17.0887.02000

FISCAL NOTE
Requested by Legislative Council
01/16/2017

Bill/Resolution No.: SB 2274

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.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$7,500,000	$6,809,900		
Appropriations			$7,500,000	$6,809,900		

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

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 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).*

Requires the DOCR in collaboration with DHS to develop and implement a community behavioral health program.

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 2 provides the DOCR with $7 million dollars of general funds and 1 FTE to develop and implement a community behavioral health program. The $7 million, net of the cost of the 1 FTE, will be paid to DHS to deliver the community behavioral health program.
Sections 3 provides the DHS with an appropriation of up to $7 million of other funds and 6 FTE to implement the community behavioral health program. For the purposes of this fiscal note the estimated appropriation amount to the DHS is the $6,809,900, which is the estimated amount provided by DOCR to DHS.
Section 4 provides $500,000 of general funds to DHS for the purpose of contracting with an entity to create and initiate and facilitate the implementation of a strategic plan to increase the availability of behavioral health services in all regions of the State.

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.*

n/a

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.*

DOCR general fund expenditures consists of the estimated cost of 1 FTE $190,100 (salary and benefits - $183,100; and operating $7,000) and funds provided to DHS to implement the community behavioral health program - $6,809,900.

DOCR - Adult Services - $7,000,000 - 100% General Funds

DHS estimated expenditures consists of the estimate cost of 6 FTE $932,695 (salary and benefits- $860,275; and operating $72,420) and funds to deliver a community behavioral health program - $6,067,305 - 100% other funds

DHS estimated expenditures also include $500,000 of general funds for developing and implementing a strategic plan to increase the availability of community based behavioral health services.

DHS - Salary and Benefits - $860,275 - 100% Other Funds
Operating - $6,449,625 - ($5,949,625 other funds; $500,000 general 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.*

DOCR - Adult Services - $7,000,000 - 100% General Funds

DHS - Salary and Benefits - $860,275 - 100% Other Funds
Operating - $6,449,625 - ($5,949,625 - other funds, $500,000 - General Funds)

NOTE: Source of DHS other funds is the DOCR general fund appropriation.

The appropriation amounts are not included in the 2017-19 Revised Executive Recommendation

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Date Prepared: 01/23/2017

2017 SENATE HUMAN SERVICES

SB 2274

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2274
1/25/2017
Job Number 27377

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Marne Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to a community behavioral health plan as a term for parole or an alternative to incarceration; to provide for a legislative management study; and to provide an appropriation.

Minutes:

10 Attachments

Chair J. Lee: Brought the meeting to order, all members were present.

Chair J. Lee: Introduced the bill (1:01-3:20)

Rep. Hogan: District 21, Test in support, no written test. Important to be aware of this piece, of this proposal regarding the behavioral health needs. On the continuum of care, we talked about originally, it is a very targeted piece, substance abuse and mental health in the correction system. But I am strongly supporting this bill as part of the whole package because it targets a specific high need population. I am supporting it also because I believe that the model that has been proposed and developed over the months, address the needs that will be served in the correctional facility but also to build a stronger behavioral health system. Many of the concepts in this proposal help up to build the infrastructure, secondary benefits. Lots of potential secondary benefits for the behavioral health system. I am strongly supporting this bill, and I this it has an opportunity within the whole context of behavioral health needs to help all of us.

Senator Anderson: Talk about why you've charge the Department of Corrections with establishing a community mental health program. That seems a little bit outside of their ordinary bailiwick. So can you explain that a little bit?

Rep. Hogan: Council of State governments will address that targeting clients served in correction system. Strong vested interest in the success of the behavioral health in reducing their costs, work with individuals who are either in diversion or in coming out of prison. in some ways they may have the stick to make it work. We're trying to build a strong enough partnership without both systems and we have a list of systems of who should be the leader. I think in the end we're trying to build a strong enough partnership so that both parties are equally vested. I think that's why my view of why it is structured the way it is.

Chair J. Lee: Please look at your FN, $7.5 million in General Funds, and it is in Appropriation. Section B, the bill provides Department of Corrections and Rehabilitation with $7 million dollars in general funds, but the money is paid to DHS to develop the community behavioral health plan. So it's not a passing of the buck, it is a partnership. Directed at those who are incarcerated but the plan will be developed through the Division of Behavioral Health in the Department of Human Services.

Rep. Hogan: It was a very complicated bill to draft. As you hear the vision and model you will understand the way it was drafted. It was one of the most complicated bills I've worked on.

Chair J. Lee: We'll hear from CSG, who will follow us through the budget.

Senator Piepkorn: The study will include a receipt of reports on the status, effectiveness, and sustainability of community behavioral health program for individual. If it starts in July and then its only 2 years, you hope to get from a study. Are we just setting it up in that time? It isn't a very long time for a study to study the effectiveness of a program like that.

Rep. Hogan: I think accountability in this kind of model is critical. I want data in the 1st month or 2, so we know which clients were serving, whatever services provided and I think both the Department of Corrections and the Behavioral Health program are really committed to things like evidence based practice and clear accountability and I think we will have data within 6 months.

Senator Piepkorn: Effectiveness, this individual got out and used it within a month, or a year and a half anyway, you will have some results.

Rep Hogan: Defer to CSG, demonstrated other states that they have those measures and those measures are very specific because we need to prove that this works and I think we know how to do that.

Senator Clemens: Where is the treatment going to take place? I mean if it's going to be in the facilities that are currently, how is that working there?

Rep Hogan: Council of State Government will talk about the model, about the service model.

Chair J. Lee: Currently definitely programs available, within the penitentiary. When they walk out the door, we don't have community support systems in place to enable them to be successful when they come out. That's part of what we're talking about here.

Steve Allen, Senior Policy Advisor (11:35-23:05) provided test in favor please see attachments #1-3 What: innovative model? Why: curve going upwards, with accompanying costs, growing state, critical to bend curve, requires investment, worth it? How: savings through changes, rented beds, state can save bed days, shorten offset savings? Referenced attach #2, talk about the model. It is an increase access to services.

Senator Piepkorn: What happens to non-residents of the state when they are released?

Steve Allen: Typically return agreements, criteria for involvement is a shared assessment by DHS and DOCR to determine which people rule out or in.

Senator Piepkorn: What's the criteria for determining where they'll live once their released? Are they sprinkled evenly geographically throughout the state, their original residence, what's considered there?

Steve Allen: Who determines their acceptable home plan. That is determined through the Department of Corrections. They review the home plan and approve and in coordination with local probation or parole.

Senator Anderson: Talk to us about paraprofessional, on list. Heard about regulatory boards, we like to be sure licensed by us, highest training etc. How do you see the paraprofessionals what their role is, who trains them, who supervises them, how do we get them to work in the environment?

Steve Allen: We're talking 2 different types of para positions, assistance sustained recovery themselves. Not a substitute for treatment, augments treatment and helps inform treatment part of a team, guide people in early recovery based on experience. Peer support invaluable how to best engage folks with mental illness, valuable form both perspective. 31 states Medicaid Reimbursement, its considered an evidence based practice. Case management services glue that holds team together. People looking at serious abuse or mental illness may also have physical health issues, along obligations to meet parole, each person on team has perspective, help team work smoothly.

Carlotta McCleary (28:20-35:25) test in favor, provided test please see attachment #4-6. Attach #5 (29:30-33:05)

Senator Kreun: Pg 3 attach #5, 41% female, what is the percentage of males?

Carlotta McCleary: I don't have that data but we can get it for you.

Senator Kreun: Full and functional care waiting time 1-2 months, is that any different than private sectors?

Carlotta McCleary: I believe this is about wanting to receive any mental health, not specific to the correctional system, and I would have to go back and look at the survey to see whether or not it's specifies whether or not it was private services or access to mental health services.

Chair J. Lee: We don't have a database for private sectors, this would be individually with service centers. I would be interested in this date on that actually, because there's been a great deal of effort to make sure things are available sooner; there's a walk in mental health clinic in Cass county, plan move through the state. Workforce is part of our challenge.

Carlotta McCleary: This survey was this fall, very recent.

Chair J. Lee: If they had an initial appointment, took that time to see anybody, is that the same from region to region, is it for the initial appointment or is for a follow-up that would be

the actual counseling. That would be something that we in the department would be working to try and pull that together a bit better too.

Carlotta McCleary: This is preliminary data, we'll try and gather more of that data for you.

Senator Piepkorn: "ND has all the resources and experience' are they identifying brick and mortar/ what are the resources, we have the people, we have the money, the gumption, the determination, what are those resources that Sheltie was talking about that we have?

Carlotta McCleary: I believe it was all of the resources that we have.

Chair J. Lee: At the time, strong economy, so the fiscal impact situation was a bit different also. But she also meant that there is interest and willingness to move forward here, but, that we have some challenges to meet as well, what came out of that was the workforce big part of needs lie.

Senator Clemens: Regarding lawsuit mentioned, if ND doesn't provide the plan and facilities to address this issue, there could be litigation, forcing state to cut other programs to take care of it? Is that something that could happen?

Carlotta McCleary: All options are on the table. I don't think anybody has specific things saying that were going to do this, this or this. But we are looking at all options at this point.

Senator Clemens: So that is a possibility then that other agencies.

Chair J. Lee: It is very much a possibility, because we have this lawsuit unintended consequences, moving rapidly. We have moved on from that, but the federal law does require parity in metal health which we prefer to say behavioral health because it covers more than just mental illness. Yes, that possibility is there, every right to sue, waste of state resources.

Senator Clemens: It is troubling to see things like that because we're not providing enough care to one group, and another group has to suffer. I think there is a need, sued because you're not doing enough. I just have a problem with that part of it.

Chair J. Lee: This wouldn't be just a suit regarding the corrections portion of this. That would be the whole continuance of services that are available and so, we spend time looking at things. Board changes, part of the effort. Lawsuit isn't top of the option list. I'm hoping we're able to rationally approach.

Pamela Mack, Advocacy Director with the ND Protection & Advocacy Project. Provided attachments #7, #8. (44:55-46:45) talk about model, this project deinstitutionalization of people with developmental disabilities, from what is now called the Life Skills and Transition Center. We had of number of people that as they were leaving the institution were exhibiting behavioral issues that became criminalized. Pulling interdisciplinary teams to address keeping people out of the criminal justice system. In 2004, P&A pulled together stakeholders, brain injury etc. We wanted to make sure the committee is aware of this process, because I think it is something that we have worked over the last decade to really make sure it becomes

part of the service delivery system. I think it will only expand options if this legislation were to move forward. Passed copy around.

Chair J. Lee: Asked for written test and highlights from manual.

Senator Heckaman: Were you part of the interim group that worked on this too?

Pamela Mack: Yes, lead P&A staff member since 2004 in processes testified to the alternatives to incarcerations committee hearings, so that both corrections and human services are well aware of process, and we have partnered with both reentry planning and also diversion and prevention models also.

Rebecca Quinn UND Center (48:20-53:05) Touch base IJP it's a great program well developed utilized very well. However, in my experience one of the things I run into with the IJP process is exactly what we're talking about today. The plan developed to do reentry post incarceration or diversion plan has to involve services. Individual needs support systems part of plan, gaps, yes this individual needs this support, in order to maintain in the community. But that doesn't exist. Hard finding those services, disheartening to have it be unsuccessful because of the lack of services. We worked with a man for 6 months as part of the Department of Human Services, Protection Advocacy was involved, we worked for 6 months to create incarceration diversion plan and when it came down to it, a piece of it was that he needed substance abuse treatment that he couldn't get access to. The judge determined the no he didn't want to accept the plan if he couldn't have this level of treatment in community. Well that level of treatment in community didn't exist. So it was one of those things, and that gentleman had been in community for 6 months and he ended up getting sentenced to 6 months in jail, and he said if I gone to jail today, I would be out by now. I shouldn't have listened to you people, you lied to me, and you cost me 6 months of my life thinking that. He acted like he had the rug pulled out from under him. IJP wonderful process, needs community support network behind it. Center Rural Health community health needs assessments send survey rural hospital, last survey behavioral health #1 need. Only need majority hospitals want. Lack of behavioral health services has been a deterrent on attracting, traditional health services, difficulty recruit physicians lack of behavioral health services was a deterrent for physicians that go to a rural community because the physicians felt that there would not be that full interdisciplinary support for them and they would be not only the full medical provider but also take on behavioral health services as well.

V-Chair Larsen: Was there a statistical breakdown about the Human Services as compared to the schools or the churches or the things like gyms and wellness for these physicians coming into the communities? Or did they just say that's one of the deal.

Rebecca Quinn: The survey is to rural hospitals, there wasn't breakdown for other avenues other than the hospital breakdown.

Chair J. Lee: Lack of behavioral health services was a higher level of concern for people who might be recruited rather than schools for children, recreational facilities, etc.

Rebecca Quinn: There was a breakdown on that, this as an issue was a high that was high to researchers. The researchers hadn't thought about that as an issue impacting recruiting, and they had thought things like schools, employment for spouses.

Senator Kreun: We did research rural health. How does this fit with the private sector match? Have we done the research so that we can match up our resources for general public coinciding for both? Are we going to solve one problem with this, the incarceration portion, and still not help our general public as well? Are we doing that or not?

Pamela Mack: I do think right now those 2 systems are pretty separate. I feel that this legislation and the work of the interim committee has been developing a system that will pull those more together to work on developing that private sector behavioral health workforce system that can fill in that gap and being more available. This way now we are just dealing with that incarceration population, but it is working on the steps and inroads in developing more of that infrastructure that bridges that gap and makes it less of a private versus public and more of a behavioral health system that individuals can access no matter what their system is. So I feel this is a positive step in that direction resulting in that infrastructure.

Chair J. Lee: 2038 talks about developing additional private providers in the network. We heard testimony this morning, this network benefits everybody, the answer to your question is yes. This will expand to have a larger network of private providers and at some point, we also have heard our goal is to enhance the whole system, but the niche we're looking at right now is this because this is a high need group.

Senator Kreun: I agree with comments, if we don't have the ability, if people works out of the system, system goes round in a circle.

Chair J. Lee: They're already in it. We want someone to be a provider in a provider network that will be probably be a private provider who.

Senator Kreun: We're coming up with the same problem especially looking at the 53% waiting two or more months, in the public sector you're waiting that long or longer already and were going to be fix this problem in the incarceration area, I don't think so, because we aren't going to have the people to do it just as you indicated before. You got this gap, we better make sure we've got the people in place. It has to work in general public or you're going wind up in the same situation over there. So we have to take a look at it all, that's my point.

Chair J. Lee: It's a bigger system than just being corrections issue.

Senator Piepkorn: The department will be authorized through this bill to authorize 6 full time equivalent positions to implement the community behavior health program. So that is not counselors necessarily.

Senator Kreun: I didn't take that as counselors and or psychology, I was referring to the implementation portion.

Chair J. Lee: We'll hear more from other speakers.

Rebecca Quinn: To just comment on that, yes the workforce is an issue in our state. We know that it is identified. But one of the things that has be a big effort within looking at health workforce across the state, is how to incorporate behavioral health workforce into that broader picture to where as far addressing that parity, no longer is it traditional health care, but more general. I think that one of areas regarding workforce and that's where we've have made big steps, but I do think that this effort will identify the implementation but also this effort of putting funding there is as the initial steps in building that infrastructure. It comes to me a little bit to me like the chicken and the egg. Where we spend a lot of time saying we can't monitor the workforce, well we're not going to have the workforce, if we build it they will come or do they come and we build it. At some point move forward with plan that a piece of implementing this is moving forward with the steps that had been identified as ways to build workforce.

Chair J. Lee: One starfish at a time.

Kurt Snyder, Heartview Foundation No written test, will email. (1:02:20-1:08:52) in favor. Wait times private vs public depends on region private has less wait periods, smaller people insured, MA has allowed the private providers to help. We've been able to leverage more doors. The walk in clinic have made a signal change. Following through with needed services right kinds of behavioral health services, not just 28 days of treatment. It's a chronic illness long term support over a long period of time which these tiers bring into play.

Senator Anderson: I like your statement focus more on early use future addiction. Ramping up all the treatment facilities we need to ramp up preventions so that we don't have any business anymore. Get that problem solved prevent in 1st place.

Chair J. Lee: If we add all the beds that are currently either all under construction or proposed, in county jails and in penitentiary will increase bed capacity by 48%. We're not going to let everybody out. They need to have consequences, locking up for 6 years, that is not productive, if we can't provide support once she gets out.

Senator Clemens: What are your feelings about 14 years old are using drugs and 40% of them stays with them into their later years, is any thought been given getting to this before it's a problem, implementing some kind of screening in schools, reporting cases where the kid is abusing, it sounds harsh, we can't wait until the kid is on the drug.

Kurt Snyder: It speaks loudly to the work that the Division of Behavioral Health is doing around a continuum of care. We need focus and prevention, the key is alcohol #1 issue, we need that education; talk about the unborn child, we've seen generations come through the doors. Predetermined genes for addictive parents, part is environment. How can we create healthy communities? Support, so it doesn't fall to next generation. We could have this punishment attitude; I'd rather teach responsibility, encourage them to live a beneficial life. Addiction is like a big rock, ripples affect everybody. We pay billions of dollars, the same rock in the recovery sense, citizens of good character, they live among us we don't even know it.

Senator Clemens: These children come from these homes, do you support implementing these prevention programs in the schools much more than we are right now?

Chair J. Lee: Pam Sagness has great stuff. The funding is not available to promote that stuff. This afternoon, handouts the really good ones what show what the percentage of people live use in ND who use alcohol.

Kurt Snyder: 22 million Americans, 1 in 10 kids, live in a home where that happens, goes across the spectrum. Yes, you are right we need to do more, it can't be punishment in a way that diverts them. There is good research about what that should be.

Senator Heckaman: There are a number of programs in schools, if might be good to have DPI here. Teachers are mandatory reporters if they suspect drug abuse. Help you understand what's available and the money that's being spent already.

Senator Kreun: People incarcerated because of minor crimes visit with judges, why people incarcerate minor infraction. They're not, according to them. In home monitoring, everything to avoid that. In Grand Forks the 3 judges told me they're not doing that. We've got to be careful about lumping the problem. Have not been responsive to minor punitive damage that has taken place. We talk about schools, but until the parents change insert child's life, we're not going to change anything.

Chair J. Lee: You are assuming intact families (1:19:25) argument.

Senator Heckaman: The judges are sentencing after trying other things. There aren't support programs. We don't' have the systems they put them back in the Department of Correction System so that hopefully that will stop. Well the treatment program there are needing help too, so that's why this bill is here is because the judges don't have those treatment programs to send the individuals too.

Chair J. Lee: I don't doubt the statistics. This is what my problem is. Grand Forks is unique done a wonderful job, housing first, much more permanent kind of life style.

Kurt Snyder We've been working Watford City, around trying to implement a screening tool in their jail, and one of the things, the judges were no longer requiring evaluation. As they're building systems in place communication back to judges that's why it's not happing in giving up recycle through systems.

Dan Ulmer Youth works (1:23:05) I remember AARC lawsuit. The legislator's plans' for tomorrow, did not take care of needs of people today. Keep that in mind as your moving forward, I think you're making great strides, you're beginning to create foundation good faith effort, needs out there to take care of Senator Lee lead a charge on this. The problem is rights, money does not matter, that's what they are talking about. I hope that you are able to stave this one off. Tell your colleagues report comes back, and your system is in crisis, that's not good sign, only 10% needs are being taken care of, obligated to do something here. I wish you well in doing it, and I promise myself I wouldn't get up and testify session but I just couldn't resist it.

No Opposition test

Neutral

Travis Fink: Legal counsel (1:26:40) Sect #5 continuation of study on alternatives to incarceration whether that be an extension of the current Sunset Clause under the previous authorization, which was 54:35:24 or whether a new committee would be established simply for studying behavior health as the rights to criminal justice. We would respectfully as that is it's a continuation of the old study that that section be amended or if a new study or new commission is enacted, that the director of the department or the Commission on Legal Counsel for Indigents have a seat at the table. We are the agency that tasked with providing attorneys to those persons who are charged with crimes and determine to be indigent. We are the person's that work with these individuals before they get to the correction system. We are the person's that work with these individuals when there not successful in finding treatment on the outside. I think we provide a valuable resource. This is something we have been doing outside of any other invitations from the Legislative Management or the Legislative Assembly. So we would respectfully request a seat at the table and believe we would provide valuable resource to any committee that would be formed.

Chair J. Lee: Please send email with your written comments. This doesn't include specific people. It would be unusual for us to specify but we could always recommend and encourage, we don't list because we might miss someone. We'd need a new committee. But yes we need a new study resolution and a new legislative management committee assigned with the task, which Sen. Carlisle committee took care of in this interim.

Travis Fink: We did try to do that. Sometimes it's more beneficial to have a seat at the table and you're actually involved in all of the discussions that go on, versus, just the.

Chair J. Lee: You can't be on legislative management. You can be on a task force that was working, so let's work together to make sure that you have a chance to do that. Absolutely!

Darcy Handt: Executive Director North Dakota Cares Coalition (1:29:55-1:31:13) Military data book. Veteran's issues. 13% prison population identifies as military experience. One of those statistics in there highlighting the issues that the veterans here in ND have. This particular program I believe would provide them a great opportunity and give them personal courage to continue on with their care. So when they do leave the prison system they will feel comfortable carrying on with the VA system and access pros services. Long term it gets the families involved. Families are critical in the recovery part for veterans.

Chair J. Lee: Please email us a written statement.

