licensed in all 50 states and the District of Columbia.

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), which is recognized by the Department of Education as the national accrediting agency for clinical training programs in marriage and family therapy, maintains rigorous standards for marriage and family therapy training. Clinical knowledge content "*will address, from a relational/systemic perspective, psychopharmacology, physical health and illness, traditional psychodiagnostic categories, and the assessment, diagnosis and treatment of major mental health issues.*" Further, MFT students complete a total of 500 face-to-face hours of direct therapy with individuals, couples, and families. Of these 500 hours, at least 250 hours must be with couples and families, which is unique to Marriage and Family Therapy as it is the only discipline that requires clinical hours with couples and families. Students typically graduate with at least 250 direct therapy hours with individuals, which is often times more clinical experience with individuals than graduates of programs from other mental health disciplines. Marriage and family therapy training programs are unique in that students are only allowed to count actual time in the therapy room with clients. Additionally, for every 5 hours of therapy students provide, students must receive a minimum of 1 hour of supervision with an AAMFT approved supervisor. Supervision includes both case report and observation of live clinical work by way of video recording, audio recording, and from behind a one way mirror. Much of this direct experience includes students working with supervisors who hold an LMFT, such as myself, to assess, diagnose, and treat clients with a range of emotional health concerns. Therefore, students are required to take coursework that includes a

thorough review of the *Diagnostic and Statistical Manual*, as well as gain direct experience. For example, I meet with students each week to discuss cases, which include evaluating the student's *DSM* diagnosis of clients they are seeing in our community training clinic where they provide therapy.

The qualifications of LMFTs are apparent in the profession's authorization as one of the five core providers of mental health services recognized by the federal Health Resource Administration (HRSA). The federal government recognizes Marriage and Family Therapists as providers through the Department of Defense, the Department of Education School Early Intervention Services, Indian Health Services, the National Health Service Corps (NHSC), the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT), the Department of Transportation Substance Abuse Program, and the Department of Veterans Affairs. Furthermore, current ND laws for LMFT's, the training requirements, and the federal recognition of LMFT's by several government agencies highlight the rigor of the profession to provide competent mental health treatment.

The North Dakota Behavioral Health Planning Final Report (Schulte Consulting, July 2014) clearly states that North Dakota is in a state of mental health crisis. The passage of SB 2046 will allow upwards of 50 credentialed providers throughout the state to help meet this dire need. Currently, 38 states already approve LMFT's to be reimbursed for medical assistance, including Minnesota. This means that I am able to be reimbursed for clients who live in Moorhead and receive MN MA, but not clients who live in ND. While I hold masters and Ph.D. degrees, have completed a medical family therapy internship at Wake Forest Medical School that emphasized diagnosis, have worked in public mental health conducting emergency suicide and substance use detox assessments in Virginia, and have extensive background assessing, diagnosing, developing treatment plans, and providing treatment in 4 states, I am currently not eligible to be reimbursed for MA under ND law. In fact, a masters prepared social worker who has potentially less training than I, is currently reimbursable while I am not.

LMFTs are already licensed and working in North Dakota. Expanding Medical Assistance Coverage to include LMFT's will help to meet the dire behavioral health needs of North Dakota. I urge you to please support the passage of SB 2046.

Thank you for your time, I'd be happy to answer any questions you may have.

2

February 25, 2015

SB2046
March 9, 2015

#2
Handed
in

To Whom It May Concern,

I, Jennifer Eberle, am writing on behalf of the North Dakota Mental Health Counselors Association. We encourage the legislative committee to support SB 2046 and include Licensed Marriage and Family Therapists as mental health professionals and that they shall be able to bill medical assistance. Licensed Marriage and Family therapist are master's level therapists that have training which makes them competent as mental health professionals.

The recipients of medical assistance would benefit from this change in the century code, particularly due to the nature of rural North Dakota and often there is only one mental health provider in these small town. By LMFT's being able to bill medical assistance, they would be able to serve their communities and help keep their communities healthy and functioning. This will also help prevent crisis calls, hospitalizations, and other means of crisis management that is too often a direct result of a lack of mental health services. When we have healthy communities, we have healthy economic growth.

In closing, we work in a field that has some major gaps between the number of services needed and the amount of professionals available. This bill can help bridge that gap and bring providers to those communities that desperately need them. Therefore, I highly encourage anyone who is looking to improve the lives within the communities of the people they serve, that they support SB 2046.

Best Regards,

Jennifer Eberle

Jennifer Eberle, LPC, NCC

Private Practice Owner/Mental Health Counselor/ NDMHCA President

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701-367-8293
jeberle@creativetherapynd.com

February 24, 2015

SB 2046
MARCH 9, 2015

#3

Handed in

Dear Representatives:

We are writing to ask you to vote in support of SB 2046, which will expand Medical Assistance Coverage to include licensed marriage and family therapists (LMFTs). The North Dakota Behavioral Health Planning Final Report (Schulte Consulting, July 2014) states that "The North Dakota mental health and substance abuse system is in crisis." The passage of SB 2046 will address the shortage of services outlined in the Schulte Report by improving access to services by offering more qualified behavioral health providers throughout North Dakota.