Dr. Lisa Peterson, Clinical Director of North Dakota Corrections and Rehabilitation (1:32:20-1:37:00) provided written please see attachment #9. We advocate for community behavior health resources rather than the brick and mortar corrections said. Secondly I wanted to speak to the concern that this bill potentially would not have a great benefit to the average citizen. I was actually speaking with somebody not long ago, who was in prison, about 20 years old. He has perpetrated some pretty serious robberies, offenses in the past, and I was working with him in a therapy setting and he asked me, why are you helping me? I've done some terrible things, why are you helping me? I said well, I care about you, I care about your life going forward and I would like you to have a better life and not be in prison, but I also would like for you not to rob anybody in the future. He kind of went, Oh, ya I did, so could you help me you're going to help the people that I am not going to hurt. He

replied, that's cool! Yes, but that is really cool actually. Recidivism reduction piece is a key outcome of this program. So that impacts all of us as we have fewer people out there perpetrating crimes and potentially victimizing us or our loved ones. Along with that the same person just a couple of days ago, said to me, do you know what I realize, I need to get better so that I can be a better model for my nephew. So that my nephew doesn't grow up thinking that this lifestyle of selling drugs and coming to prison is normal. I replied absolutely right. So I just wanted to call attention to that, because each of these people that need help with the program like this is going to then positively impact those folks in their life. Back to script. (1:35:40)

Senator Anderson: Give us a vision of how and where that pilot might work?

Dr. Lisa Peterson: Start with a smaller group get a feel for our design, and actually seeing the outcomes that we want. Then if it is then we can replicate in other areas. To show this is working. This is going to save us money, then move forward with taking to a larger scale.

Senator Anderson: Licensed psychologist how do you envision the case management people interacting with other boards like yours? What role can they play, how do we train them?

Dr. Lisa Peterson: They would serve a unique role, not therapeutic, they wouldn't have necessarily the task of giving the person the actual intervention that they need to see changes. They would be the navigator that support person that could help link them up to actual service provider. That goes beyond what can occur in a 50minute therapy session or a two- hour group. So that gives them the ability to a point of contact. For housing, peers, liaison probation officer to help them solve problems that might come up in terms of their requirements of their probation.

Senator Anderson: Maybe Pam has an idea how to do the training of the case managers and giving them some identity and information that they need to make those connections and so forth, I guess, that's the next step. Of course we don't recognize them in some way it's difficult to give them the creditability to say are your board by other boards that this is the place that we can get a referral.

Dr. Lisa Peterson: Case managers in place for adults with serious mental illness but this would be an expanding and existing resource to the targeted population that also included that high risk criminality portion.

Senator Piepkorn: Out of 10, twenty year olds, who responded positive, now how many out of 10 will be successful next few years. What kind of improvements in your optimistic attitude do you think they could may out of 10 people that you visit, in a couple from now when this program is in place, how many might have a shot?

Dr. Lisa Peterson: I don't necessarily work in the odds or rely on data, we have recidivism as an outcome measure essentially, and that range is 30-35% after 3 years post release from prison. So, that's our current state, other outcome measurements, quality of life. My hope for a project like this is that we will be able to implement other outcome measurements beyond just our recidivism piece to look at quality of life for folks. A lot of times in my line of work I

tend to work with the most severe, with inter-populations so we look progress towards a goal in smaller indicators of success. Maybe they stay out of prison longer, maybe they stay sober longer than they have in the past. We want to focus on day to day measures of success like that so that it wouldn't pull them back into prison within 3 years. If would be nice to see more data to show up to meet with their probation officer, to be in employment that works for them.

Senator Heckaman: Given budget, what do you know about decrease in number of probation and parole officers expected in the next biennium?

Dr. Lisa Peterson: I would defer that question to Dan.

Dave Krabbenhof: Director of Administration. That revised executive recommendation we don't have a decrease in any, we've maintained funding.

Chair J. Lee: What are you going to do if someone retires?

Senator Kreun: Which program works best for job procurement. From your standpoint where do we go so that these people can meet with their parole officers so they can make their appointments for their doctors plus to have a job. Do we go out, which program would be best to go out and help those people get the job, and then be able to able to meet the requirements that we have as far as their parole or other things too in your mind?

Dr. Lisa Peterson: Employment and vocational rehabilitation that is not necessarily my area of expertise, but I can speak to is DOCR has implemented what we feel are high fidelity effective quality programs identify, and the emphasis of our programs is helping the person item size risky situations and then learn skills to deal with that. Avoid conflict. Often times the workplace is a hot bed sort of a risky situation because they have conflict with their boss, maybe they have job demands that they can't meet. To me the various programs are in place. For me it's more about equipping that person to tolerate that stress, stay on the job. Specific path, that's less key in my mind.

Ms. Pam Sagness, Director Department of Human Services, Behavioral Health Division. (1:46:05) Just to provide a little bit of information regarding some of the questions that have been asked, if I may. Sen. Kreun you asked a question about what type of vocational services, it really is individually based. So there would be an assessment for that individual regarding which path best, it is an individual level assessment.

Senator Kreun: Who would work with job service for them that job that way? After you make that assessment, and figure out what they can do, and what's the best fit for them, do we have a case worker goes with to get that job, do we go with that go to employers to hire these individuals with criminal records. Which ones will allow these individuals to work for them? We will help you monitor them, or something of that nature. Which ones are you successful with that makes it work better?

Ms. Pam Sagness: Maybe need to paint the picture, we look at partnership DOCR and DHS, for 2 reasons, criminogenic risk, looking high add needs, or high addiction needs or human health concerns. There are 2 things we are looking at. They are each individual needs to be assessed based on those two different things, and looking at how they interact. So then when

we look at treatment, this is very different from the classic sense of treatment, that you may have in your head. This isn't for example well we are just going to call up Curt and go to day treatment. This is one of those situations where we even did, based, on those risks and the needs of those individuals. You heard Steve mention earlier about these different tiers. So what we do is we align for success, and one of the outcomes of success would be are if this individual maintain employment, housing, pass drug test, stay sober and meet with their probation officer. Those are some of the measures we look at on month to month basis, data right away, yes, contract with service providers, private provider. Procure contract with would ensure client gets treatment, client does well. That's the different conversation that were talking about here. We aren't having a conversation to say are they going to get treatment, how are they doing what are they're needs. That is the responsibility of those providers. Private public partnership, we are truly looking at wellness, not service. To address Senator Anderson, you had asked specifically about the qualifications for paraprofessionals. I think it's important to note that the Behavioral health division within the Department of Human Services, is working right now in certification for peer support specialists and recovery coaches. We are also working with payers to insure what we are looking at for credentialing makes sense for the state, will meet the needs of those who provide the service but also those who may be paying for the service in the future. That certification really sets a foundation of what the standards will be. So that it's not necessarily under a Board, but rather from a certification process.

Chair J. Lee: That varies from state to state I think does it not?

Ms. Pam Sagness: replied yes.

Senator Anderson: I feel strongly they are most important links in this process here because those of us who have a particular profession are not particularity good about finding somebody different help that they might need. But these people should be plugged into whatever the client needs and getting them the right services. I think that's important.

Ms. Pam Sagness: If you think about this in terms of what the outcomes are, instead of what the service is, it certainly addresses that. The biggest issue here is that we're not looking for traditional treatment as it is. Where are the service providers in this wait list? The wait list is really irrelevant to this issue, because these will be individuals that will be contracted to have ongoing services based on their need not based on what the provider does. That is a really important difference. What are the needs of the individual in order for them to achieve those outcomes at the end of the month? That means paraprofessionals are not just peer support but also looking at case aid services that would be available, how we would wrap around individuals. It is employment supports and also the housing first model.

Chair J. Lee: Tell me if you think that this is a fair parallel, but we are seeing more and more community health workers being used for example by ambulance services and at home by hospitals to do this post discharge visitation and so forth to prevent re-admission. (1:52:05) That is seen as kind of comparable in a way, not the community support workers are going to be these peer support providers, but there is a career ladder for each of these. It isn't that any of them are less important, they are really just a result of education training and certification in licensure and all of that. Am I kind of on the same page as you are with that?

Ms. Pam Sagness: The integration here with physical health, combined with behavioral is so important. Based on the individual needs of each individual, health chronic disease outside of their addiction, like diabetes we're going to look at wrap-around team of services.

Chair J. Lee: Diabetes is a good analogy, (1:53:01-1:53:45).

Ms. Pam Sagness: Surgeon general, isn't an opinion, addiction is a fact and the way we treat a chronic disease, a comparison like diabetes.

Chair J. Lee: How about you tell us what happens now with someone in DOCR looking to be released, can you walk us through a little example between the two of you?

Ms. Pam Sagness and Dr. Lisa Peterson: Some of the barriers, standard release integration process for the vast majority of people coming out of prison but then we had a specialized mental health release integration which really becomes behavioral. We refer people to that when they have more serious mental illness needs. We meet monthly with representatives of the Human Services Center, to try to hook people up with appointments for psychiatry, case management if they are eligible for that. At times when they are not having to deal with those wait times, you know sometimes we are affected in doing that, sometimes not. But I think another one of the issues that we see is that when people have been able to access their primary treatment if its substance abuse treatment, or otherwise in the community, the folks who say they received treatment at West Central are going to be prioritized to get into West Central's after care versus if they did their time and treatment in prison they still have that after care need outside of our walls, but they had a hard time getting into that service because there is a constant stream of folks coming from the primary program who need after care. So the benefit here I think is another way of linking that person with that service but then also the service could potentially be an extension of the program that they had in prison. So right now we have different curriculum, different model, and so they would get follow up that would be consistent with the skills they had in prison.

Ms. Pam Sagness: I think the point is the beginning of reform, beyond the correct population that's true. It is the same provider. When you work with Heartview that provider is not just serving the corrections population, but other individuals. So if we start to provide services in a different way, for one population, that has an impact on all the rest of the population especially if for the first time we're seeing an impact that we haven't seen before. I will tell you as there is no one who got into this business, for any purpose other than that they care about people. So, if they see a positive outcome they will move in that direction if they see it. That is the opportunity we have here. There isn't to be able to help a provider or professional that I know that is providing this service because it's great pay and amazing work that makes you bounce home at night. Because it is not. But the reality is, if you can find a what helps people that's what you will do. That's the opportunity in a program that changes the way they look at outcomes.

Senator J. Lee: Does either of you have any additional comment that you would like to make before we end our committee hearing? Any information we should have that we haven't already heard?

Mr. Steve Allen: We talked very briefly about the positions and I think they are characterized in the bill as implementation. I want to add to that model as being highly critical to the success of the program. Here's why. In the model that Pam is talking about, this is innovative. Providers get money up front for doing this work, to impact outcomes, improve stability in housing, work, recovery, etc. Part of this model also requires providers after they have provide these services to bill every dollar that they can for federal health care monies. Now of course with that debate going on in Washington, who knows where that ball is going to land. But there is an opportunity for the state to recover significant dollars of investment back into state coffers to either choose to be used for other purposes or enhance the scope of this project. The current sizing in this program to be clear doesn't serve everybody who has addiction or mental illness in the correction system. This is a modest initial investment frankly. Those positions that are targeted for this purpose help initial implementation, getting providers to be interested in do this work as it is not easy work, developing the guidelines to do it well, insuring the providers have the right training to be qualified to do the work effectively and then critically, financially those positions are also in place to insure the providers are billing for the services that are billable, reimbursable federally, and that money that they are billing for goes back into the state coffers. So, even though it's an outline of half a dozen positions on the front end of this the benefits of those positions in initial implementation in successful implementation and then recovery of revenue on the back side are critically important.

Chair J. Lee: Closed the hearing on SB 2274
Attachment #10 provided after the hearing for committee reference.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2274
1/30/2017
Job Number 27599

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Sandy Baumgartner for Marne Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to a community behavioral health plan as a term of parole or an alternative to incarceration; to provide for a legislative management study; and to provide an appropriation.

Minutes:

Chair J. Lee: In Dr. Peterson's conversation along with Pam Sagness, we want a program outcome that has outcomes and not just providing services. We know that we are going to have to do something smaller than what this calls for. But the original bill calls for the 7.5 million, because that's what it takes to do the whole project.
Senator Anderson: This is an initiative trying to fix the whole criminal justice system and add in treatment into it. It comes down to whether you are comfortable with negotiating with the Appropriations committee the way the bill is now or if you feel you want to have the option to have the smaller project. That's something to amend at Appropriations committee. If you got the sense they weren't going to go for whole deal. At this point I would say, we can move ahead with the bill the way it is, and then just be known, you are the one who will have to negotiate with Appropriations as the prime sponsor and committee chair.
Chair J. Lee: I would not object to that, but I want us all to be aware that there is no way this is coming out with 7.5 million. As a rule, we are going to do those kinds of decisions in here. We are going to establish the priorities, and I don't want them deciding. They don't know all the policies and provisions for all of the departments for which they're doing the budgets. I want them to see what it takes to do this. It has to tie with the corrections side also. They are discussing the corrections budgets now too. The corrections bill isn't heard until tomorrow. There is not total agreement on the other part. I want you to know I want your input.
Senator Clemens: We've been having behavioral issues in the last 4-5 years. It is really coming to the forefront that we need more help.
Chair J. Lee: We're finally recognizing it. We got to do something about this. For the people who are numbers people, it is costing the state a boat load of money in the ramifications of which is our protected services and other kinds of support services that are involved for folks with mental illness. We don't have enough providers and they are not in the work force. They are getting benefits. If we can get them well enough to functioning, they're better off and so is the state.

Senator Anderson: The research is advancing and we're realizing this is one of the ways to the solution to the problem is to get that care in the corrections facilities. I few years ago we didn't recognize that. That's one of the reasons why the approach has changed. We are hoping to save money down the road, but we can't prove that. All costs go up, it's hard to categorize. If our jails aren't full in 10 years, we'll know we did the right thing.
Senator Clemens: You probably answered it, but we get reports that 80% of our jails are occupied by behavioral drug abuse. Hopefully this is what this will help.
Chair J. Lee: We're not going to be able to prove we are going to save any money right away because there is a transition time here. But if we can provide treatment in the jails. It's already in the pens. But then for people who are released from jail, there aren't adequate resources for them. There aren't any community services in some places. I was told that from Bismarck to Minot, there's 1 psychiatrist. If we can help these people come out of jail, and hook up with less expensive services, it will cost us less money. We are going to increase our bed-count in jails by 48%. That's huge! If we can get them out of the habit. They don't have jobs, can't support themselves or their habit. If we can get them out of the habit, then we can get them into the jobs where we really need them to. It's a big partnership deal. We can keep costs down if we can keep the recidivism down.
Vice-Chairman Larsen: We need to look at a different approach. If you're a murderer, it costs a certain amount a month, in the pen you still have someone addicted to drugs. They are in the pen, being housed and it costs the same amount. If we can split that away and we can go this behavior route which is $7.5 million of new money. If those folks are being taken care of in that line to stop the revolving door of them coming back, maybe our pens will taper off and not continue to rise. We will be keeping the real- bad actors in the area they need to be and as time goes on it will be a split. I'm not for letting people who have the addictions and theft to get off by any means. We need a place where they can be held accountable and be helped just like in the pen system where it has to be separate. There was a question of the length of time it takes to get somebody in to see a therapist. With the behavioral health state people, it says here it was 1-2 months. My wife is in private practice; she is out 3 months. You cannot see her. You just can't just walk in to her.
Chair J. Lee: Unless you are a suicide threat, it will take you about 6 weeks to see someone. There are 2 districts and another is farther west where there is walk-in mental health treatment.
Senator Heckaman: I have to agree with Senator Anderson on sending this bill out as it came in with the understanding that we know it probably won't go through. The thing I'm scared about is when we go into Appropriations and we use the word "pilot" project. I wish there was another way we could say it as an implementation project. We want some kind of incubator so this keeps growing.
Chair J. Lee: How about Incremental Implementation? I'd like to not see this as 2-year deal. That behavioral health plan we brought in last session was intended to be a 3 session plan. So we would start with this and see how it went and then expand as we got more work force. That was what we were hoping for.
Senator Kreun: Give us the explanation of this project. What are we encompassing, what are we trying to accomplish? What are we including?
Chair J. Lee: Look at the CSG testimony from Steve Allen. It is really a good review. It started because CSG was willing to and visited with other states doing something comparable to this, to assist us in how we can get our arms around this. We have too many people in jails. We don't have enough behavioral health services and they aren't connected

to how we can pull this all together. Their mission is to get everyone moving in the same direction. Which isn't always easy.
Senator Kreun: That's the incarceration.
Chair J. Lee: No, that's the behavioral health. We have to have the services. We don't have them come out the door and fall off the cliff. We have to find the places where they can go and the people to connect with wherever they live.
Senator Kreun: When people come in today we are talking about the children, 0-3 infants and that kind of thing. Isn't that part of it?
Chair J. Lee: That's part of it. The little ones have the behavioral health issues as well.
Senator Kreun: That's another component that we are putting together on this whole big picture of behavioral health.
Chair J. Lee: Absolutely, but this one is just a niche which has to do with those who are in incarceration.
Senator Piepkorn: What are we asking for?
Chair J. Lee: The 50,000-foot level covers include children's and adolescent's behavioral health, adult behavioral health, substance abuse and workforce, which effects all 3. This one has a small section which is just the incarcerations crowd of those that includes veterans, and tribal members, and so forth. But it also connects up to the corrections part. So, it is sort of something like this. If I had a visual with a ball that had all this stuff in it with 4 different parts. There would be the nucleus and all the electrons with protons and electrons. Out here would be corrections, which is another ball. There would be a bridge between the 2.
Senator Kreun: We still have the basic 4. Then even from there we will throw out electrons.
Senator Heckaman: I relate it to the sort of thing like the DD lawsuit that we got in. We didn't go in and change it until we got into a lawsuit. Well we know we're not doing the right thing. The Schulte report was commissioned and we understood when we read it and we knew how bad services are. Over the interim, Human Services did a lot of ground work to help us know what we should be doing.
Senator Kreun: As we go through these components, remind me which component we are at and where it fits in. Then delve into the nitty gritty. Just like the incarceration portion, just throw that out so we know where we're at.
Chair J. Lee: This bill is not specific, its intended to permit corrections and behavioral health division to work together to develop plans for good outcomes. I'm going to ask them to come up with an example for Appropriations Committee that will be the kind of thing we would look forward to as part of our incremental implementation.
Senator Kreun: We will have 4 basic quadrants, and then you take more satellites off of there. We have to give visual of these.
Senator Clemens: This is the 1st job I have never had any training for. I understand the 7.5 million that comes from the general fund. That 6.8 million, where's that from?
Chair J. Lee: It's confusing, it looks like there is a total of 14 million dollars and that is not the case. What happens is the money goes to the Department of Corrections, who will transfer it to the Department of Human Services the other amount for implementation of the programs. It is sort of like a shell game. It is all very obvious and very legal. It isn't 14 million dollars in round numbers, its 7.5 million that will go into the hands of DLCR, and then they will move it over to the Department of Human Services as they pay for services that are delivered. So that is kind of the flow chart.
Senator Heckaman: If you look at bottom of FN, you will see how it is divided out. Explanation followed.

Senator Heckaman: Do pass on 2274. I don't think we will amend it. Re-refer to Appropriations.
Vice-Chair Larsen: Second
Chair J. Lee: Any discussion? If not, please call the roll.
Motion passes 7-0-0
Chair J. Lee will carry

Date: 1/30 2017

Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2274

Senate 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 Sen Heckaman Seconded By Sen Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman	X	
Senator Oley Larsen (Vice-Chair)	X		Senator Merrill Piepkorn	X	
Senator Howard C. Anderson, Jr.	X				
Senator David A. Clemens	X				
Senator Curt Kreun	X				

Total (Yes) 7 No 0

Absent 0

Floor Assignment Sen. Lee

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

REPORT OF STANDING COMMITTEE

SB 2274: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2274 was rereferred to the **Appropriations Committee**.

2017 SENATE APPROPRIATIONS

SB 2274

2017 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2274
2/9/2017
Job # 28091

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Emmery Grotberg for Rose Laning

Explanation or reason for introduction of bill/resolution:

Relating to a community behavioral health plan as a term of parole or an alternative to incarceration.

Minutes:

Testimony Attached # 1 – 3

Legislative Council: Alex Cronquist
OMB: Becky Keller

Chairman Holmberg: Called the committee to order on SB 2274. Roll call was taken.

(3:45 – 7:20) **Pamela Sagness, Director, Behavioral Health Division, Department of Human Services**
Testified in favor of SB 2274. Testimony Attached # 1.

(7:25 – 12:50) **Dr. Lisa Peterson, Clinical Director, Department of Corrections & Rehabilitation**
Testified in favor of SB 2274. No written testimony.

One of the most effective things about this bill is that it links principles of effective correctional intervention with effective behavioral health service so we can use research and what we know based on prior data to design the most effective program we have available to us at this time. Pam mentioned the level of service inventory revised, that is the tool we use to determine who amongst our criminal justice involved population prevents the greatest risk for future crime. I have it compared to insurance companies and how they determine what to charge you. They give you a cost upon based on the risk they feel you present to them as a company. We do the same thing; we look at variables that have been shown to predict future criminal behavior and those are some similar things, like criminal history. An individual can be given a score and that tells us on a percentage how likely they are to do crime in the future. The Level of Service Inventory – Revised (LSI-R score) helps predict parole outcomes, success and correction halfway houses, institutional misconducts, and recidivism. In order to collect the data you have in front of you, we looked at our current people who are on supervised release in the community and we determined how many of those folks have an LSI-R score of 30 and above. We chose 30 because it is the point where we can consider someone moderate-high in terms of future criminal risk and we are looking at that point greater than 50% likelihood that the person will engage in crime in the future. I think it

depends on the study but it is in the 50-60% range all the way to more than 70% in the higher categories. That is based on a ND sample where that person is considered moderate-high. We asked ourselves how many people do we currently have on supervised release who meet that criteria and from there we try to estimate how many people are currently on community supervision who also have a substance abuse disorder or a serious mental illness. We don't actually collect that data for our probation sample, the problem is that probationers receive services in all kinds of community avenues. It might be from a human service center or it might be from a private provider. So our provision and parole officers don't necessarily have a data base that would include their behavioral health diagnosis. We did look at how many people we know in prison who have a substance use disorder diagnosis or a serious mental illness. We know that about 75% of incarcerated people have a substance use disorder. 10% - 15% of men have a serious mental illness and 20% of women. We use those numbers to estimate the prevalence of substance use disorder and serious mental illness amongst probationers. We thought we were able to do that because we preselected a higher risk group of probationers. That is how we came up with that number you see here.
Dr. Peterson continued to provide information from Page 1, Attachment # 1.

Chairman Holmberg: Is there anything with jail capacity in Ramsey County?

Dr. Lisa Peterson: No, that's not a factor.

Senator Judy Lee, Bill Sponsor, District 13: Testified in favor of SB 2274. This bill is an important part of the project to fill a niche of those need behavioral help who are those who are incarcerated or being released from incarceration. I am sure you hear this but when they leave the correction facilities, they fall off the cliff. We do not have the services that will allow them to be able to return to a healthy lifestyle, to our workforce, and reduce the kinds of costs which are extraordinary to build additional beds. We have seen remarkable collaboration between the Department of Corrections and Rehabilitation and the Division of Behavioral health and the two experts are here to share that information with you. We gave you the bill at the full appropriation knowing that that is not something that is going to happen this year but that it is important for you to understand what it is going to take to fully implement something like this. As a result, we need to look at some kind of incremental implementation. What we are looking at is something that Miss Sagness and Dr. Peterson have worked to put together that I think is very worthy of your consideration. We recognize what the challenges are with the budget but this is something that if we can begin this implementation and start small, we may be able to bend the curve on that recidivism and on the additional needs that we have for incarceration. Not only will it save money but we will have better outcomes for the individuals involved.

Pam Sagness: Miss Sagness continued with her testimony (See Attachment #1). This is a different model than what ND is used to in regard to behavioral health services. We currently have a system of services that is a fee for service model which means that providers get paid for the services they provide. This proposal looks at paying for outcome so the proposal is that there would be a monthly fee that will be for each of the tiers that we discussed earlier. So an individual that only needs tier 1 services or an individual that only needs tier 3 services would be reimbursed at a different rate than at the tier 1 service level. One of the things that is important to note is that the expectation would be that there are outcomes at the end of every month so the data and the outcomes would be quick to turn around in regard to a two-

year period which has been part of the discussion. For example, did the individual stay employed during that month and were they healthy? Those would be the types of outcomes that would be looked at the end of every month. That is how the reimbursement would work. In that, I think it is important to note that this proposal has a lot of flexibility and so I wanted to point out some of the variables. The number of participants that would actually be served is going to be based on a couple of things. It will be based on the number of participants per tier, for example there is a higher cost for individuals in the tier 3 service than those in tier 1. Another variable would be the wait per tier as I mentioned earlier.

Chairman Holmberg: I think I misunderstood; you said there was more cost for someone in tier 3?

Pam Sagness: Sorry, tier 1. So the rate per tiers will be different. Until we have actually selected the participants, it would be difficult to know how many individuals would be at each tier level and it is also important to note that the tiers will change as an individual is stabilized and participates in the community, engaged in employment and has support around them, they will move to a tier that has less need.
The other this is that the provider rates could be different. When we look at our rural areas in the state, a provider often changes a different amount than in an urban area. It can be based on competition; it could be based on the workforce so I think it is important to note that there could be different rates based on the provider of their location. Lastly, part of the proposal brought forward here is that anything that can be reimbursed will and that money will be returned. For example, if a provider is providing services to an individual at a tier 1 level and that individual is struggling and needs to go into a partial hospitalization program, that is a reimbursable service whether they are Medicaid or Blue Cross Blue Shield so it would be expected that the provider would return that funding. Those are all variables that would have an impact on the depth or the number of individuals that would be served in a proposal like this.
A few considerations: this is completely new model for ND. It really is looking at the wellness of someone instead of the sickness or need. We currently have a substance abuse system that is really based on acute treatment. What that means is that there is a start and an end so an individual who has a chronic disease like addiction will enter a program for a set number of days or weeks. We know that is not the most effective way to treat addiction. When something is a chronic disease, there's more effective ways and one of those things being peer support or recovery coaches. This changes the model for ND and in that there will be a lot of training and a need for oversight, especially when we look at an outcome based payment system. Also the types and volume of services will be individualized to meet the need of that individual. Lastly, each tier would have a monthly rate which is based on the outcome of success or what those measures would be.

(20:50) **Senator Mathern:** Would this model be part of the regular system or just a carve out for these people?

Pam Sagness: One of the benefits of an initiative like this is that these are the same providers that provide service whether we are talking about the federal block grant or other state funding. The opportunity here is that it is the same providers that will be learning this new model, learning more about chronic disease management and it also builds the capacity of the workforce to provide better services.

Senator Mathern: So the answer is no?

Pam Sagness: I believe the answer is yes.

Senator Mathern: So folks who are not incarcerated that are not in violation of the law would get this same model in this state?

Pam Sagness: This proposal specifically would not affect those outside corrections; however, I do believe it is one of the first steps towards that direction. I can say that from the Department of Human Services perspective in the behavioral health division, we are looking at this model for the other funding that we administer which includes the substance abuse prevention and treatment block grants, the SUD voucher, etc.?

Senator Mathern: Is that in your plan of action for this biennium going forward to have this model available for all citizens who need behavioral health treatment?

Pam Sagness: I don't believe those systems can transform in less than two years, but we are working towards that.

Senator Mathern: How long will it take to have providers ready to provide this model of service?

Pam Sagness: We don't have set amount of time, but we do want to acknowledge the fact that there will be extensive training that will be required. Especially because this is a very specific population that has criminogenic risk but also behavioral health issues. It really is a specialty and we think it is going to be important that there be that recognition of the need for training. There are a few variables that could affect that: workforce and private providers.

Senator Mathern: The human service system wouldn't morph the human service system staff into these providers necessarily? You would be looking at a new cadre of people?

Pam Sagness: Correct.

Senator Kilzer: Could you tell me a little about the training of the behavioral health provider?

Pam Sagness: The term behavioral health provider is broad. We know that about 75% of the individuals that are incarcerated have a substance use disorder and approximately 10-20% have a serious mental illness. The provider is going to be based on the need of the individual so when you look at contracting services with private providers, this is a public-private partnership based on the need of the individual and becomes the responsibility of the vendor that we are working with to reach out and ensure that all of those services can be provided. . They have serious problems. When we look at providing services.. It's public/private partnership. All would need to be credentialed. If an individual needs a psychiatrist, then

Senator Kilzer: Who determines the needs?

Pam Sagness: First the participants have to be identified based on the needs we talked about earlier: diagnosis, functional status, and criminogenic risk. However, after that we have to be able to look at point in time. Then we would look at a current assessment of the individuals that have been identified as being those highest risk individuals and then a partnership between probation and parole, the department of human services through our behavioral health division, and the clinicians that are providing those services to identify what is the clinical need or medical necessity for those individuals.

Senator Kilzer: Is it the probation officer who determines the needs?

Pam Sagness: The clinical guidance would come from the clinicians and certainly probation of parole is part of that team, however when we are making diagnosis or clinical recommendations that would need to come from a professional who is trained to make those recommendations.

Senator Kilzer: What is their training?

Pam Sagness: It would depend on their specialty.

Senator Kilzer: No, I am talking about the initial person who determines the needs.

Lisa Peterson: I think you are asking how we are going to filter people into this program. One part of this is to serve people who are transitioning out of jail or prison. We have a process already in place for specialized release and integration for people with serious mental illness and we would have all of information. Part of our process would be to develop criteria for each tier and so coming out of prison, we could already have people assigned to tiers and referred to the program for six months before they leave our doors. For people who are on diversion status and are not coming to prison, we would have to develop a process for assessing them for those criteria for each tier on an outpatient community basis but we could certainly apply the same process that we are using for prison transition to that community side. I think the type of provider who actually makes that determination depends on what service we chose to focus on. I think in some ways it makes sense to focus on substance use disorders, so we would be looking at potential license addiction counselor or a masters level clinician counselor.

Senator Kilzer: So there will be a definite set of criteria set up?

Lisa Peterson: Yes. The DOCR has people who are certified trainings of a cadre of effective correctional interventions. That may include core correctional practices which is a communications style and a style of reinforcement in consequence behavior that we like all of our staff to utilize; that includes thinking for a change which is an empirically supported program that targets criminal thinking, cognitive behavior, or interventions for substance abuse. These are all things we would be able to provide to the community service providers immediately. We would not need to go through the process of investing in that training; we have already done that.

Senator Bowman: After we have been doing this program for a few years, who can evaluate the success of this program to find out if we are really gaining anything from this. We need an unbiased group to see if it is working.

Lisa Peterson: I can offer a couple of suggestions in terms of determining the effectiveness of the program. Miss Sagness and I have already spoken about the importance of developing outcome measures that look at both long-term outcomes in terms of the criminal recidivism for each person who receives this service. But also for more short-term positive successes. Remember preselecting a high-risk group in terms of their criminality; if we can move that number in terms of their recidivism or their risk for future crime in a positive direction, we are seeing a lot of success. I know the council of state governments have suggested when all of these services are implemented correctly, you can expect a 20-40% reduction in recidivism. Like I said, after 2 years realistically if we nudge that number in a positive way, we would be successful. Miss Sagness and I have also spoken about the importance of being transparent in terms of the outcome measure whether we have been able to show success and also if we haven't shown success, why we might think that might be. Certainly, if there is decision to go to some sort of outside resource, The Department of Corrections utilizes a correctional program checklist which is an auditing tool for our programs and we have a team that includes staffers from other agencies that aren't necessarily affiliated with DSCR to evaluate our program. So we are familiar with that process already; there are also several researchers in the state who would also be familiar with that process and be that objective outside resource.

Senator Grabinger: Looking at fiscal note, it shows 6 new FTEs for nearly $1M. Can you explain what those FTEs are?

Pam Sagness: This proposal is not currently in our budgets; we were asked by Senator J. Lee to talk about what has been discussed on behalf of the council for state governments and what has been discussed with our departments. These FTEs would be the positions who work with probation and parole to ensure that individuals are palced in the right level or tier, that the clinical services are provided as they are reported. These are the individuals that are responsible for the oversight of those monthly outcomes which are directly related to the payment. This is an entirely new program and so we don't have the resources to staff this program without additional FTEs. The proposal of 6 FTEs was statewide; covering full-service statewide.

Senator Grabinger: Are they licensed addiction counselors? Who are they?

Pam Sagness: They pay was based on what is considered a health and human services program administrator III witch we would be looking at that clinical background, they would have to be able to assess whether an individual has clinical needs and also have the accountability to know what would be appropriate services available. They also will end up providing the training and technical assistance to the providers. This is a new model and a new way of providing service so there are going to be a lot of questions and a lot of training that is going to be needed. These individuals are highly skilled in regard to behavioral health. Those would the individuals who would be tracking the expenditures and the monthly outcomes.

(36:15) **Senator Dever:** I see $7M to DOCR from general fund. $7M from federal funds to the Human Services. I am curious about how that flows. Also I see on the fiscal note that it says Note: source of DHS other funds is the Department of Corrections general fund appropriation?

Dave Krabbenhoft, Director of Administration, Department of Correction and Rehabilitation:
The original appropriation from general funds would come to DOCR and then transfer to DHS. So you see that $7M coming in as general funds and then the payments to the providers would actually come from Human Services. When you move money from one agency to another, the receiving agency typically shows it as special funds.

Senator Dever: So the $7M to the Department of Corrections of general fund money would be partially used to develop the program and then the balance would be transferred to the Department of Human Services to implement it?

Dave Krabbenhoft: The way I understood the bill was that there would be one FTE to the Department of Corrections that would help in preparing the program, so the $7M less the cost of that 1 FTE would go to the Department of Human Services.

Senator Dever: Is participation on the part of the individual voluntary? Could this be used as a diversionary program and avoid incarceration?

Lisa Peterson: We do have Appendix A that requires the person to adhere to any recommended treatment so we have the hammer so to speak to utilize if folks are struggling and not participating in the program and we can certainly provide a consequence. One of the chief goals of this program is to use it as diversion and not only that but to be able to recognize if someone is struggling and be able to pull them in and engage them. Maybe more them up a tier or engage them back into that low level 3 tier before they progress to the point where they have engaged in further crime or violated their conditions of probation. We would see this as a way to bring the person in and offer them the opportunity to have help and intervention before it gets to that point so they can turn themselves around.

Pam Sagness: If I could just go back to the question asked by Senator Kilzer, I think it is important to note that in ND administrative code, it is already required that anyone who is treating someone with a substance use disorder is required to follow ASEM to make sure they are placed in the right level of care for their diagnosis and status. That is already required in administrative code and I think it is important to note that because that is a requirement that would affect how people are assessed and who can do those assessments. Those tiers are flexible so an individual month to month could have different needs so it is important to note that there would need to be a monthly review that would identify whether that individual was in the right tier and that is going to be important for money to make sure we are not paying the rate of a tier 1 if an individual only needs tier 2 or tier 3 services. That is going to be an ongoing continuous assessment and it is important that we have skilled individuals with the oversight of this program.

Senator Mathern: I am intrigued about this becoming the standard form of delivery. There is a lot of research behind this suggestion that makes sense. What is the problem in terms

of implementing this right now? DOCR says they have the trainers and you agree with the model and defining it.

Pam Sagness: It's a process of change; currently individuals or any provider is reimbursed based on illness. If someone is sick and needs a high level of care, there is reimbursement for that high level of care. Changing the model to looking at wellness changes the day to day workings of a provider. At this point in time, that has been a conversation in early stages but even in looking at the way that we implemented the substance use disorder voucher; there were providers that were resistant to this model. They believe they should be paid for the services that they do and right now the typical model is an acute model that provides a service and so we also need to make some administrative rule changes because that model that I mentioned earlier that is tied to the ASEM criteria and the types of services that are provided. We are working on editing in order to open up some of those barriers and move in this direction.

Senator Mathern: If people are unwilling to do this and we know it is the proper way, do we still pay them?

Pam Sagness: Right now it is a fee for service payment model. I am not suggesting all of the services provided are ineffective but we know they are not the most effective or best practice. Part of it is there needs to be reimbursement for the services that are outside of that acute treatment; things like peer support, recovery coaches, medication assisted treatment, the things that right now there is no coverage for, there are several things we have done to address that. For example, looking at reimbursement for methadone within our budget. It is a lot of moving pieces and I think the issue comes down to the number of providers. When you are in an area where there are only three providers and they are cash only, we have very little influence in their decisions.

Senator Robinson: Realistically, if this bill would be fully funded what kind of impact will we have on the population of DOCR in the next two years?

Lisa Peterson: I want to be realistic about what we can over the two-year period and that is why we are proposing an incremental implementation because like you said, there is going to be a major investment of time at the outset in getting things set up. What we have found when we have done other things is that when we are starting a project like this, we can do a lot of good for a fairly small number of people so that is something we could realistically expect over the next few years. We want slow implementation. Even if we could keep the recidivism rate from going up for this group, or move it in a positive direction, that could potentially equate to significant cost savings for DOCR if those are those folks who would have been in prison otherwise. In terms of numbers, I don't know if I feel qualified to make an assessment of that in this point of time. Council of State Government has offered that when all of these things are fully implemented, you are going to see that 20-30% reduction in recidivism and this group may be at that 70%likelihood of recidivism. So it is important to keep in mind that this is that preselected high risk group but the research has consistently supported that we get the most bang for our buck when we target that group and we can be the most efficient. Other studies I have seen that have looked at the implementation of one manualized cognitive behavioral program that targets criminogenic needs, you can look at a

10-11% reduction in recidivism. I think a lot depends on the implementation but we do want to be realistic about what will happen over the next two years.

Senator Robinson: That certainly depends upon what level of funding comes through this session as well?

Lisa Peterson: It does and I know the situation around FTEs is not a positive outlook. I think the importance of having a position from my perspective is that that person would be tasked with ensuring the success of this program and this program would be their portfolio. I think having someone fully invested in this project is key to a positive outcome.

Senator Dever: I suspect that most people's initial entry into the correction system is not through the DOCR for the state prison but a county jail. Is this a program that could become a model for use in the county jails or could it be incorporated into the program as you develop it?

Lisa Peterson: It absolutely could be included into the model for county jails; both Miss Sagness and I have been part of a work group during this past interim that included administrators from the jails in some of the larger counties and we know from that work that they are excited about something similar to this and we could implement that referral criteria inside the jail as well and get people referred at the point in time they are coming into the jail.

Pam Sagness: I think it's important to note that this would hopefully stop someone from ever having a criminal history in the first place. Using a model that looks at someone finding recovery from as substance use disorder, this is all pre jail and corrections. I know Senator Mathern was asking about the implementation much broader, I think it is important to note that it does have an implication for services for all individuals is that we focus on wellness and help someone find recovery versus that acute fee for service model.

(51:05 – 59:00) Carlotta McCleary, Mental Health Advocacy Network (MHAN)
Testified in favor of SB 2274. Testimony Attached # 2.
Mental Health Advocacy Network brochure – Testimony Attached # 3.

Chairman Holmberg: The Schulte Report was written when the state had more resources available. This was one of the issues that came through the legislative branch through study and interim work and it doesn't show up in the executive budget because it is a legislative product. At the end of the day, we have to decide what our priorities are.

(1:00:05) **Lorene Davis, Founder & Executive Director, Native American Development Center** Testified in favor of SB 2274. No written testimony.
The Native American Development Center has been in existence for about 2 ½ years. We're here to provide support services to Native Americans and we have a federal grant that we received through the poverty strategy but the social part is in recovery. We have support groups and they are funded by the Otto Bremer Foundation. I serve on the Mental Health & Substance Abuse Planning Council with Pam Sagness, we have a mentoring MOU with the Department of Corrections since last year for mentoring services.

We do get letters from the prison asking for our support services and someone just donated a 12 passenger van by the United Tribes Technical College because of the success of our support groups.
Miss Davis gave the committee information on the success of the support groups.

(1:06:05 -) **Daniel Ulmer, Youthworks**
Mr. Ulmer informed the committee about services offered by Youthworks and reiterated the importance of the bill in building a foundation to deal with behavioral health.

Chairman Holmberg said the SB 2274 is similar to SB 2015 and asked the subcommittee of Senator Wanzek, Senator Hogue, Senator Mathern to take a look at both bills.

Chairman Holmberg: Closed the hearing on SB 2274.

2017 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2015 / SB 2274
2/16/2017
Job # 28444

☒ Subcommittee
☐ Conference Committee

Committee Clerk Signature Mary Muender for Rose Laning

Explanation or reason for introduction of bill/resolution:

To provide an appropriation for defraying the expenses of the department of corrections and rehabilitation.

Minutes:

Testimony Attached # 1.

Legislative Council: Alex Cronquist
OMB: Becky Keller

Senator Wanzek: Called the committee to order on SB 2015. Senator Hogue and Senator Mathern were present.

Senator Wanzek: Said he needed 24 hrs. to think about it. No epiphanies. DOCR, in my mind, we need to keep the discussion going of how we can help the DOCR with their limited resources in sentencing people to prison. We all have a role to play. I came prepared to support Senator Mathern's amendment. There is a lot of heartburn over prison bed allocation. I think we could remove Section 8 and still give authority to DOCR on how they manage their inmate population. In the year 2013, we gave prioritization authority to DOCR to control the number of inmates. It's referred to refusal of admissions to inmates, gives them authority when maximum capacity is full. LeAnn can you come elaborate a little more on this.

LeAnn: It's really prioritization, once we've reached maximum capacity for housing. We had lion's share of days taken up by one county. That provision spurred a lot of support. We were fully funded at that point. With all jail funding, this would give us management, for contract housing and what we consider management plan. It is like a pyramid and we prioritize the highest crime and work down and it gets us to the same point. People refer to the quota system and what it really does is divide up resources equal in all counties. It gives the DOCR the ability to manage the budget.

Senator Mathern: Is this legislation intact if we eliminated section 8?

LeAnn: I think It's questionable. Legislative Council says yes. Our council says no. We are not refusing. We would eventually take everyone but it is a matter of prioritization.
Would like just the title redone. Prioritization and not refusal.

Senator Wanzek: We'll get together with Alex Cronquist and try to get the language right. It was the allocation language.

Senator Mathern: We could finish our meeting.

Senator Wanzek: It involves taking Senator Mathern's amendment (17.0523.01005) and remove section 8. Put in language that we would re-title section 6 of 2013's SB 2015 budget bill to "Prioritization of Admission of Inmates." (page 2 of SB 2015 in the 2013 Legislative Session – Testimony Attached # 1.)

Vote # 1 -

Senator Mathern: moved that motion.
Senator Hogue: Seconded the motion.

Senator Hogue: When legislature adopted that prior language, how did that work? How did dialogue go?

LeAnn: We never got to that point because we were fully funded. We have not been deficient since I've been here. We did everything to NOT invoke that authority.

Senator Hogue: How would that communication go? Would you put counties and the courts on alert?

LeAnn: If you are keeping that section with counties and giving them that ability, I think we would start dialogue right away and let them know where we are in our appropriation. Tell them in advance, if they are looking at transports we will say, "Hey look if you have double A's, we'll take them when we have room."

Alex Cronquist: Removing section 8 and 11 which is clarification from Senator Mathern's amendment and replace it with section 6 from 2013 legislative session's SB 2015. The new section 8 there are some different opinions whether it's valid or not. Would you want it to be ND Century Code or session law?

Senator Wanzek: I personally think it should be NDCC. As we go through the Legislative process there might be additional reasoning, but we can let that play out.

Senator Mathern: I agree.

Senator Hogue: I'm ok either way and I think that will be a subject for conference committee.

Senator Wanzek: I don't know what harm it would be in re-stating it anyway.

Alex Cronquist: There is no harm in re-stating it, just whether it was necessary. In code, it's meant to be their authority.

Senator Wanzek: I just think if we are going to ask them to try and hold the line in their budget, they have to have some tools to be able to address it. The important thing is communication. I don't think we want to point fingers, but we all want to be part of the solution and need to communicate and let counties know.

LeAnn: I am hopeful that with that language, that gives the counties the ability to manage their jail population.