We are writing to you as designated Approved Supervisors and Clinical Fellows by the American Association for Marriage and Family Therapy (AAMFT) and faculty in the North Dakota State University Couple and Family Therapy program. We would like to address Marriage and Family Therapists (MFTs) scope of practice, training standards and preparation, and current federal coverage.

The North Dakota Century Code (43-53-01) establishes that licensed Marriage and Family Therapists are qualified to diagnosis, assess, and treat all mental health disorders as well as provide therapy to individuals, couples, and families. Additionally, the current ND Administrative Rules (111 2.a) specify that in order to qualify for licensure, MFTs must demonstrate that they have completed course work specifically related to diagnosis and assessment of mental health disorders. It seems important to highlight that a mechanism for ensuring this competence is already included in the ND Century Code and is regulated by the North Dakota Board of Marriage and Family Therapy.

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), which is recognized by the Department of Education as the national accrediting agency for clinical training programs in marriage and family therapy, maintains rigorous standards training, which includes coursework and clinical experience that covers mental health diagnosis and assessment, theories, clinical skills, ethics, and research. These standards ensure that LMFTs are able to perform the same clinical tasks as all other mental health clinicians would be expected to do, for example, provide mental health assessment and suicide assessment. As a profession, LMFTs value comprehensive training that prepares practitioners to work effectively with clients who face a wide range of concerns, from mental health diagnosis such as depression and anxiety to parent-child dynamics. Further, MFTs are licensed in all 50 states and the District of Columbia.

At the federal level, LMFTs are currently authorized as one of the five core providers of mental health services as recognized by the Health Resource Administration (HRSA). The federal government recognizes Marriage and Family Therapy in nine primary provider capacities; through the Department of Veterans Affairs, the Department of Defense, the Department of Education School Early Intervention Services, the National Health Service Corps (NHSC), the Department of Transportation Substance Abuse Program, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT), and Indian Health Services. The recognition of LMFTs by these notable federal agencies reflects the competence of the profession to diagnose and treat a range of conditions for individuals, couples, and families.

LMFTs are already licensed and working in the state and expanding Medical Assistance Coverage to include LMFT's will help to meet the behavioral health needs of North Dakota. Please support the passage of SB 2016.

Sincerely,



Kristen E. Benson, Ph.D., LMFT



Tom Stone Carlson, Ph.D., LMFT



Christi R. McGeorge, Ph.D., LMFT

February 25, 2015



#4
Handed in

SB 2046
MARCH 9, 2015

Representative Robin Weisz
Chair, House Human Services Committee
ND State Legislature

Dear Chairman Weisz and Committee Members:

I am writing this letter as an employer in the human services field with over 200 employees in the state of North Dakota.

We are in full support of Senate Bill 2046, allowing Licensed Marriage and Family Therapists reimbursement for services provided under Medical Assistance coverage. This would be a significant step forward for behavioral health services in North Dakota.

Our service area covers a large section of the Upper Midwest. As such, we have the opportunity to employ Licensed Marriage and Therapists both in North Dakota and other states. On the macro, we have found the level of education, training, and professional efficacy to be as high, or in some cases higher, than every other masters prepared and licensed behavioral health profession, including social workers and professional counselors. Those North Dakotans who need behavioral health services, and have Medical Assistance as a payer source should have access to these professionals.

In addition, North Dakota State University has for many years had a masters program in Marriage and Family Therapy. It has been a real disservice that North Dakotans who are educated at a North Dakota state institution and are licensed by the state of North Dakota must leave the state to receive equity in reimbursement as a behavioral healthcare professional.

Senate Bill 2046 would address workforce issues in the area of behavioral health and we fully support its passage.

Sincerely,

Joy Ryan
Executive Vice President

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#5

Handed
an

SB 2046
March 9, 2015

February 24, 2015

Dear Chairman Weisz and members of the House Human Services Committee,

Over the past 7 years I have worked alongside many Licensed Marriage and Family Therapists (LMFT) in our Fargo community. During this time, I have seen LMFT's provide high quality, therapeutic services to individuals, children, families and couples. I believe their educational training and licensure requirements ensure LMFT's are strong clinicians with competencies in completing diagnostic assessments and ongoing therapy services to both individuals and families. In my work, I see a high demand for competent, well-trained, therapists to meet a growing unmet need of young children and their families to receive therapy services to promote their overall well-being. There are many well-trained, passionate, LMFT's that are highly qualified to respond to this need. Currently, children, families and individuals are suffering delayed services due to long wait-times to get an appointment because of a shortage of clinicians who are able to accept their health insurance. This delay results in intensified mental health symptoms and contributes to a lower quality of life. By increasing coverage of highly trained providers, which I believe LMFT's are, our communities will benefit greatly and the overall health of our state will improve.

Thank you for your time.

A handwritten signature in black ink that reads "Joni Medenwald, LICSW".

Joni Medenwald, MSW, LICSW
Clinical Supervisor
The Village Family Service Center

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