A Roll Call Vote was taken: 3 yeas, 0 nays, 0 absent.

Vote # :

Senator Hogue: Moved to forward the bill as amended to full committee.
Senator Mathern: Seconded the motion.

A Roll Call Vote was taken: 3 yeas, 0 nays, 0 absent.

Vote # 3:

Senator Hogue: Moved to recommend a Do Not Pass to the full Senate Appropriations Committee on SB 2274.

Senator Mathern: Seconded the motion.

A Roll Call Vote was taken: 3 yeas, 0 nays, 0 absent.

Senator Wanzek: Closed the hearing on SB 2015.

2017 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2274
2/17/2017
JOB # 28489

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	

Explanation or reason for introduction of bill/resolution:

A DO NOT PASS Relating to a community behavioral health plan as a term of parole or an alternative to incarceration.

Minutes:

Chairman Holmberg: called the Committee to order on SB 2274. Roll call was taken. All committee members were present. Levi Kinnischtzke, Legislative Council and Lori Laschkewitsch, OMB were present. Allen H. Knudson, Legislative Council was also present.

Chairman Holmberg: made comments regarding the status report. SB 2274 was a companion bill that was folded into 2015.

Senator Wanzek: moved a Do Not Pass. 2nd by Senator Grabinger.

Chairman Holmberg: Any discussion. Call the roll on a Do Not Pass on 2274.

A Roll Call vote was taken. Yea: 14; Nay: 0; Absent: 0. Senator Grabinger will carry the bill.

Chairman Holmberg: This should go on the calendar after SB 2015. The hearing was closed on SB 2274.

Date: 2-16-17
Roll Call Vote #: ______

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. ______

Senate Appropriations Committee

☒ Subcommittee

Amendment LC# or Description: recommend a DO NOT PASS on SB 2274 to full Senate Approps.

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

Other Actions: ☐ Reconsider ☒ SubCommittee Recommendation

Motion Made By Hogue Seconded By Mathern

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Mathern	y	
Vice Chair Krebsbach			Senator Grabinger		
Vice Chair Bowman			Senator Robinson		
Senator Erbele					
Senator Wanzek	y				
Senator Kilzer					
Senator Lee					
Senator Dever					
Senator Sorvaag					
Senator Oehlke					
Senator Hogue	y				

Total (Yes) 3 No 0

Absent 0

Floor Assignment ______

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

Date: 2-16-17
Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2274

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 Wanzek Seconded By Grabinger

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Mathern	✓	
Vice Chair Krebsbach	✓		Senator Grabinger	✓	
Vice Chair Bowman	✓		Senator Robinson	✓	
Senator Erbele	✓				
Senator Wanzek	✓				
Senator Kilzer	✓				
Senator Lee	✓				
Senator Dever	✓				
Senator Sorvaag	✓				
Senator Oehlke	✓				
Senator Hogue	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Grabinger

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

REPORT OF STANDING COMMITTEE

SB 2274: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO NOT PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2274 was placed on the Eleventh order on the calendar.

2017 TESTIMONY

SB 2274

SB 2274
Attach #1
1/25

JUSTICE ★ CENTER
THE COUNCIL OF STATE GOVERNMENTS

Testimony on Senate Bill 2274
to
The Senate Human Services Committee

By Steve Allen
Senior Policy Advisor, State Initiatives
Council of State Governments Justice Center
January 25, 2017

Chairwoman Lee, Vice Chairman Larsen, and members of the Senate Human Services Committee:

Thank you for the opportunity to testify before you on SB 2274, which would help both cultivate an adequate network of community behavioral health care practitioners and increase access to effective community-based behavioral health treatment for people in the criminal justice system.

I. North Dakota' s Justice Reinvestment Approach

Over the past decade, the number of people in North Dakota's prisons and jails on probation and on parole has increased, and the state and county governments have spent tens of millions of dollars expanding the capacity of existing correctional facilities and building new facilities to accommodate this growth. Unless action is taken, the prison population is projected to grow by 46 percent by FY2022, and 79 percent by FY2025, at a cost of $485 million to accommodate the entire projected growth.[i]

In October 2015, to begin a process to address these challenges, North Dakota state leaders from all three branches requested technical assistance from The Council of State Governments (CSG) Justice Center to use a data-driven justice reinvestment approach to help the state reduce a rapidly growing prison population, contain corrections spending, and reinvest savings in strategies that can reduce recidivism and increase public safety.

Four months later, the state embarked on a justice reinvestment approach, with an interim committee, The Incarceration Issues Committee (IIC), being formed, which was composed of state lawmakers, judiciary members, corrections officials, state's attorneys, and local law enforcement executives, to study the state's criminal justice system. The 16-member

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committee met five times between January and September 2016 to review analyses conducted by the CSG Justice Center and discuss policy options,

Key stakeholders help develop policies that will curb prison population growth by reducing the numbers of people in prison who have committed lower-level felony offenses and those who have violated the conditions of their supervision. By implementing these proposed policies, the state will avert a minimum of $63.8 million by FY2022 in costs for the contract beds that would be necessary to accommodate the projected prison population growth, and will be able to reinvest those savings in strategies that can reduce recidivism and increase public safety.

These policies will also ensure that people with chronic or serious behavioral health needs or those assessed as being at high risk of reoffending receive effective post-release supervision and programming.

II. Behavioral Health Findings and Challenges

State's attorneys, judges, and other stakeholders report that drug use is common among people who commit crimes and violate the terms of their supervision. Supervision officers in the state report that approximately 75 percent of people on supervision need substance abuse or mental health treatment. Research shows that behavioral health treatment tailored to the unique needs of people in the justice system when combined with effective corrections supervision reduces recidivism and improves recovery outcomes.

The availability of substance use treatment is not keeping pace with the level of need for all North Dakota residents. Stakeholders report long waitlists when services are available. Seventy percent of judges reported sentencing people to prison to ensure access to needed treatment services. North Dakota has the sixth-highest rate of alcohol and drug abuse in the country but is ranked 43rd in availability of treatment.[ii] Participation in substance use treatment decreased 15 percent between 2009 and 2013 for the general population.[iii]

III. SB 2274

Increasing the availability of and access to effective community-based behavioral health treatment for people in the criminal justice system can significantly reduce recidivism and improve public health outcomes, and Senate Bill 2274 will do so in the following ways.

A. Increase access to effective community-based behavioral health treatment for people in the criminal justice system.

Untreated mental illnesses and substance use disorders contribute significantly to people's ongoing involvement in the criminal justice system.

People in the criminal justice system who have substance use and mental health treatment needs have a high likelihood of failing on probation at great cost to themselves and society. Yet many people transitioning from incarceration to probation who have behavioral health needs do not have timely access to treatment, a key component to successful reentry. By increasing

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access to community-based treatment services and programs, the state can help reduce recidivism and improve public health outcomes for people in the criminal justice system.

This policy option increases access to effective community-based behavioral health treatment by providing funding for service delivery partnerships between private health care providers and DHS to ensure that people in the criminal justice system have access to a full continuum of support services. To encourage quality of care, private health care providers will have an opportunity to earn value-based incentives where they receive additional compensation for exceeding key outcomes set by DHS.

B. Cultivate an adequate network of community behavioral health care practitioners to serve people in the criminal justice system.

Across the state, access to community-based behavioral health treatment is not keeping pace with need. North Dakota will not be able to improve access without growing its behavioral health workforce. To meet the pressing immediate needs while building towards a robust and sustainable network of community behavioral health care providers, the state must implement short-, medium-, and long-term strategies.

i. *Short-term*

This policy option begins to address the state's workforce shortage by increasing utilization of key paraprofessionals, specifically peer support specialists and case management services. This policy requires the Department of Human Services (DHS) and Department of Correction and Rehabilitation (DOCR) to work jointly to establish training and certification processes for peer support specialists to work in criminal justice settings.

Peer support specialists are people with lived experience of mental illness or addiction who are in stable in recovery who become trained to support others with similar conditions. Services peers provide don't replace needed professional services. Peers work within healthcare teams to support treatment and help sustain progress towards recovery. In leveraging their lived experience, peer support specialists can provide unique insights and assistance that professional health care providers cannot. DHS will be required to establish the basic qualifications of the peer support specialist position and develop a training module that prepares peer support specialists to deliver recovery-oriented services in partnership with professional treatment providers.

This policy option also requires utilization of case management services within the array of treatment services for the targeted population. People at high risk of ongoing criminal justice involvement with behavioral health disorders require comprehensive, multi-faceted, approaches and significant collaboration, communication and coordination among both behavioral health and primary care providers as well as community supervision agents to improve outcomes. Research suggests that for adults with mental illnesses and substance use disorders, corrections supervision combined with treatment is more effective at reducing

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recidivism than supervision alone.[iv] Case management provides those essential case coordination functions.

ii. Medium-term

This policy option requires the development of a statewide strategic plan for increasing the number of community-based behavioral health care providers who have received the necessary education and training to work effectively with criminal justice populations. The strategic plan should analyze barriers to development and recruitment of behavioral health care providers, propose strategies for recruitment and retention, strengthen career ladders, create practical and affordable options for clinical supervision, and identify key outcome metrics to be reported to the legislature on an annual basis. Community-based behavioral health care providers include a broad range of professionals and paraprofessionals, including; certified peer support specialists, case managers, licensed substance use counselors, psychiatric nurses, licensed mental health professionals, psychologists and psychiatrists. By developing a strategic plan to cultivate an adequate network of appropriately trained community-based behavioral health care providers in rural areas, the state can begin to meet the behavioral health needs of people in the criminal justice system and reduce recidivism.

iii. Long-term

This policy option requires funding sufficient to implement the workforce strategic plan. Strategies may include:

- Strengthening of behavioral health career ladders,
- Outreach to create interest in behavioral health careers,
- Incentives to bolster recruitment and retention,
- Loan forgiveness and scholarships, and
- Funding supports for clinical supervision.

DHS and DOCR may also collaborate with North Dakota's systems of higher education to develop specialized curricula can prepare health care workers to be effective in working with criminal justice populations.

IV. Projected Impact of SB 2274:

SB 2274 is an integral part of the justice reinvestment policy package, which has the potential to generate substantial costs and lower recidivism. By averting the projected growth in the state prison population, effective implementation of the policy framework will help the state avoid up to $63.8 million in contract bed costs to accommodate the growing prison population by FY2022.

V. Conclusion

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The use of prison for people who violate the terms of their supervision and people convicted of lower-level nonviolent offenses is stretching corrections resources and limiting the state's ability to hold its supervision population accountable with effective sanctions. These criminal justice system challenges are exacerbated by the fact that people supervised in the community receive insufficient treatment for mental illnesses and substance use disorders, which hampers the state's ability to reduce recidivism and improve recovery outcomes.

North Dakota policymakers have reached a crossroads: if the state does not address the factors contributing to crime and recidivism, it will be forced to spend tens of millions more to accommodate prison population growth.

Leaders from all three branches of state government plus criminal justice system stakeholders have dedicated significant time to reviewing analysis of North Dakota's criminal justice and community behavioral health systems.

I would be happy to assist committee members with any questions.

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[i] North Dakota Department of Corrections and Rehabilitation (DOCR) estimated prison population projection. DOCR one-day inmate population snapshots for 2005–2007 are as of January 1 of each fiscal year. DOCR one-day inmate population snapshots for 2008–2015 and projected population snapshots for 2016–2025 are as of the last day of each fiscal year (June 30). Email correspondence between CSG Justice Center and DOCR, 2015 and 2016.

[ii] Based on state rankings of percentages of the adult population with reported dependence or abuse of illicit drugs or alcohol and mental health workforce availability. Mental Health America. "Parity of Disparity: The State of Mental Health in America," 2015. http://www.mentalhealthamerica.net/sites/default/files/Parity or Disparity 2015 Report.pdf.

[iii] Single-day counts reflect the number of persons who were enrolled in substance use treatment on March 31, 2009; March 31, 2010; March 31, 2011; March 30, 2012; and March 29, 2013. Substance Abuse and Mental Health Services Administration. "Behavioral Health Barometer North Dakota, 2014" http://store.samhsa.gov/shin/content//SMA15-4895/BHBarometer-ND.pdf .

[iv] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment* (2009).

SB2274
Attach #2
1/25

North Dakota's Justice Reinvestment Approach

Behavioral Health Policy and Reinvestment Package

Expand Provider Workforce

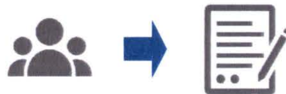
Rationale: Lower correction costs and reduce recidivism by cultivating a network of community behavioral health providers to help meet treatment needs of people in the criminal justice system

Strengthen Para-Professional Workforce

Case Management:
Providing assessment, case planning, referrals, care coordination and monitoring in collaboration with clinical services and probation or parole

Peer Support Specialists:
People with lived experience of a mental illness or addiction in sustained recovery who are trained to support others

Create Strategic Plan



Establish committee to create a strategic plan to increase number of community behavioral health providers in the state, especially in rural areas

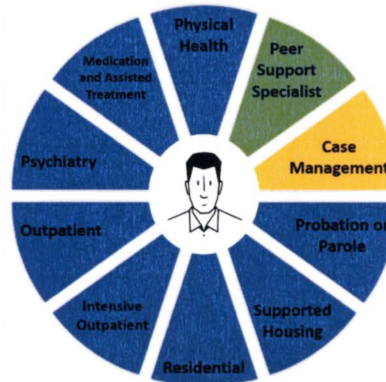
Fund and Implement Plan

Begin investing to implement strategic behavioral health workforce plans for items such as:

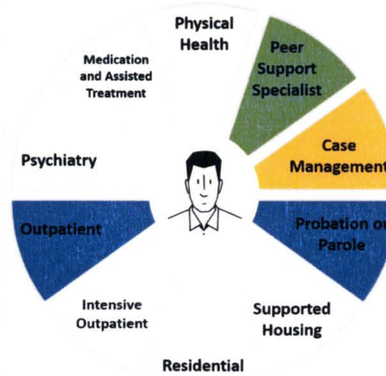
- Scholarships and loan forgiveness
- Outreach to develop interest in professions in rural areas
- Strengthening of "distance learning" opportunities
- Strengthening of behavioral health career ladders
- Supports for clinical supervision services
- Strategies for out of state recruitment and retention
- Psychiatric fellowships

Increase Access to Services

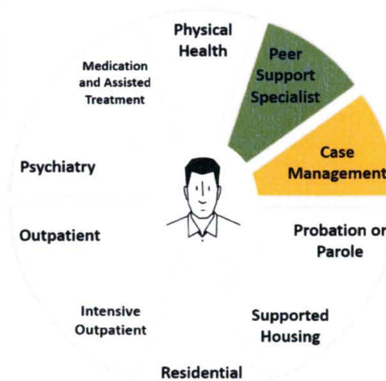
Rationale: Improve healthcare outcomes and reduce recidivism by 20 to 30 percent by delivering high-quality community behavioral health treatment with effective supervision *



Tier 1: Comprehensive and intensive services for target population to stabilize behavioral health conditions and reduce criminal justice involvement



Tier 2: Moderate array of services designed to people sustain and strengthen their early recovery and reduce their risk for recidivism



Tier 3: Minimal services for people to help sustain full recovery, monitor for relapse and minimize additional justice involvement

* Washington State Institute for Public Policy, Evidence-Based Adult Corrections Programs: What Works and What Does Not, January 2006 ; D. A. Andrews and James Bonta, *The Psychology of Criminal Conduct, 5th ed. (New Providence, NJ: Mathew and Bender & Company, Inc., 2010).*

#3

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Senate Bill 2274 – Increases the availability of and access to effective community-based behavioral health treatment for people in the criminal justice system

Justice Reinvestment in North Dakota

Senate Bill 2274 is part of North Dakota's justice reinvestment approach, which is designed to avert growth in corrections populations and shift a portion of avoided costs into strategies to increase public safety. The policy framework in is estimated to avert forecasted growth in North Dakota's prison population and avert a minimum of $63.8 million in future costs, providing the state financial flexibility to make reinvestments, including increasing access to high-quality community behavioral health treatment services needed to reduce recidivism.

Senate Bill 2274 increases access to high-quality community behavioral health treatment that, when combined with effective supervision, is shown to reduce recidivism. The legislation:

- Establishes private-public partnerships to improve quality and timely access to behavioral health treatment services for criminal justice-involved people with mental illness and/or substance use disorders;
- Establishes contracts with private health provider agencies with linkages to services provided in the regional human services centers;
- Creates a strategic plan to increase the state's behavioral health workforce to meet population requirements.
- Conducts an extended study of the status, effectiveness, and sustainability of the community behavioral health program noted above to inform action moving forward.

Rationale

Stakeholders report that people on community supervision—especially those who live in rural areas—have difficulty accessing behavioral health treatment due to insufficient service capacity and not enough providers. 70 percent of judges reported sentencing people to prison to connect them with mental health or substance use treatment. Probation and parole officers reported that 75 percent or more of their clients needed substance use treatment but struggled to find those services in the community.[1] Untreated mental illnesses and substance use disorders contribute significantly to people's ongoing involvement in the criminal justice system. Research suggests that for adults with mental illnesses and substance use disorders, supervision combined with treatment is more effective at reducing recidivism than supervision alone.[2] Insufficient community-based treatment resources greatly limit the state's ability to address treatment needs, improve outcomes, and reduce recidivism, and therefore pose a challenge to public safety.

SB 2274 will address the above by cultivating an adequate network of community behavioral health care practitioners and increasing access to effective community-based behavioral health treatment for people in the criminal justice system. To increase the network of community behavioral health care providers, the state must implement short-, medium-, and long-term strategies.

A. Short-term Strategy

Require the Department of Human Services (DHS) and Department of Corrections and Rehabilitation (DOCR) to establish training and certification for peer support specialist positions to work with people in the criminal justice system. Require the provision of case management services within the private-public service delivery system to ensure appropriate case management, collaboration, coordination and communication to improve outcomes.

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[1] 2014 CSG Justice Center North Dakota Judicial Survey; CSG Justice Center Probation and Parole Officer Survey.

[2] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment* (2009).

B. Medium-term Strategy

Develop a statewide strategic plan for increasing the number of community-based behavioral health care providers who have received the necessary education and training to work with criminal justice populations. By developing a strategic plan to cultivate an adequate network of appropriately trained community-based behavioral health care providers in rural areas, the state can begin to meet the behavioral health needs of people in the criminal justice system and reduce recidivism.

C. Long-term Strategy

This policy option requires funding sufficient to implement the workforce strategic plan. Strategies may include;

- Strengthening of behavioral health career ladders
- Outreach to create interest in behavioral health careers
- Incentives to bolster recruitment and retention
- Loan forgiveness and scholarships
- Funding supports for clinical supervision

DHS and DOCR may also collaborate with North Dakota's systems of higher education to develop specialized curricula can prepare health care workers to be effective in working with criminal justice populations.

SB 2274 increases access to effective community-based behavioral health treatment by creating a partnership between private health care providers and DHS to ensure that people in the criminal justice system have access to a full continuum of support services. To encourage quality of care, private health care providers will have an opportunity to earn value-based incentives where they receive additional funding for meeting target outcomes set by DHS.

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Fraser, Ltd.
Individual Consumers & Families

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Attach #4
1/25

Testimony
Senate Human Services Committee
Senator Judy Lee, Chairman
January 25, 2017

Chairman Lee and members of the committee, my name is Carlotta McCleary. I am the Executive Director for both North Dakota Federation of Families for Children's Mental Health (NDFFCMH) and Mental Health America of North Dakota (MHAND). Today I speak on behalf of the Mental Health Advocacy Network (MHAN) in support of Senate Bill 2274 and how this effort can be the start that we need to address the behavioral health crisis in the state of North Dakota. MHAN advocates for a consumer/family driven mental health system of care that provides an array of service choices that are timely, responsive, and effective.

MHAN has provided testimony throughout the interim human service committee meetings regarding our priorities. We argue that peer to peer and family support, consumer choice, diversion from corrections, a core services zero-reject model, and conflict free grievance and appeals processes, and the access to a full and functional continuum of care serve as the backbone to correcting the crisis in North Dakota's behavioral health system.

In the time since MHAN started testifying on these issues, there has been a growing consensus that the status-quo must not be tolerated. The Interim Incarceration Issues Committee had been notified that more than two thirds of North Dakota judges have sentenced someone to prison—even if they were not a high-risk offender—in order to receive behavioral health services. For years the crisis was brewing, but in 2013 the North Dakota legislature chose to address the growing problem regarding the lack of services in North Dakota's mental health system. The legislature most notably commissioned the Schulte Report in 2013, which was released the following July. The Schulte Report

made it resoundingly clear that this system is in crisis and drastic action must be taken. Hopes were high for the 2015 legislative session, and while progress was very modest, progress was being made. Then the allotment came. Nearly all of the gains that were made were taken away.

The Schulte Report delivered a warning to the state of North Dakota when it said, “Lawsuits are happening across the country in states which are not offering a choice of services to individuals or requiring that they seek only institutional care.” This is in reference to the *Olmstead* decision of 1999, regarding the Americans with Disabilities Act. MHAN is often asked if we will pursue litigation against the state of North Dakota. To that we respond: all options are on the table. We would like the North Dakota legislature to lead in developing the state’s policy for community mental health services, not the courts or the federal government. You have opportunity here. Schulte did say that the state of North Dakota was well-equipped to tackle the crisis. “North Dakota has all the resources and experience it needs to turn things around.”

That is why Senate Bill 2274 is important. MHAN believes diversion from the North Dakota Corrections System is a top priority in systemic planning efforts through prevention, early intervention and treatment. While this bill does not address all of the behavioral health needs in North Dakota, it does address alternatives to incarceration as well as prevent recidivism for those with behavioral health needs. We urge you to support Senate Bill 2274.

Thank you for your time and I would be happy to take any questions you have.

Carlotta McCleary, Spokesperson
Mental Health Advocacy Network
523 North 4th Street
Bismarck ND 58501
Email: cmccleary@mhand.org
Phone: (701)255-3692

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The Mental Health Advocacy Network (MHAN)

A coalition for North Dakota

Mission: MHAN advocates for a consumer/family driven mental health system of care that provides an array of service choices that are timely, responsive and effective.

Members of MHAN have long recognized the lack of mental health care and treatment in the state. With the release of the Schulte Report* in the summer of 2014, policymakers, including the North Dakota legislature, also became keenly aware of the crisis in mental health - and the associated risks of maintaining the status quo. Following the release of the Schulte Report, legislators also heard from the Bazelon Center for Mental Health Law, relative to the State's legal obligations for behavioral health services. MHAN was formed to assure that consumer and family voices are included in recommendations for improvements and in decision-making.

Values: MHAN values the work done by many in this arena including the ND Department of Human Services and County Social Service agencies, legislators, public and private sector providers and the Behavioral Health Stakeholder group. However, these efforts do not go far enough – or respond quickly enough to solve the critical nature of the gaps in service, the lack of access and, ultimately, to the prevention of loss of life. Additionally, there has not been an intentional effort to engage consumers and obtain family input for these deliberations. For those reasons, MHAN shares the following values, upon which we build a case for leadership and action for policymakers and the public to consider.

1. **Peer-to-Peer and Family-to-family Support:** MHAN believes that these services should be included and adequately funded (not volunteer, but with fair wages and benefits) in every region of the state through Regional Recovery Centers, family and consumer run non-profits, or other appropriate outlets. Schulte agrees: ***"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 services."***

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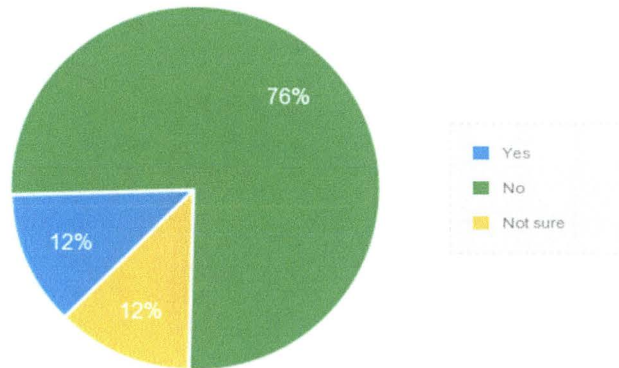
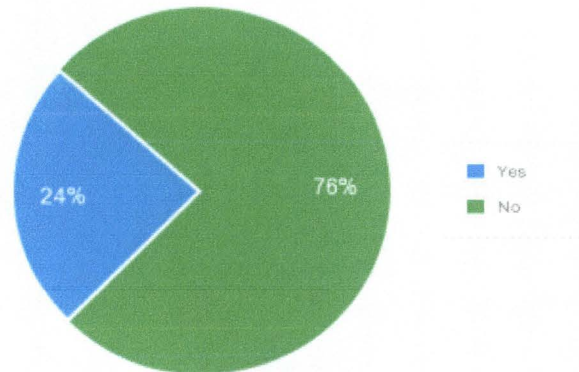
2. **Consumer Choice:** When someone with a mental health disorder is poor, or uninsured in North Dakota, one is captive to the services made available through the Regional Human Service Center. While these services are intended to be effective, they are not available equitably in all regions, nor are they adequate to meet the need. MHAN believes that the state should redirect funding through a voucher system or like model, to allow consumers choice and access to services in the private sector. Such choice can foster results driven accountability. Schulte agrees: ***"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. The HSCs are the sole provider of many services not giving consumers any options. 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. 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 was noted."***

Do consumers and families have sufficient choices in their local community where they can obtain mental health services? *223 Professionals surveyed said....*



In your opinion, are there sufficient choices in your local community on where or a family member can obtain mental health services? *149 consumers surveyed said....*



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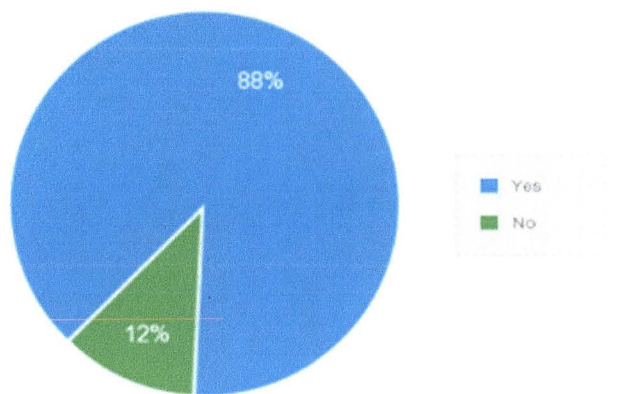
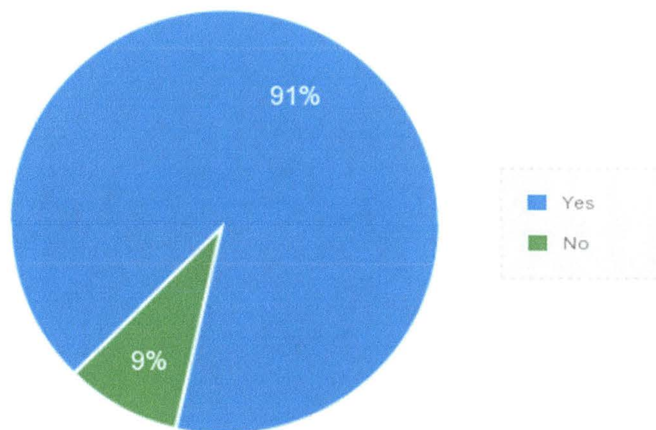
3. **Diversion from Corrections Systems:** Too many North Dakotans are ending up in youth or adult corrections systems due to lack of mental health care, both inpatient and outpatient. MHAN believes that diversion needs to be a top priority in systemic planning efforts through prevention, early intervention and treatment. A recent report from the ND Department of Corrections and Rehabilitation supports this premise: ***In ND 63% of youth in juvenile corrections have mental health concerns that require a medication that must be managed by psychiatry staff. 41% of female inmates have mental health concerns that are being treated by DOCR psychiatry staff.***

Are you aware of children being in a detention center, youth correctional centers, or jail due to a behavioral health issue? *223 professionals surveyed said...*



Are you aware of consumers being involved with the criminal justice system due to a behavioral health issue? *223 professionals surveyed said...*



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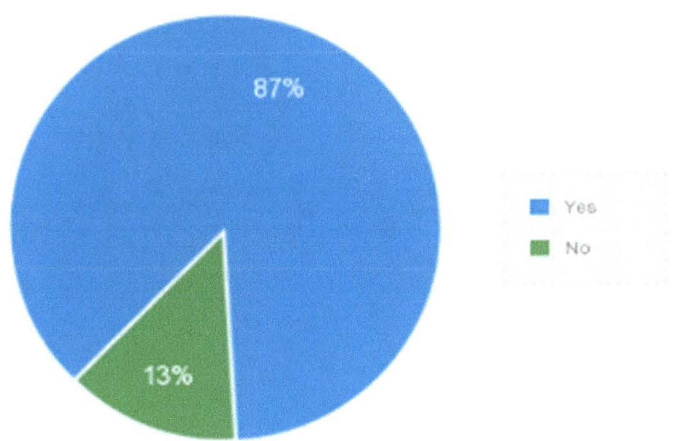
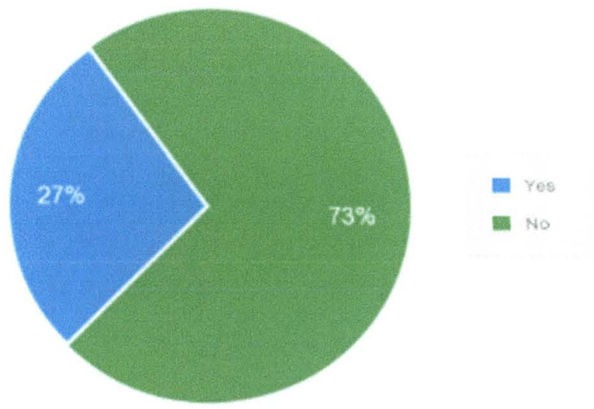
Have children been involved with the juvenile justice system due to behavioral health issues? *223 professionals surveyed said....*



4. **Core Services, Zero Reject Model and Adequate Funding for Public and Private Services:** MHAN believes that consumers and families are key to defining the core services they need to maintain good mental health and productivity. MHAN believes that a state system of care requires a zero- reject model rather than turning people away because of waiting lists, wait times, non-cooperation or being too sick or not sick enough. Adequate funding for mental health services is a federal requirement that is not being met by the State of North Dakota, thus exposing the state to legal action. Schulte agrees. The Schulte Report said another goal is to: ***"Increase funding options for youth and adults" as "There is a large gap in funding options for services in North Dakota." The study judged that, "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."***

Do consumers and families have convenient access to mental health services in their local community? *223 professionals surveyed said...*



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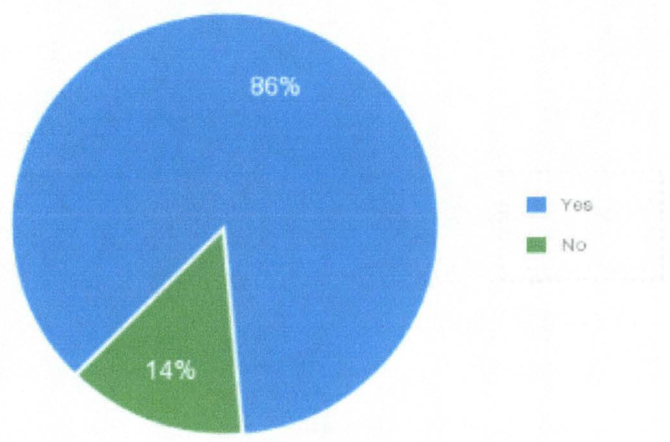
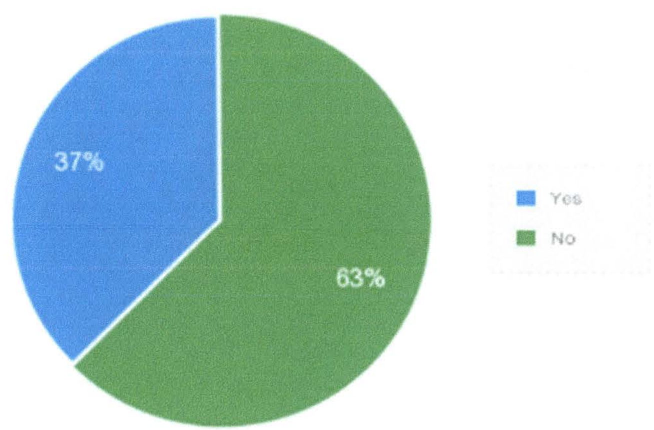
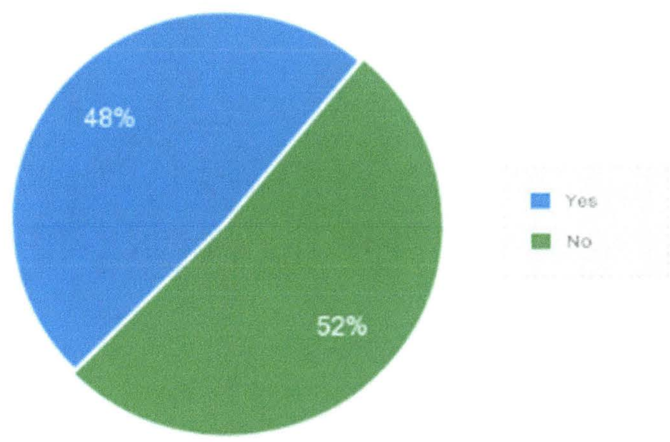
Are consumers and families experiencing waiting times to receive any mental health services? *223 professionals surveyed said...*



Are consumers and families able to access the mental health coverage then need with their insurance/medical plan? *223 professionals surveyed said...*



Have families been asked or recommended to relinquish custody of their child in order for the child to obtain mental health services? *223 professionals surveyed said...*



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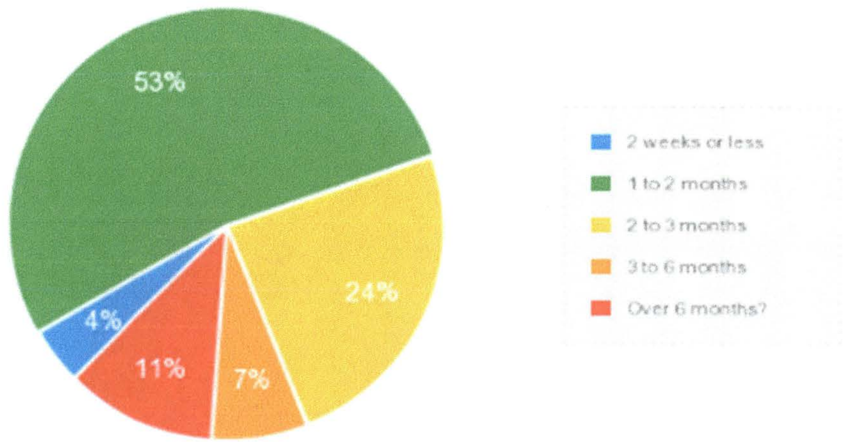
5. **Conflict Free Grievance and Appeals Processes**: When consumers and families are faced with a concern about DHS services, they have nowhere, other than the DHS, to turn. Schulte states it best and MHAN agrees: ***"When looking at the system in North Dakota, one thing that sets it apart from many 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."***

6. <u>**Access to a Full and Functional Continuum of Care**</u> that provides people with disabilities the rights to receive services in the most integrated setting appropriate, as described by the Olmstead decision (1999). People with mental disabilities, and those at risk, must also be afforded community-based treatment when appropriate, as indicated in the Americans with Disabilities Act (ADA – 1990). Community-based supports might include mobile crisis intervention, crisis residential placement, recovery centers, supportive housing, employment training and opportunities, and benefits planning for money management. Schulte agrees: ***"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."***

List the length of wait time to receive any mental health services. *223 professionals surveyed said...*



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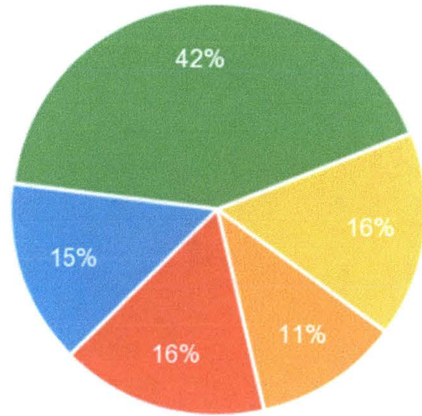
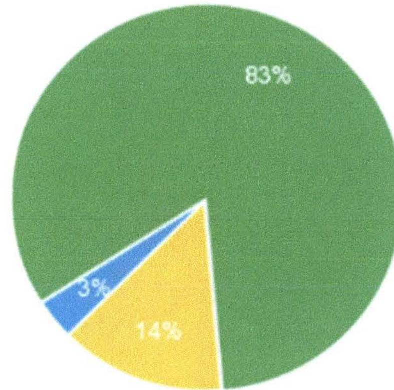
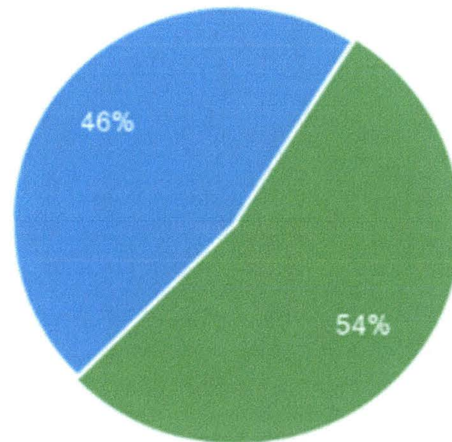
List the length of wait times to receive any mental health services. *149 consumers surveyed said…*

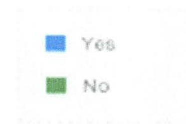


Are there sufficient crisis residential facilities in the consumer's and family's local community? *223 professionals surveyed said…*



Have you or a family member been in need of phone crisis services to address emergency mental health needs at any time? *149 consumers surveyed said…*





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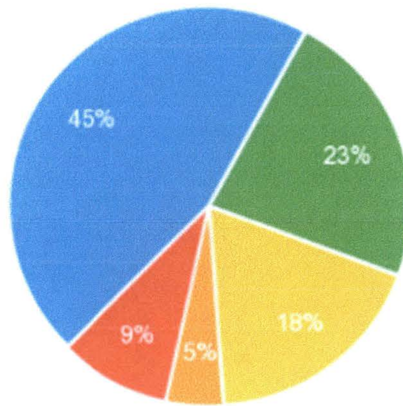
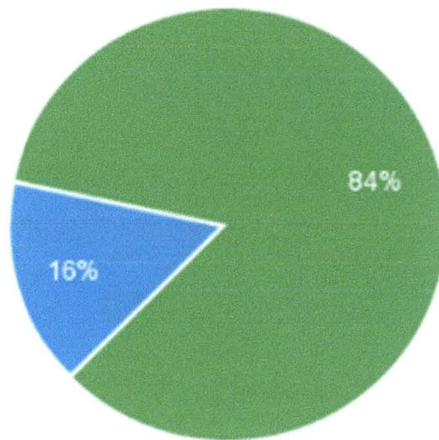
Please rate your satisfaction with phone crisis services to address emergency mental health needs. *149 consumers surveyed said….*



In your opinion, are there sufficient crisis residential facilities in your local community? *149 consumers surveyed said…*



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The Mental Health Advocacy Network stands in support of the efforts of people and organizations that work to improve services for those who live with mental illnesses. However, MHAN insists on the direct involvement of consumers and families, including those from tribal and rural areas, as well as Veterans, in prevention, education, service planning and delivery - nothing about us without us.

The Mental Health Advocacy Network supports a responsive and immediate solution to the existing gaps in mental health services in North Dakota and rejects the notion of a phased-in, years-long approach to service development. For many North Dakotans, this is a matter of life and death. To quote Schulte again, the ***"...system is in crisis."***

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SCHULTE Report

In the summer of 2014, the Shulte Report* made policymakers and legislators keenly aware of the mental health crisis in North Dakota — and the associated risks of maintaining the status quo. MHAN was formed to assure consumer and family voices are included in recommendations for improvements and in decision-making.

*For the full report, go to: http://www.mhan.org

MENTAL HEALTH ADVOCACY NETWORK
A DIVISION OF MENTAL HEALTH AMERICA NORTH DAKOTA
523 North 4th Street | Bismarck, ND 58501
mhan.org | mhand.org

A North Dakota Coalition advocating for consumer driven mental health services. MHAN calls for immediate solutions to gaps in services.

Mental Health Advocacy Network

pg. 1

WE Support

- **PEER TO PEER AND FAMILY TO FAMILY SUPPORT:** These are evidenced-based mutual support programs proven highly effective and fiscally efficient.
- **CONSUMER CHOICE:** A voucher system or like model to allow cons[illegible] choice and access to services in the private sector.
- **DIVERSION FROM CORRECTION SYSTEMS:** A top priority in systemic planning efforts, prevention, early intervention, and treatment are important.
- **A ZERO REJECT MODEL.** Consumers and families can provide solid input to core services, but adequate state funding is needed.
- **INDEPENDENT AND IMPARTIAL GRIEVANCE AND APPEAL PROCEDURES.** Mental health providers should not review themselves.
- **ACCESS TO A FULL AND FUNCTIONAL CONTINUUM OF CARE THAT PROVIDES OPTIONS FOR SERVICES IN OUR COMMUNITIES.**

MHAN Believes

Nothing about us—without us…

- Direct involvement of consumers and families, veterans and those from rural and tribal communities in shaping prevention and intervention, service planning, and delivery.
- [illegible]e is value in the work being [illegible]e by individuals, communities, and legislators to improve services. However, these efforts do not go nearly far enough to prevent the loss of life.
- We believe the North Dakota Mental Health System is in crisis.

THE NEED IS Immediate

- 18.1% of adult North Dakotans (roughly 105,523) have experienced some form of mental illness.
  (SAMHSA's 2014 National Survey on Drug Use and Health and Kids Count's 2015 Population Estimates for North Dakota.)
- Between 13 to 20% of children in North Dakota (between 22,610 and 34,785) have a mental disorder.
  (Center for Disease Control and Prevention "Mental Health Surveillance Among Children-United States, 2005-2011" and North Dakota Kids Count's 2015).
- F-M Ambulance Services in North Dakota report that 1/3 of their calls are behavioral health related, including depression, suicidal ideation, anxiety and depression.
  Sherm Syverson, F-M Ambulance Service Testimony (March 8, 2016).
- 70% of North Dakota judges have sentenced at least one person to prison (even if they were not considered high-risk) to receive mental health, alcohol, or drug addiction treatment.
  ("Justice Reinvestment in North Dakota: Interim Report," (April 20, 2016.)
- 89% of youth in juvenile corrections have mental health problems.
  Director of Division of Juvenile Services, North Dakota Department of Corrections and Rehabilitation Testimony (January 6, 2016).
- 75% of youth in juvenile corrections have a serious emotional disorder.
  Director of Division of Juvenile Services, North Dakota Department of Corrections and Rehabilitation Testimony (January 6, 2016).
- 56% of youth in juvenile corrections have a mental health issue that requires medication which must be monitored by psychiatry.
  Director of Division of Juvenile Services, North Dakota Department of Corrections and Rehabilitation Testimony (January 6, 2016).
- Approximately 44% of the inmate population is diagnosed with a mental illness and 30% are prescribed psychiatric medications.
  North Dakota Department of Corrections and Rehabilitation, 2011-2013 Biennial Report.

Together

Individuals, families, professionals, and legislators can positively effect change.

- Peer and family supports should be adequately funded.
- Consumer choice should be equitable in all regions of the state by developing a model to access private services through individual vouchers.
- Avoid overuse of correction systems due to lack of mental health care.
- Treatment should be recovery-focused.
- A proper checks and balances model.
- A choice of home and community-based services to avoid institutional care.

Mental Health Advocacy Network (MHAN) is a grassroots organization created to highlight issues and bring awareness to mental health service needs in North Dakota. You may also go to www.mhan.org to make an online contribution or for more information.

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House Appropriations – Human Resources Division

Sixty-fifth Legislative Assembly of North Dakota

Senate Bill No. 2274

January 25, 2017

Good Morning, Chairman Lee and Members of the Senate Human Services Committee: I am Pamela Mack, Director of Advocacy Services for the Protection & Advocacy Project (P&A).

P&A is an independent state agency. Its mission is to advocate for the human, civil, and legal rights of people with disabilities. P&A strives to ensure that every individual with a disability is treated with the same dignity and respect as all other ND citizens.

P&A is here today to support SB 2274 to address the need for community-based services for people with behavioral health needs who have become involved in the criminal justice system.

For many years now, P&A, through a partnership with the Department of Human Services (DHS) and the Department of Corrections & Rehabilitation (DOCR), has been discussing challenges that people with disabilities within the criminal justice system are facing. Through that collaboration, the "Individual Justice Planning" process (IJP) was brought into our current service delivery system.

The IJP process first began in the 1980's when people with Developmental Disabilities were leaving our state institution and moving into

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the community. Some of the unique behavioral issues that were being seen in our communities were concerning as they would be considered criminal behavior. In 2004, stakeholders from a number of entities within the state were convened to expand the use of the IJP process to people of all types of disabilities, to include people with behavioral health needs.

Here are two very helpful sections of the IJP manual, which provides a brief overview of the IJP process and how it can be used as part of prevention, diversion, alternatives to incarceration and as part of the re-entry process from Corrections:

Who is this manual intended to help?

This manual is intended to help people whose disability interferes with the full expression of their rights by the consideration of alternatives not explicitly offered through routine legal processes. In this manner, the Criminal Justice System (CJS) will be aided in its due process duties for the individual and to protect the public.

A person's disability may or may not impair that person's ability to interact with the CJS. This manual is designed to assist the people for whom the disability limits their ability to adequately interact with the CJS. An IJP is not appropriate for all individuals or situations and may not be agreed upon by all parties in the CJS process.

Purpose:

- First, it presents alternatives for the CJS to consider, as well as the resources, contacts, and tools needed to follow through with the process.
- Second, it provides a framework for education of and cooperation between private/public human service agencies and the various facets of the CJS. It is through this framework the two systems can provide the most appropriate services for people with disabilities with the best outcomes for everyone.

The IJP process is one tool that can be helpful in the process of addressing the needs of people with behavioral health issues who have become involved in the criminal justice system. However, the key to the success of an IJP also lies with the need to have services and supports within the community to meet the unique healthcare needs of people with behavioral health needs.

P&A has been involved with the development of IJPs for people with disabilities for over a decade now, with great success. P&A appreciates the Committee's ongoing efforts to address the need for community-based behavioral health services. This is a critical need within our state and SB 2274 will definitely be a step in the right direction.

Thank you for your consideration. I'm happy to answer questions that you may have.

An electronic copy of the IJP manual can be accessed on the P&A website.

http://www.ndpanda.org/docs/IndividualJusticePlanManualAccessible.pdf

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Individual Justice Plan (IJP)

Education Guide and Users Manual

Task Force on Justice Planning

Sponsored by

North Dakota Protection and Advocacy Project
Spring, 2005

TO OBTAIN THIS MATERIAL IN AN ALTERNATIVE FORMAT, PLEASE CONTACT THE PROJECT AT:
1-701-328-2950, 1-800-472-2670,
RELAY ND 711 TTY, or panda@nd.gov

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INDIVIDUAL JUSTICE PLAN STAKEHOLDERS

Protection & Advocacy Project
ND Center for Persons with Disabilities
Minot Police Department
Division of Juvenile Services
Parents/Guardians
ND Sheriff's and Deputies Association
ND Department of Corrections
ND Legislators
ND State Court System
ND Department of Human Services (DD, MHSA, NDDC & NDSH)
Mandan Police Department
Mental Health Association in North Dakota
ND Governor's Office
Dakota Center for Independent Living
ND Attorney General's Office
Attorneys at Law
Lake Region Special Education
Catholic Charities of North Dakota
Bismarck Police Department
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Red River Human Services Foundation
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Chapter 1

Introduction

Who is this manual intended to help?

This manual is intended to help people whose disability interferes with the full expression of their rights by the consideration of alternatives not explicitly offered through routine legal processes. In this manner, the Criminal Justice System (CJS) will be aided in its due process duties for the individual and to protect the public.

A person's disability may or may not impair that person's ability to interact with the CJS. This manual is designed to assist the people for whom the disability limits their ability to adequately interact with the CJS. An IJP is not appropriate for all individuals or situations and may not be agreed upon by all parties in the CJS process.

Vision:

Tailoring society's response to criminal behavior for people with disabilities.

Purpose:

The purpose of this manual is two-fold.

- First, it presents alternatives for the CJS to consider, as well as the resources, contacts, and tools needed to follow through with the process.
- Second, it provides a framework for education of and cooperation between private/public human service agencies and the various facets of the CJS. It is through this framework the two systems can provide the most appropriate services for people with disabilities with the best outcomes for everyone.

Scope of the Manual:

This manual is an attempt to integrate issues from the area of human services and the CJS and is designed to be a tool that can be used by people involved in these systems. This process is not intended as a safe-

harbor from all consequences or as a shortcut to negate civil rights – both of which can occur. Not everyone with a disability who encounters the CJS needs support beyond that of their attorney and other natural networks (family, friends, etc.). Therefore, an Individualized Justice Plan (IJP) is only effective when a concerned, caring, and respectful exchange of information results in the mutual advantage of both the society and the individual. The safety of the public is a priority in development of IJP services.

In order for this process to be effective, all people involved must share a common understanding and philosophy of how the process can be used and what can be accomplished with the use of an IJP. The IJP process is voluntary, provides a framework for services, and does not carry any legal authority to mandate or require services.

A list of terms and their definitions used within this manual is provided in Appendix 2.

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Chapter 2

WHO WILL BE SERVED BY THE INDIVIDUAL JUSTICE PLAN

Introduction

Individuals with disabilities have special needs, in general, and when encountering the CJS may require assistance beyond what is already available. For this reason the IJP is identified as a potential source of assistance.

Eligibility for an IJP

Eligibility for an IJP is based on significant mental/cognitive impairment as defined further in this chapter. This determination must be made by a qualified mental health professional[1]/human service professional and/or may also include a service delivery or treatment team. This impairment is: (1) persons with a developmental disability; (2) an individual with an identified brain injury that has resulted in severe cognitive impairment; (3) an individual with a major mental illness and significant impairment[2]. This should not be construed as excluding individuals with disabilities for assistance from the various identified community services.

Cognitive/mental impairment, broadly defined, substantially limits one or more of the following: (1) Learning; (2) Self-direction; (3) Receptive or expressive language; (4) Ability to understand. For further details, please refer to examples later in this chapter.

People with disabilities may not view themselves as incapable, different, or "limited" which can result in the disability going unnoticed. Most people with disabilities assume themselves to be capable and have developed many coping skills to "mask" any limitations, hiding their challenges from those around them. Police officers, attorneys, judges, and correctional staff may have difficulty recognizing subtle disabilities given the number of

[1] Source: NDCC Chapter 25-03.1-02,10a-f
[2] Any Axis I diagnosis with severe function limitation to include at least two major life areas: self-care, financial, social, occupational, mental/cognitive and legal-at least one of which requires cognitive/mental impairment.

people they encounter in the system. This may be compounded by co-occurring disabilities such as drug and alcohol abuse or dual diagnoses.

The individual may not view the process as beneficial or worthwhile, and may be reluctant to participate. Therefore, it may require someone within the individual's support network (e.g., team, physician, provider, advocate, family, defense attorney) to initiate, develop, and/or implement the IJP. This needs to include discussion with the individual about consent for the development and use of an IJP.

The following are case examples of individuals with a disability who have become involved with the CJS. Example IJPs are included in Appendix 5 for these cases.

Case example 1:
Joe is an 18 year old male with a diagnosis of mild mental retardation and depression. He recently graduated from high school with a modified diploma and is trying to find a job. He lives by himself in an apartment in the community. Joe began dating and is very happy because this is his first girlfriend. They decide that they are going to have intimate relationships. Late in the summer, police arrive on Joe's doorstep and take him to the police station for questioning. Joe tells the police officer that he has been dating this girl for the summer and that they had intimate relations. As a result, Joe is now being charged with committing a sexual offense because of the girl's age. Joe has no idea what he did wrong; he does not understand that this was a criminal act.

The IJP identifies increased compliance with the need for supervision in the community, and treatment and counseling recommendations to assist Joe to prevent further offending behaviors.

Case example 2:
Jim is a 38 year old male who has moderate mental retardation and a diagnosed impulse control disorder. He has struggled with community placements for many years because of physical aggression related to his diagnosis of impulse control disorder. When in community placements, he has had behavioral programming that has focused on maintaining an environment where he maintains control. This has at times been paired with medications to assist with his anxiety and impulse difficulties, however, he has experienced side effects from medications and changes in medications have taken place. During these periods of instability, he has

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"struck" the staff members whom work with him, typically when they have made requests of him that he perceives as frustrating.

The IJP identifies strategies and options for the provider to implement in an effort to prevent the behaviors from occurring.

Case example 3:

Marie is a 24-year old female who recently sustained a closed head injury as a result of a motorcycle accident. Marie has experienced a great deal of difficulty with impulse control since the accident. She has also experienced difficulties with memory recall. This affects her ability to take her medications, attend appointments as required and maintain her services. Marie has assaulted people within her home and community, and law enforcement personnel. Marie has also had difficulty with parenting her children and has been verbally and physically abusive toward them. Marie is currently facing three counts of assault and felony child abuse charges.

The IJP identifies services and supports that may address Marie's service needs.

Case example 4:

Mike has paranoid schizophrenia. This developed up out of Obsessive-Compulsive Disorder and he still has marked obsessions. This is complicated by strongly anti-capitalist views and a deep abhorrence of status ranking by and of humans. He values violent self-defense, death by violence, and is frequently despairing and self loathing. He has no friends. Over the course of his short life, Mike has abandoned all recreations save for listening to music and watching movies. He would like friends but finds the social interactions far too painful. Legally he is prone to fights but the only people he has assaulted that weren't actively castigating him are police officers or his own parents.
Past offenses include fighting at school, striking his mother and several assaults while at the hospital. Mike is currently facing charged of reckless endangerment, terrorizing, criminal mischief, and fleeing a police officer.

Mike's IJP has been developed to ensure that he complies with his medication regimen and also so that those working with him are aware of the structure of services that is needed in order to maintain Mike in the community.

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Chapter 3

An IJP and the Criminal Justice System (CJS)

How an IJP can be used within the CJS

A system's response to identify and advocate for an individual eligible for an IJP should be at the earliest point of contact by any agency working with the individual. This would require a clear understanding that the individual's disability, as defined in Chapter 2, is related to their potential involvement with the CJS.

If an individual with a disability is at risk of becoming involved in the CJS, their support network should be encouraged to consider the development of an IJP to outline responses to prevent involvement in the CJS. An IJP may also provide recommendations for a treatment plan when there is further involvement in the CJS.

The intent of an IJP is to identify the training, services, and support necessary to prevent criminal behavior from re-occurring. The IJP will reference other treatment or service plans that provide detailed information to effectively provide care. Examples of these plans can include: individual treatment plan, crisis plan, behavior support plan, medication management plan, aftercare plan and similar service delivery documents.

Once involved in the CJS there are various points within the process that development of an IJP may be considered, or can be referenced if an IJP already exists:

- **Upon initial contact with law enforcement personnel**.

  If a service agency or case manager is involved in an individual's care, notification that an IJP exists can be provided to law enforcement when initial contact or arrest occurs. This notation could then be included in any documentation completed by law enforcement. Notation of an IJP's existence could be in the law enforcement database, if available or utilized by a community.

- **Upon arrest and intake assessment by jail personnel**.

When an intake assessment is being conducted by jail personnel and an individual with a possible disability is identified, a referral should be made to their service provider if they identify one. If no provider is identified, a list of possible information sources in each region is provided in Appendix 3. This may provide a foundation of information that would immediately be available to the prosecution for consideration when charges are being filed. For example—Jail personnel could fax a list of new arrestees to the Human Service Center so this can be quickly identified.

- **When the case is sent to the municipal prosecutor/States Attorney's office for initial review.**
  If the option for an IJP is not identified during the first two steps of contact, a States Attorney/prosecuting attorney has the option to consider an IJP. This is also a point in time when fitness to proceed/ competency should be considered. If this is the situation that has arisen, the States Attorney/ Prosecuting Attorney can refer to Appendix 3 for possible information sources in an identified region to make a referral.

- **If not identified by a prosecutor or States Attorney, a judge does have the option to question whether an IJP would be appropriate for an individual with a disability**.

- **When a defense attorney becomes involved in the case.**
  A defense attorney may present an IJP as an option for an individual who has been charged and has been found to be eligible. The option of an IJP can be presented during the negotiation process with the prosecution. This can be used with initial charges being filed, amended charges and/or sentencing. If not identified by the States Attorney, the defense attorney may also question fitness to proceed/ competency.

- **During or after an order for examination of competency and/or fitness to proceed or criminal responsibility.**
  A professional assigned to do an examination relative to fitness to proceed, competency, or criminal responsibility has the option of identifying an IJP as being an effective tool to consider. If this occurs, it would be beneficial to have the examiner include this as a recommendation within their written document. This

recommendation would be available for the prosecution, defense attorney and judge to review and consider.

- **During the Pre-Sentence Investigation (PSI) process.**
  During the period of time when a PSI is being conducted, an IJP can be presented as an option to Department of Corrections and Rehabilitation (DOCR) staff conducting the investigation. An IJP can be a supplemental report that is attached to the PSI. Defense counsel will facilitate the incorporation of the IJP.

- **Reduction of Sentencing (Rule 35):**
  The Court, within 120 days after the offender has been sentenced, may entertain a motion for reduction in the sentence. Such motion must be to the judge as early as possible as the court loses jurisdiction at 120 days. Within this time, if it is determined that an offender is eligible for an IJP, who was not previously considered, a motion for reduction in sentence may be pursued in compliance with ND Century Code (NDCC) and Administrative Rules of the Court. Any party that wishes to introduce an IJP shall include confirmation that the individual is eligible for the IJP and the proposed plan.

- **During re-entry/aftercare planning**:
  If an individual who is eligible for an IJP is sentenced to a term in prison, an IJP may be developed prior to discharge to the community.

In summary, early identification and development of an IJP will maximize the impact for the benefit of both the individual and the CJS.

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Chapter 4

CONCEPTS

When designing an IJP, several concepts or themes must be kept in mind:

- **Accountability**: The IJP must be planned to ensure that the individual is accountable for his/her behavior, just as an every day citizen would be.

- **Competency**: The individual is presumed competent, unless otherwise established by the court.

- **Least Restrictive Alternative**: The IJP recommendations should be based on an approach that represents the least restrictive, effective alternative for the individual. This may mean the least restrictive alternative within a particular situation.

- **Control vs. Incarceration**: There may be other, less restrictive and more appropriate methods to ensure positive behavior support rather than incarceration. Incarceration is not only the most restrictive alternative but a costly one as well.

- **Due Process:** The IJP should ensure that due process is followed, and that the case can be handled in a timely and meaningful manner. Does the individual have access to an attorney? Has the individual been informed of his/her rights? Does he/she understand them? Has the individual given informed consent for the IJP?

- **Normalization**: Natural consequences should be utilized in an effort to provide a normalized lifestyle for the individual

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Chapter 5

WRITING THE INDIVIDUAL JUSTICE PLAN

This chapter will describe, in step-by-step fashion how to construct an IJP. The IJP outline and examples are summarized in Appendix 4 and 5.

I. PRESENTING PROBLEMS

The specific behaviors that brought the individual into the CJS should be described including how often, how severe, history of past offenses, and the likelihood of reoccurrence.

The social implications of the behavior should also be assessed in terms of the impact on the individual, other people, society and property. The potential impact on the individual may include loss of housing/housing assistance, other entitlement programs, services, prison, jail, parole/probation, fines, hospitalization/treatment, or other residential programs.

II. ASSESSMENT

The motivation or cause for the presenting problem needs to be thoroughly evaluated. The assessment phase outlines domains that should be considered. Within each domain, some questions to consider are:

- whether the domain is contributing to the presenting problem (e.g. skill deficit, environmental structure, medical problem);
- whether changes in a domain may lessen or eliminate the problem; and
- whether the domain constitutes an area of strength for the individual which may be built upon to assist in eliminating the problem.

The following domains of the individual's life should be examined to determine how they contribute to the problem or potential solutions:

A. Residential

- Does the current residential environment have an impact on the behavior?

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- Does the current setting meet the individual's needs in terms of the presenting behavior?
- Would a change in living environment be appropriate/recommended?

B. Vocational

- Does the individual's current job situation contribute to the behavior?
- Does it provide a source of stability and structure for the individual?
- Can the behavior be controlled in this setting?

C. Education/Training

- Does this individual have skill deficits (e.g., social skills, learning deficits, communication) that contribute to the presenting behavior?
- What, if any, further education/training might eliminate the behavior?

D. Medical

- Do medical needs or physical disabilities contribute to the behavior?
- Are there needs in this area that are unmet and may contribute to the behavior?
- Are medications taken and at proper dosage?

E. Mental/Behavioral Health

- Does the individual have a mental illness that contributes to the behavior?
- Does the individual have coping deficits that impact the behavior?
- Are services needed/appropriate to assist the individual?
- Are psychotropic medications taken and at proper dosage?

F. Financial

- Does the individual manage his/her own money?
- Is the behavior related to lack of funds or to mismanagement of money?
- Are services needed/appropriate to assist the individual?

G. Social/Recreation

- Does the individual have excessive free time and/or lack of ability to organize free time that contributes to the behavior?
- Does the individual have friends who may encourage the behavior?
- What services may assist the individual in positive development of skills in this domain?

H. Family

- Does the individual have an active and supportive family?
- Do family influences contribute to the behavior?
- Can family assist in appropriate behavior development?

I. Cultural background

- Are there cultural factors that should be included in the assessment process?
- Does culture have an impact on the behavior?
- Are services needed/appropriate to assist the individual?

J. Transportation

- How mobile is the individual?
- Do transportation factors contribute to the behavior?
- Is there accessible transportation available in the community?
- Are services needed/appropriate to assist the individual?

K. Advocacy

- Is the individual his/her own legal decision maker?
- Is the individual able to ensure his/her rights are upheld?
- Is an outside advocate needed/desired?
- Is a guardian needed?
- If a guardian has been appointed, is the guardian able to ensure his/her ward's rights are upheld?

L. Further Assessment

- Is there further assessment or other relevant information that would assist in identifying or addressing the behavior?

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III. RECOMMENDATIONS

Recommendations regarding resources available should be identified, clearly organized and an integration of the CJS and community-based services. The least-restrictive, most effective services should be recommended for implementation. Specific service providers/responsible parties should be identified for each recommendation.

The following support options should be considered:

A. Positive Behavior Supports: Systematic use of reinforcements to strengthen appropriate alternative behavior and consequences to help suppress the illegal behavior.

B. Counseling: The individual may benefit from a therapeutic effort such as one to one counseling or group therapy.

C. Supervision and/or case management: Increased supervision or case management services may be necessary to support an individual within the community.

D. Community Service: Engaging in a relatively less desirable activity may serve to suppress the problem behavior. This is usually a prearranged placement by the court. (Example: picking up garbage in a local park).

E. Hospitalization: Inpatient psychiatric services may be necessary for the individual at this time.

F. Agency Transfer: Another facility may be better equipped or provide more specialized treatment to address the behavior.

G. Other treatment/training: Further treatment or training may need to be considered.

H. Psychotropic medication management: Medication management issues may need to be addressed to ensure compliance, appropriateness of medications, and ongoing review by a physician.

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I. **Restitution**: If the individual is found guilty of a charge which involves damage to property or some other type of monetary loss to the victim, it may be appropriate for the individual to make some type of restitution to the victim or do some type of service for the victim.

J. **Fine:** A monetary fine may have the desired impact on the individual and result in suppression of the problem.

K. **Probation:** A probationary period may be indicated. A recommendation regarding level of supervision may be appropriate.

L. **Incarceration**: A sentence of incarceration may be indicated. This may include serving the customary sentence or a shorter but immediate jail sentence.

Based upon the outcomes, an IJP should be shared with entities that are involved. Throughout this process, there may be a need for continued involvement by the service system or case management.

IV. OTHER RECOMMENDATIONS

In addition to the recommendations noted in the previous section, the IJP team may have other recommendations that would serve to lessen or eliminate the presenting problem.

V. ANTICIPATED OUTCOME

The plan should specify in descriptive terms what the outcome(s) of the current situation should be. This may be evident by a treatment or service plan or identified services. Additionally, the plan should take into account the possible reoccurrence of the target behaviors and should include a written description of what will take place should the behaviors occur again.

For example: If the person has a developmental disability and one could expect that it would be life-long, an anticipated outcome may be that a behavioral supports are developed and that with ongoing training, the individual can learn appropriate behavior which would then eliminate the

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behavior that places them at risk of involvement in the criminal justice system.

VI. INTEGRATION

An IJP should be integrated within the individual's existing service plan.

VII. REVIEW OF THE IJP

A review process and responsible reviewer should be clearly outlined for each IJP (e.g., monthly, annually, or as needed).

VIII. CONSENT

An individual and their legal decision maker should be involved throughout the process of IJP development. Once the IJP is developed, the individual and/or legal decision-maker (guardian or custodian) must be fully informed of all components of the IJP. Written confirmation of this process and their consent must be documented on the IJP document. See Appendix 6 for informed consent form.

IX. CONFIDENTIALITY

An individual's records are considered confidential information and should not be disclosed without proper authorization. See Appendix 6 for sample authorization to disclose.

See Appendix 5 for examples of an IJP based on the case examples in Chapter 2.

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Chapter 6

THE NORTH DAKOTA LEGAL SYSTEM

PROCESS

Often when an individual with a disability is suspected of violating the law, involvement in the legal system is initiated. Throughout this process, careful consideration needs to be taken to ensure that the individual's rights are protected. A disability may affect a person's ability to understand and exercise their rights, initiate planned thoughts or actions, and ensure their right to due process. This is especially true in regard to the individual's ability to independently seek assistance throughout the process (e.g., involve defense counsel as early as possible). It is imperative that all involved parties are aware of their responsibilities and the aspects of the individual's disability that may affect his/her understanding. A flow chart that outlines the judicial process has been included in Appendix 8.

The information below outlines perspective responsibilities that various parties may have in the process. Some of these processes may be protections provided under the American with Disabilities Act (see Terms & Definitions in Appendix 2) and others may be requirements of the legal system in relation to criminal offenses.

ROLES

When developing an IJP, a number of people may be involved during various points of the process. The following is a list of people and the roles that they may play in the process. A list of regional referral/resources is included in Appendix 3.

Law Enforcement/Jail Personnel: In most cases the first point of contact for an individual coming into the legal system will be a law enforcement officer. Their role may be to interview the individual relative to the circumstances of the alleged crime. If they are concerned that the individual has a disability, this should be noted in the initial documentation. A referral should be made to the local human service center or advocacy agency to enlist assistance to assure that protections are provided. Law Enforcement Personnel should complete the IJP Referral Form (see Appendix 6) and include it with the initial report.

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States Attorney/Prosecuting Attorney: The next point of contact may be the States Attorney, who will determine if and what charges will be filed. The States Attorney may determine that an IJP is appropriate or may serve as a point of contact for others involved in the individual's life. If the States Attorney recognizes that the individual has a disability that is interfering with his/her understanding (e.g., has not obtained defense counsel), he/she may seek assistance from advocacy or human service personnel.

Defense Attorney: Many people with disabilities do not have the financial means to employ a defense attorney or have the ability to understand the process to apply for court appointed counsel. As a result, he/she may need assistance with this process. Other people who support the individual (advocate, mental health or human service professional, and perhaps the guardian, etc.) may be appropriate sources of information. Careful consideration needs to be given to protect attorney-client privilege. The defense attorney may also play a critical role in the identification of the need for, development of, and presentation of an IJP to the court.

Judge: If the presiding Judge recognizes that the individual has a disability that affects his/her understanding that has not been addressed, the Judge may ask for an evaluation of fitness/competency or provide other direction to the attorneys including consideration of an IJP.

Parole/Probation: Because an IJP can be initiated at several points throughout the legal process, parole/probation officers may have a role in the development and implementation of an IJP. This may occur during a pre-sentence investigation, a period of parole or probation, or following completion of a sentence.

OTHER CONSIDERATIONS:

Throughout the process, questions of fitness to proceed (criminal competency) or culpability should be considered by the defense attorney, states attorney, and Judge. Each of these terms has a specific legal meaning and context in which it is answered in a forensic evaluation. Capacity for making decisions, on the other hand, is generally considered in the context of the establishment of a guardianship.

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APPENDIX 1

History of the Individual Justice Plan

The Original IJP

In the spring of 1987 a group of professionals from the Fargo area met to discuss the development of a consistent response for people with developmental disabilities who may find themselves involved in the CJS. The goal of this group was to ensure that knowledge was obtained regarding the legal process and in addition, that the legal process has an increased awareness of issues related to people with developmental disabilities. Another goal of this group of professionals was to develop a cooperative effort between professionals in the field and the criminal justice system so that client's needs were first in people's minds. As commissioned by the Governor's Task Force on Developmental Disabilities, this group organized a statewide conference, held June 23rd & 24th, 1988. This was made possible through a grant from the North Dakota Developmental Disabilities Council. There was also the expectation that this conference be educational in nature and promote integration for these systems.

Along with this training effort, the group developed a manual, which included a process that could be used to develop an IJP. In the development stages of this manual, information was obtained from a variety of relevant sources, including the DD community, judges, lawyers, and law enforcement officials. In addition, a wealth of information was gathered from other states.

It was the hope of this group that the IJP process would continue to develop, and that the increased knowledge between the two systems would provide for a consistent and person-centered approach.

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Implementation Years

Throughout the next 17 years, the IJP process was utilized sporadically within the Developmental Disabilities (DD) system. Some agencies used variations of the initial processes as outlined in the original manual.

The New IJP

In early 2004, the ND Protection & Advocacy Project (P&A) was asked to revise the IJP manual and bring this process to the forefront of services. Discussion regarding this resulted in a commitment by P&A to spearhead the task of revising the manual.

The intention of the IJP process is to expand the concept to other areas of disability (major mental illness and brain injury), along with ensuring that there is adequate information regarding all other IJP-related systems included in the manual. The process began in June 2004 at which time P&A held the first IJP Stakeholders Meeting in Bismarck, ND. This large group was then represented by a steering committee, which was given the task of revising the manual and developing a training and implementation plan.

The revision of the manual continued through September 2005 when a draft manual was presented to the Stakeholders group for their review.

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APPENDIX 2

TERMS AND DEFINITIONS

(When available, official definitions were taken from ND Century Code)

Acquired/Traumatic Brain Injury[3] means an injury to the brain resulting in total or partial disability or impairment, that may result in mild, moderate, or severe impairments in one or more areas including cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem solving, sensory perceptual and motor abilities, psychosocial behavior, physical functioning, information processing, and speech. Traumatic brain injury refers to a physical injury caused by an external physical force including open and closed head injuries. The term does not include brain injuries that are congenital or degenerative or brain injuries induced by birth trauma, but may include brain injuries caused by anoxia and other related causes. Acquired refers to a brain injury caused by disease or other internal event (e.g., Stroke).

Advocacy[4] means action to assist or represent a person or group of person with developmental disabilities or mental illness in securing their rights, obtaining needed services, investigating complaints, and removing barriers to identified needs.

Americans with Disabilities Act (ADA)[5] The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. The ADA was signed into law by President, George H. W. Bush on July 26, 1990.

Assisting in Own Defense[6] means the essence of the ability to consult with an attorney with a reasonable degree of rational understanding is that the defendant must be able to confer coherently with counsel and formulate a defense.

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[3] Source: NDCC 50-06.4-01 (2) & http://cancerweb.ncl.ac.uk/cgi-bin/omd
[4] Source: NDCC 25-01.3-01 (2)
[5] Source: US Department of Justice
[6] Source: State v. VanNatta, 506 N.W. 2d 63 (N.D. 1993)

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Attorney-client privilege[7] means that whatever is communicated by a client to his attorney acting in his professional capacity is considered as a confidential communication and the latter is not permitted to divulge it, for it is the privilege of the client and not of the attorney. Various jurisdictions extend this principle to communications with priests, doctors and others.

Behavior Support Plan is a plan developed by an interdisciplinary team working with a person that focuses on behaviors that are of a concern and strategies to replace the behaviors with more appropriate behaviors.

Capacity/Incapacity[8] A contention of diminished capacity means that although the accused was not insane, due to emotional distress, physical condition or other factors he/she could not fully comprehend the nature of the criminal act he/she is accused of committing, particularly murder or attempted murder. It is raised by the defense in attempts to remove the element of premeditation or criminal intent and thus obtain a conviction for a lesser crime, such as manslaughter instead of murder. While the theory has some legitimacy, at times juries have been overly impressed by psychiatric testimony. The most notorious case was in People v. Dan White, the admitted killer of San Francisco Mayor George Moscone and Supervisor Harvey Milk, who got only a manslaughter conviction on the basis that his capacity was diminished by the sugar content of his blood due to eating "Twinkies."

Community service[9] means performing work within the community as part of sentencing for committing a criminal act. Community service may be imposed in place of other sentencing, e.g. community service work in place of a fine being imposed.

Confidential (meeting or records)[10] means all or part of a record or meeting that is either expressly declared confidential or is prohibited from being open to the public for further disseminate.

Consent [11] means to voluntarily agree to an act or proposal of another, which may range from contracts to sexual relations.

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[7] Source: Lectric Law Library
[8] Source: http://dictionary.law.com
[9] Source: Merriam-Webster's Dictionary of Law, © 1996 Merriam-Webster, Inc.
[10] Source: NDCC 44-04-17.1 (3)
[11] Source: Merriam-Webster's Dictionary of Law, © 1996 Merriam-Webster, Inc.

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3 elements of consent

Information-All relevant facts and material must be provided and include:

- Full explanation of the procedure/action.
- Purpose of the procedure/action
- Description of presumed benefits and potential risks or discomforts that could be involved.
- Description of alternatives, with their potential risks/benefits.
- Statements explaining they are free to withdraw their consent

Capacity-Ability to make a decision

- Mental competence to understand what is happening, and to understand the consequence of their decisions/actions.
- Ability to engage in an objective and rational decision-making process.
- Be capable or expressing their decision.
- Be of majority age (although the same procedure should be encouraged with children to teach them how to make decisions and accept responsibility).

Voluntary- freely

- Freedom from coercion, or duress, intentional or unintentional.
- Concurrent or substitute consent-someone else making the decision.
- Person should be free from any conflict of interested and unbiased.

  Person must act on the basis of the best interest of the person involved.

  Person must be competent, adequately informed, and free from any coercion.

Correction or Reduction of Sentence[12]

(a) Correction of Sentence. The sentencing court may correct an illegal sentence at any time and may correct a sentence imposed in an illegal manner within the time provided herein for the reduction of sentence.

(b) Reduction of Sentence. The sentencing court may reduce a sentence within 120 days after the sentence is imposed or probation is revoked, or within 120 days after receipt by that court of a mandate issued upon affirmance of the judgment or dismissal of the appeal, or within 120 days

[12] Souce: ND Supreme Court Rules, Rule #35

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after entry of any order or judgment of the Supreme Court of the United States denying review of, or having the effect of upholding a judgment of conviction or probation revocation. Changing a sentence from a sentence of incarceration to a grant of probation constitutes a permissible reduction of sentence under this subdivision. Relief under this Rule may be granted by the court only upon motion of a party or its own motion and notice to the parties. If the sentencing court grants relief under this Rule, it shall state its reasons therefore in writing.

Criminal responsibility[13] means:

1: An individual is not criminally responsible for criminal conduct if, as a result of mental disease or defect existing at the time the conduct occurs:

a. The individual lacks substantial capacity to comprehend the harmful nature or consequences of the conduct, or the conduct is the result of a loss or serious distortion of the individual's capacity to recognize reality; and

b. It is an essential element of the crime charged that the individual act willfully.

2: For purposes of this chapter, repeated criminal or similar antisocial conduct, or impairment of mental condition caused primarily by voluntary use of alcoholic beverages or controlled substances immediately before or contemporaneously with the alleged offense, does not constitute in itself mental illness or defect at the time of the alleged offense. Evidence of the conduct or impairment may be probative in conjunction with other evidence to establish mental illness or defect.

Culpable[14] A determination that a person is sufficiently responsible for criminal acts or negligence and thus to be at fault and liable for the conduct. Sometimes culpability rests on whether the person realized the wrongful nature of his/her actions and thus should take the blame.

Court appointed counsel means a lawyer hired and appointed by the court to defend a person against specific charges. The lawyer is not then the person's general purpose lawyer.

Defense Attorney[15] means:

[13] Source: NDCC 12.1-04.1-01 (1a & 1b)

[14] Source: http://dictionary.law.com

[15] Source: http://dictionary.law.com

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1: the attorney representing the defendant in a lawsuit or criminal prosecution
2: a lawyer who regularly represents defendants who have insurance and who is chosen by the insurance company
3: a lawyer who regularly represents criminal defendants. Attorneys who regularly represent clients in actions for damages are often called "plaintiff's attorneys."

There are standards for defense attorneys that apply within the State of ND. These include the American Bar Association, Department of Justice Compendium Standards and the National Legal Aid and Defenders Association.

Developmental Disability[16] means a severe, chronic disability of a person which:

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
b. Is manifested before the person attains age twenty-two;
c. Is likely to continue indefinitely;
d. Results in substantial functional limitations in three or more of the following areas of major life activity:
   (1) Self care;
   (2) Receptive and expressive language;
   (3) Learning;
   (4) Mobility;
   (5) Self-direction;
   (6) Capacity for independently living
   (7) Economic self-sufficiency; and
e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong extended duration and are individually planned and coordinate.

Disposition of mentally unfit defendants[17] No person who, as a result of mental disease or defect, lacks capacity to understand the proceedings against the person or to assist in the person's own defense shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity endures.

[16] Source: NDCC 25-01.2-01 (1)
[17] Source: NDCC 12.1-04-04

Dual-diagnosis[18] means the presence of one or more disabilities that significantly impact a person's life. For example, a person who has both an alcohol or drug problem and an emotional/psychiatric problem is said to have a dual diagnosis. Another example is a person who has a developmental disability and an emotional/psychiatric problem is also said to have a dual diagnosis. This may also be referred to as co-occurring disorders.

Due process[19] means:

1 : a course of formal proceedings (as judicial proceedings) carried out regularly, fairly, and in accordance with established rules and principles called also *procedural due process*

2 : a requirement that laws and regulations must be related to a legitimate government interest (as crime prevention) and may not contain provisions that result in the unfair or arbitrary treatment of an individual called also *substantive due process*

Fine[20] means a financial penalty imposed by a judge on a party or attorney for violation of a court rule, for receiving a special waiver of a rule, as a fine for contempt of court or as a penalty for committing a crime. If a fine, the sanction is paid to the court.

Guardianship[21] means a person who has been appointed by a judge to take care of a minor child or incompetent adult (both called "ward") personally and/or manage that person's affairs.

Incarcerate[22] means:

1 : to put in prison

2 : to subject to confinement

Incompetency[23] means that a defendant is incompetent to stand trial when he neither has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, nor a rational as well as factual understanding of the proceedings against him.

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[18] Source: National Mental Health Association, www.nmha.org

[19] Source: Merriam-Webster's Dictionary of Law, © 1996 Merriam-Webster, Inc.

[20] Source: http://dictionary.law.com

[21] Source: http://dictionary.law.com & NDCC 30.1-26

[22] Source: Merriam-Webster's Dictionary of Law, © 1996 Merriam-Webster, Inc.

[23] Source: State v. Heger, 326 N.W.2d 855 (N.D. 1982); State v. VanNatta, 506 N.W. 2d 63 (N.D. 1993)

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Least restrictive form of intervention (in relation to guardianship)[24] means that the guardianship imposed on the ward must compensate for only those limitations necessary to provide the needed care and services, and that the ward must enjoy the greatest amount of person freedom and civil liberties consistent with the ward's mental and physical limitations.

Mental Health Professional[25] means:

a. A psychologist with at least a master's degree who has been either licensed or approved for exemption by the North Dakota board of psychology examiners.
b. A social worker with a master's degree in social work from an accredited program.
c. A registered nurse with a master's degree in psychiatric and mental health nursing from an accredited program.
d. A registered nurse with a minimum of two years of psychiatric clinical experience under the supervision of a registered nurse as defined by subdivision c or of an expert examiner.
e. A licensed addiction counselor.
f. A licensed professional counselor with a master's degree in counseling from an accredited program who has either successfully completed the advanced training beyond the master's degree as required by the national academy of mental health counselors or a minimum of two years of clinical experience in a mental health agency or setting under the supervision of a psychiatrist or psychologist.

Mental Illness[26] means significant mental illness or emotional impairment as determined by a mental health professional.

Mentally Ill Person[27] means an individual with an organic, mental, or emotional disorder which substantially impairs the capacity to use self-control, judgment, and discretion in the conduct of personal affairs and social relations. "Mentally ill person" does not include a mentally retarded or mentally deficient person of significantly sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior. Chemical dependency

[24] Source: NDCC 30.1-26-01 (3)
[25] Source: NDCC 25-03.1-02 (8)
[26] Source: NDCC 25-01.3-01 (12)
[27] Source: NDCC 25-03.1-02 (9)

does not per se constitute mental illness, although persons suffering from that condition may also be suffering from mental illness.

Mental Retardation[28] means significantly subaverage general intellectual functioning (IQ of 70 or less) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. The onset must occur before age 18 years.

Parole[29] means the release of a convicted criminal defendant after he/she has completed part of his/her prison sentence, based on the concept that during the period of parole, the released criminal can prove he/she is rehabilitated and can "make good" in society. A parole generally has a specific period and terms such as reporting to a parole officer, not associating with other ex-convicts, and staying out of trouble. Violation of the terms may result in revocation of parole and a return to prison to complete his/her sentence.

Pre-sentence investigation (PSI)[30] Before sentencing a defendant on a felony charge under section 12.1-20-03, 12.1-20-03.1, 12.1-20-11, 12.1-27.2-02, 12.1-27.2-03, 12.1-27.2-04, or 12.1-27.2-05, a court shall order the department of corrections and rehabilitation to conduct a presentence investigation and to prepare a presentence report. A presentence investigation for a charge under section 12.1-20-03 must include a risk assessment. A court may order the inclusion of a risk assessment in any presentence investigation. In all felony or class A misdemeanor offenses, in which force, as defined in section 12.1-01-04, or threat of force is an element of the offense or in violation of section 12.1-22-02, or an attempt to commit the offenses, a court, unless a presentence investigation has been ordered, must receive a criminal record report before the sentencing of the defendant. Unless otherwise ordered by the court, the criminal record report must be conducted by the department of corrections and rehabilitation after consulting with the prosecuting attorney regarding the defendant's criminal record. The criminal record report must be in writing, filed with the court before sentencing, and made a part of the court's record of the sentencing proceeding.

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[28] Source: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), Fourth Edition-American Psychiatric Association. In addition, NDCC 25-03.3-01 (3)

[29] Source: http://dictionary.law.com

[30] Source: NDCC 12.1-32-02 (11)

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Probation[31] means a chance to remain free (or serve only a short time) given by a judge to a person convicted of a crime instead of being sent to jail or prison, provided the person can be good. Probation is only given under specific court-ordered terms, such as performing public service work, staying away from liquor, paying a fine, maintaining good behavior, getting mental therapy and reporting regularly to a probation officer. Violation of probation terms will usually result in the person being sent to jail for the normal term. Repeat criminals are normally not eligible for probation.

Prosecutor/States Attorney[32] means the lawyer/public prosecutor that represents county government.

Psychotropic medications are medications that are prescribed by a physician to treat the symptoms of a mental illness.

Re-entry planning[33] is the process of preparing prisoners for release in ways that reduce their risk of re-offending. In reference to people with disabilities, this includes the establishment of appropriate supports and services within the community.

Restitution[34] means an amount of money to be paid to the victim of a crime. In determining whether to order restitution, the court shall take into account:

a. The reasonable damages sustained by the victim or victims of the criminal offense, which damages are limited to those directly related to the criminal offense and expenses actually incurred as a direct result of the defendant's criminal action. This can include an amount equal to the cost of necessary and related professional services and devices relating to physical, psychiatric, and psychological care. The defendant may be required as part of the sentence imposed by the court to pay the prescribed treatment costs for a victim of a sexual offense as defined in chapters 12.1-20 and 12.1-27.2.

b. The ability of the defendant to restore the fruits of the criminal action or to pay monetary reparations, or to otherwise take action to restore the victim's property.

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[31] Source: http://dictionary.law.com

[32] Source: NDCC 11-16-01 (1-16)

[33] Source: Transition from Prison to Community Initiative, Abt Associates and National Institute of Corrections

[34] Source: Merriam-Webster's Dictionary of Law, © 1996 Merriam-Webster, Inc. & NDCC 12.1-32-08 (1a, 1b & 1c)

c. The likelihood that attaching a condition relating to restitution or reparation will serve a valid rehabilitational purpose in the case of the particular offender considered.

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ASSOCIATIONS

(Updated 3/07)

Association for Persons with Severe Handicaps: .1-202-263-5600

Epilepsy Foundation of America:......................1-800-332-1000

Learning Disabilities Association of America:......1-412-341-1515

Indigenous Head Injury Association:.................1-701-222-3636
....1-800-489-5013

National Down Syndrome Society:....................1-800-221-4602

North Dakota Association for the Disabled:........1-701-775-5577

North Dakota Center for Disabilities:.................1-701-858-3580
....1-800-233-1737

North Dakota Long Term Care Association:........1-701-222-0660

North Dakota Mental Health Association:...........1-701-255-3692
....1-800-472-2911

Pathfinder Family Center:..............................1-701-837-7500
....1-800-245-5840

United Cerebral Palsy Association:....................1-800-872-5827

Federation of Families:..................................1-701-222-1223
....1-701-222-3310

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WILLISTON REGION – HSC I

HSC I Counties served: Divide, McKenzie, Williams

Williston P&A office-counties served for Protective Services: Divide, Burke, Renville, Bottineau, Willliams, Mountrail, Ward, McHenry, McKenzie, Dunn, Northern McLean, Golden Valley, Billings, Stark, Slope, Hettinger, Bowman, Adams

Advocacy Services: Covered by Dickinson and Minot P&A offices.

Addiction

Alcoholics Anonymous (Williston) 572-9882
....................................or 572-1118
(Ray)............................... 568-3583
....................................or 568-3377
....................................or 568-3861
Mercy Recovery Center (Williston) 774-7409
Family Recovery Home Center for Charge............... 774-9625

Abuse

Child Protective Services (see County Social Services)
Family Crisis Shelter (Williston) (24 hr #).......... 572-9111
(office) 572-0757
Victim/Witness Assistance Program (Williston)......... 577-4577
Vulnerable Adult 1-800-231-7724

County Social Services

Divide ....(Crosby) .... 965-6776 or 965-6521
McKenzie..................(Watford City)................... 444-3661
Williams ....(Williston) 572-4575

Crisis Intervention

Mental Health Info/Intervention 1-800-472-2911

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Northwest Human Service Center 1-800-231-7724
.... or 1-701-572-9111
(office hours) 774-4600

Guardianship—DD

Catholic Charities of ND (after hours) 241-0524

Homeless

CMI Case Management (NWHSC) 774-4600
Community Action 572-8191
Salvation Army 572-2921

Hospitals

McKenzie County Memorial . (Watford City) 842-3000
Mercy .... (Williston) 774-7400
St. Luke's .... (Crosby) 965-6384
Tioga Medical Center .... (Tioga) 664-3305

Law Enforcement

Municipal (for towns not listed, call county)
Crosby 965-6359
Tioga 664-2514
Watford City 444-2400
Williston 577-1212

County Law Enforcement

Divide .... (Crosby) 965-6461
McKenzie .... (Watford City) 444-3654
Williams .... (Williston) 577-7700
State Radio 1-800-472-2121

County Social Services

Burke .... (Bowbells) 377-2313
Mountrail .... (Stanley) 628-2925

Hospitals

Mountrail County Medical Center . (Stanley) 628-2424

Law Enforcement

Bowbells 377-2311

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Stanley 628-2225

County Law Enforcement

Burke............................(Bowbells).................. 377-2311
Mountrail........................(Stanley) 628-2975

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MINOT REGION – HSC II

HSC II Counties served: Bottineau, McHenry, Pierce, Mountrail, Burke, Renville, Ward

Minot P&A office-counties served for Advocacy: Divide, Burke, Renville, Williams, Mountrail, Ward & Northern McLean

Protective Services: Covered by Williston P&A office.

Addiction

Alcoholics Anonymous 838-2740
........................or 838-6091
Chemical Dependency ....(Minot) 857-2480

Abuse

Child Protective Services (see County Social Services)
Domestic Violence Crisis Center . (hospital) 857-2000
(office) 852-2258
Victim/Witness Assistance Program (Minot) 857-6480
........................or 857-6487
Aging Srvcs/Vulnerable Adult (Not DD or MI) .. 1-888-470-6968

County Social Services

Bottineau .....(Bottineau)................................... 228-3613
Burke...........(Bowbells)..................................... 377-2313
McHenry.......(Towner).. 537-5944
McLean ....(Washburn) 462-8103
Mountrail......(Stanley).. 628-2925
Pierce ....(Rugby) 776-5818
Renville........(Mohall) 756-6374
Ward ....(Minot) 852-3552

Crisis Intervention

Mental Health Info/Intervention 1-800-472-2911

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North Central Human Service Center (Minot) 857-8500
.... or 1-888-470-6968

Guardianship—DD

Catholic Charities of ND (after hours)..................... 852-2854

Homeless

CMI Case Management (NCHSC) 852-8500
Community Action 839-7221
........................or 852-3028
Salvation Army Church 838-8925
(store)................. 839-1859

Hospitals

Kenmare Community Hospital....(Kenmare) 385-4296
Trinity Clinic..........................(Mohall) 756-6841
Garrison Memorial Hospital........(Garrison) 463-2275
Mountrail County Medical Center (Stanley) 628-2424
St. Andrew's ....(Bottineau)........... 228-9318
Trinity ....(Minot) 857-5000
Indian Health Services..(New Town & White Shield).. 627-4701

Law Enforcement

Municipal (for towns not listed, call county)

Bowbells.. 377-2311
Kenmare 385-4411
Minot 852-0111
Mohall.. 756-6386
Rugby .... 776-5245 or 776-6112
Stanley 628-2225
Westhope 228-2740
New Town and White Shield BIA........................... 627-3314

County Law Enforcement

Bottineau ...(Bottineau)....................................... 228-2740
Burke.........(Bowbells).. 377-2311
McHenry.....(Towner).. 537-5633

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Mountrail.... (Stanley) 628-2975
Pierce .... (Rubgy) 776-5245
Renville...... (Mohall) 756-6386
Ward .... (Minot) 857-6500
McLean ...... (Washburn) 462-8103
State Radio.. 1-800-472-2121

DEVILS LAKE REGION – HSC III

HSC III Counties served: Benson, Cavalier, Eddy, Ramsey, Rolette, Towner

Devils Lake P&A Office-counties served for Advocacy: Bottineau, Towner, Cavalier, McHenry, Pierce, Benson, Ramsey

Belcourt P&A Office-counties served for Advocacy: Rolette & Turtle Mountain Indian Reservation

Protective Services: Covered by Turtle Mountain P&A office.

Addiction

Alcoholics Anonymous 665-1041
Alcohol and Drug Abuse Unit (LRHSC).................... 665-2200

Abuse

Child Protective Services (see County Social Services)
Adult Protective Services (LRHSC)........................ 665-2200
Safe Alternatives for Abused Families.................... 662-7378
After hours # 662-5323
.... or 1-888-662-7378
Victim/Witness Assistance Program (Devils Lake)..... 662-7378

County Social Services

Benson....... (Minnewaukan) 473-5302
Cavalier...... (Langdon) 256-2175
Eddy.......... (New Rockford)............................... 947-5314
Ramsey...... (Devils Lake) 662-7050
Rolette....... (Rolla) 477-3141
Towner....... (Cando) 968-4355

Crisis Intervention

Lake Region Human Service Center . (Devils Lake) 665-2200
Mental Health Info/Intervention 1-800-472-2911
Suicide/Crisis Intervention .... (Helpline)......... 662-5050

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Guardianship—DD

Catholic Charities of North Dakota (after hours)........ 241-0524

Homeless

Emergency Services/Crisis Line 662-5050
SMI Case Management (LRHSC) 665-2200

Hospitals

Cavalier County Memorial .... (Langdon) 256-6100
Mercy .... (Devils Lake) 662-2131
Presentation Medical Center .... (Rolla) 477-3161
Towner County Medical Center .... (Cando) 968-4411

Law Enforcement

Municipal (for towns not listed, call county)
Cando 968-3353
Devils Lake 662-5323
Langdon 256-2555
Rolla 477-5623

County Law Enforcement

Bensen....... (Minnewaukan) 473-5357
Cavalier...... (Langdon) 256-2555
Eddy .... (New Rockford) 947-5515
Ramsey...... (Devils Lake) 662-5323
Rolette....... (Rolla) 477-5623
Towner....... (Cando) 968-4350

Hospitals

St. Aloisius Medical Center .... (Harvey) 324-4651

Law Enforcement

Harvey 324-2225

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GRAND FORKS REGION – HSC IV

HSC IV Counties served: Grand Forks, Nelson, Pembina, Walsh

Grand Forks P&A office-counties served for Advocacy: Pembina, Walsh, Nelson, Grand Forks

Grand Forks P&A office-counties served for Protective Services: Rolette, Towner, Cavalier, Pembina, Pierce, Benson, Ramsey, Nelson, Walsh

Addiction

Alcoholics Anonymous and Al-Anon 772-2952
Altru Psychiatry and Chemical Dependency 780-6697
Narcotics Anonymous (Fargo) ....(701) 234-9330
NE Human Service Ctr Alcohol & Drug... 775-0525 or 795-3000
Northridge Counseling Centre, Inc 772-7203

Abuse

Child Protective Services 787-8560
Community Violence Intervention Helpline 746-8900
Office 746-0405
Tri-County Crisis Intervention Crisis Line 352-3059
Office 352-4242
Crisis Crime Victim/Witness Assistance Program
(Grand Forks) .... 746-8900 or 775-9623
Office 746-0405
.... 1-866-746-8900
Victim/Witness of Walsh County ...... (Grafton) 352-4237

County Social Services Offices

Grand Forks County .. (Grand Forks) 787-8500
Nelson County .... (Lakota) 247-2945
Pembina County .... (Cavalier) 265-8441
Walsh County .... (Grafton) 352-4499

Crisis Intervention

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Mental Health Association of North Dakota...... 1-800-472-2911
NHSC (Grand Forks)................ 1-800-845-3731 or 775-0525

Guardianship services – DD

Catholic Charities of North Dakota(Grand Forks)....... 775-4196
(On-Call Emergencies) 701-241-0524

Homeless

Case Management (NEHSC) 795-3059
Northland Rescue Mission.................................. 772-6609
Red River Valley Community Action 746-5431
Salvation Army.. 775-2597
(Store) 775-7255
Grand Forks County Social Services....................... 787-8500
Shelter House 746-5431
St Vincent DePaul Store.................................... 795-8614

Hospitals

Altru Medical Center............. (Grand Forks).......... 780-5000
Altru Health Institute............ (Grand Forks).......... 780-2311
Nelson County Health System. (McVille)................. 322-4328
Northwood Deaconess .... (Northwood)............ 587-6060
Pembina County Memorial...... (Cavalier) 265-8461
First Health Care Center......... (Park River) 284-7555
Unity Hospital .... (Grafton) 352-1620
Stadter Center .... (Grand Forks).......... 772-2500

Municipal Law Enforcement

Grafton Police Department ..... (Grafton) 352-1411
Grand Forks Police Department(Grand Forks).......... 787-8000
Lakota Police Department ...... (Lakota) 247-2572
Larimore Police Department ... (Larimore) 343-2012
Northwood Police Department. (Northwood)............ 587-5651
Park River Police Department.. (Park River) 284-6644
Walhalla Police Department.... (Walhalla)............... 265-4122

County Law Enforcement (Sheriffs)

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Grand Forks County Sheriff .... (Grand Forks)........... 780-8280
Nelson County Sheriff............ (Lakota) 247-2474
Pembina County Sheriff .... (Cavalier) 265-4122
Walsh County Sheriff............. (Grafton) 352-2041

Mental Health Residential Services

Duane Dornheim Adult Group Home (GF) 795-3889/3866
Prairie Harvest Human Services Foundation (GF) 795-9143
Ruth Meiers Adolescent Group Home (GF) 795-3870/3871

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FARGO REGION – HSC V

HSC V Counties served: Cass, Ransom, Richland, Sargent, Steele, Traill

Fargo P&A office-counties served for Advocacy: Griggs, Steele, Traill, Barnes, Cass, Lamoure, Ransom, Richland, Dickey, Sargent

Fargo P&A office-counties served for Protective Services: Grand Forks, Griggs, Steele, Traill, Cass, Ransom, Sargent, Richland

Addiction

Southeast Human Service Center 298-4500
Pathway 232-5955
Alcohol Anonymous (Fargo)................................ 235-7335

Abuse

Child Protective Services (see County Social Services)
Village Family Service Center................................ 232-1684
Rape and Abuse Center .... 1-800-344-7273 or 293-7273
Victim/Witness Coordinators (Fargo)..................... 241-5850

County Social Services

Cass .... (Fargo)... 241-5765
Ransom.... (Lisbon)... 683-5661
Richland ... (Wahpeton)....................................... 642-7751
Sargent.... (Forman) 724-3292
Steele ...... (Finley) 524-2584
Traill........ (Hillsboro)... 636-5220

Crisis Intervention

Crisis/Suicide 232-4357

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Hotline 235-7335
Mental Health Info./Intervention 1-800-472-2911
Southeast Human Service Center (Fargo) 1-888-342-4900
or 298-4500

Guardianship—DD

Catholic Family Services (after hours) 235-4457

Homeless

CMI Case Management .. (SEHSC) 298-4500
Dorothy Day House .... (Moorhead, MN) 1-218-233-5763
New Life Center .... (Fargo—males only) 235-4453
Salvation Army .... (Fargo) 232-5565
YWCA Shelter .... (Fargo—women only) 232-3449

Hospitals

Community Hospital ...... (Hillsboro) 636-4501
Lisbon Medical Center .... (Lisbon) 683-2214
Meritcare .... (Fargo) 234-2000
Union Hospital .... (Mayville) 786-3800
Prairie at St. John's ...... (Fargo) 1-877-333-9565
or 476-7216
Innovis Health 364-8000

Law Enforcement

Municipal (for towns not listed, call county)
Casselton 347-5223
Enderlin 437-2233
Fargo 235-4493
Hillsboro 636-4441
Lisbon 683-4632
Mayville 788-2555
Milnor 724-3302
Wahpeton 642-7722
West Fargo 433-5500

County Law Enforcement

Cass .... (Fargo) 241-5800
Ransom .... (Lisbon) 683-5255
Richland ... (Wahpeton) 642-7711

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Sargent.... (Forman) 724-3302
Steele ...... (Finley) 524-2742
Traill .... (Hillsboro)... 636-4510

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JAMESTOWN REGION – HSC VI

HSC VI Counties served: Barnes, Dickey, Foster, Griggs, LaMoure, Logan, McIntosh, Stutsman, Wells

Jamestown P&A office-counties served for Advocacy: Wells, Eddy, Foster, Kidder, Stutsman, Logan, McIntosh

Jamestown P&A office-counties served for Protective Services: Wells, Eddy, Foster, Kidder, Stutsman, Barnes, Logan, Lamoure, McIntosh, Dickey

Addiction

Alcoholics Anonymous ..(Jamestown)...................... 252-9493
(Valley City) 845-3705
State Hospital ....(Jamestown)..................... 253-3650

Abuse

Child Protective Services (see County Social Services)
Abused Persons Outreach Center........................... 845-0072
Adult Abuse & Rape Crisis Center .... (Jamestown) 251-2300
Victim/Witness Assistance Program . (Jamestown) 252-6688

County Social Services

Barnes ..... (Valley City)...................................... 845-8521
Dickey ..... (Ellendale)... 349-3271
Foster ...... (Carrington)..................................... 652-2633
Griggs...... (Cooperstown)................................... 797-2127
LaMoure ... (LaMoure).. 883-4282
Logan ...... (Napoleon)....................................... 754-2283
McIntosh .. (Ashley) 288-3343
Stutsman . (Jamestown) 252-7172
Wells .... (Fessenden) 547-3694

Crisis Intervention

South Central Human Service Center . (Jamestown)... 253-6300
1-800-260-1310
Mental Health Info./Intervention 1-800-472-2911

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Guardianship—DD

Catholic Charities of ND(after hours) 241-0524

Homeless

CMI Case Management .. (SCHSC) 253-6300
Salvation Army .... (Jamestown) 252-0290

Hospitals

Ashley Medical Center ....(Ashley) 288-3433
Carrington Health Center .....(Carrington) 652-3141
Cooperstown Medical Ctr......(Cooperstown) 797-2221
St. Aloisius Medical Center ...(Harvey) 324-4651
Jamestown Hospital ....(Jamestown) 252-1050
Oakes Community Hospital...(Oakes) 742-3291
Mercy ....(Valley City) 845-6400
Wishek Community Hospital .(Wishek) 452-2326

Law Enforcement

Municipal (for towns not listed, call county)
Ashley 288-3360
Carrington 652-3321
Harvey 324-2225
Jamestown 252-1000
Oakes 742-2172
Valley City 845-3110
Wishek 452-2469

County Law Enforcement

Barnes ...... (Valley City) 845-8530
Dickey ...... (Ellendale) 349-3215
Foster .... (Carrington) 652-2251
Griggs .... (Cooperstown) 797-2202
LaMoure .... (LaMoure) 883-5720
Logan .... (Napoleon) 754-2495
McIntosh ... (Ashley) 288-3724
Stutsman .. (Jamestown) 252-9000
Wells .... (Fessenden) 547-3211

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BISMARCK REGION – HSC VII

HSC VII Counties served: Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, Sioux

Bismarck P&A office-counties served for Advocacy: Sheridan, Southern McLean, Oliver, Mercer, Burleigh, Morton, Grand, Sioux, Emmons

Bismarck P&A office-counties served for Protective Services: Sheridan, Southern McLean, Mercer, Oliver, Burleigh, Morton, Grant, Emmons, Souix

Addiction

Alcohol Crisis Hotline and Treatment............. 1-800-234-0420
Heartview Foundation..(Bismarck) 222-0386
Narcotics Anonymous..(Bismarck) 223-3560

Abuse

Child Protective Services (see County Social Services)
Abused Adult Resource Center. (Bismarck)..... 1-866-341-7009
222-8370
McLean Cty Abuse & Rape Crisis Hotline (Washburn). 462-8643
1-800-651-8643
ND Council on Abused Women's Services................ 255-6240
Domestic Violence Sexual Assault Hotline 1-800-472-2911
Victim/Witness Assistance Program . (Bismarck) 222-6629
Woman's Action and Resource Center .(Beulah)........ 873-2274
(Hazen) 873-2274

County Social Services

Burleigh ... (Bismarck).. 222-6622
Emmons... (Linton)... 254-4502
Grant....... (Carson)... 622-3706
Kidder...... (Steele)... 475-2632
McLean .... (Washburn)... 462-3235
Mercer ..... (Stanton).. 745-3384
Morton ..... (Mandan)... 667-3395

Oliver....... (Center) 794-3212
Sheridan .. (McClusky).. 363-2283
Sioux .... (Fort Yates).. 854-3821

Crisis Intervention

Bismarck Emergency Food Pantry, 207 E. Broadway.. 258-9188
Crisis/Suicide 1-800-472-2911
Mental Health Info./Intervention 1-800-472-2911
West Central Human Service Center (Bsmk) ... 1-888-328-2662
328-8888
Vocational Rehab 1-888-862-7342
328-8800

Guardianship—DD

Catholic Charities of ND(after hours)...................... 241-0524

Homeless

Aid Incorporated..........(Bismarck) 223-9150
(Mandan) 663-1274
CMI Case Management .(WCHSC).......................... 328-8888
Community Action 258-2240
Mercer County Housing Authority . (Beulah)............. 748-3855
Ruth Meiers Hospitality House...... (Bismarck).......... 222-2108
Salvation Army......................... (office).............. 223-1889
667-1215

Hospitals

Community Memorial ...(Turtle Lake)...................... 448-2331
Garrison Memorial........(Garrison) 463-2275
Heartview Foundation...(Bismarck) 222-0386
Jacobson Memorial.......(Elgin) 584-2792
Linton Hospital ....(Linton)............................. 254-4511
MedCenter One .... (Bismarck) 323-6000
Sakakawea Medical Center (Hazen) 748-2225
St. Alexius .... (Bismarck) 530-7000
Standing Rock Hospital ..... (Fort Yates).................. 854-3831

Law Enforcement

Municipal (for towns not listed, call county)
Beulah 873-5252

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Bismarck (in Bismarck/Mandan—911) 223-1212
Hazen 748-2414
Linton 254-4460
Mandan (in Bismarck/Mandan—911) 667-3455
Washburn 462-8103

County Law Enforcement

Burleigh ..... (Bismarck) 222-6651
Emmons..... (Linton) 254-4411
Grant......... (Carson) 622-3331
Kidder........ (Steele) 475-2422
McLean ...... (Washburn) 462-8103
Mercer .... (Stanton) 745-3333
Morton .... (Mandan) 667-3330
Oliver......... (Center) 794-3450
Sheridan .... (McClusky) 363-2200
(after business hours) 363-2384
Sioux .... (Fort Yates) 854-3481

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DICKINSON REGION – HSC VIII

HSC VIII Counties served: Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, Stark

Dickinson P&A office-counties served for Advocacy: McKenzie, Dunn, Billings, Golden Valley, Slope, Hettinger, Bowman, Adams, Western Grant, Western Morton, Western Mercer, Stark

Protective Services: Covered by Williston and Bismarck P&A offices

Addiction

Alcoholic Anonymous (Dickinson) 264-7552
Heart River Alcohol & Drug Abuse Service............... 483-0795
West Winds Consulting Center, Inc 225-1050

Abuse

Child Protective Services (see County Social Services)
Domestic Violence & Rape Crisis Center.. (Dickinson) 225-4506
1-888-225-4506

County Social Services

Adams .... (Hettinger)................................. 567-2967
Billings .... (Beach) 872-4121
Bowman .... (Bowman)................................... 523-3285
Dunn .... (Killdeer) 764-5385
Golden Valley .. (Beach) 872-4121
Hettinger .... (Mott) 824-3276
Slope .... (Bowman)................................... 523-3285
Stark .... (Dickinson) 456-7675

Crisis Intervention

Badlands Human Service Center (Dickinson) 227-7500
Mental Health Info/Intervention 1-800-472-2911

Guardianship—DD

Catholic Family Services (after hours) 241-0524

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Homeless

Community Action (Dickinson) 227-0131

Hospitals

Richardton Health Center .....(Richardton) 974-3304
St. Joseph's ....(Dickinson)................. 456-4000
Mental Health Unit ....(24-hr.) 456-4396
SW Healthcare ....(Bowman) 523-5265
West River Health Services...(Hettinger) 567-4561

Law Enforcement

Municipal (for towns not listed, call county)
Amidon 879-6271
Beach 872-4733
Belfield.. 575-4485
Bowman... 523-5672
Dickinson (within city, call 911) 456-7759
Halliday... 938-4411
Killdeer 764-5678
Mott 824-2935
New England... 579-4422
Richardton 974-3700
South Heart 677-5398

County Law Enforcement

Adams .... (Hettinger)................................. 567-2530
Billings.......... (Medora) 623-4323
Bowman......... (Bowman)................................... 523-5421
Dunn .... (Manning).................................. 573-4449
Golden Valley .. (Beach) 872-4733
or 745-3333
Hettinger......... (Mott) 824-2935
Slope .... (Amidon) 879-6271
Stark .... (Dickinson) (within county, call 911) 456-7759

Mental Health Unit (Dickinson) 456-4396

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EMERGENCY MANAGEMENT TEAM
BADLANDS HUMAN SERVICE CENTER

Dana Ravinius .... 227-7545.......... 290-7545 (Alternate)
Tim Sauter............ 227-7538.......... 400-8873 (Alternate)

These individuals will decide whether to implement the Center's disaster plan and will have the most current information about the status of BHSC services.

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APPENDIX 4
IJP WORKSHEETS

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Client Name
Individual Justice Plan

Presenting Problems

Assessment

Residential

Vocational

Education/Training

Medical

Mental/Behavioral Health

Financial

Social/Recreation

Family

Cultural background

Transportation

Advocacy

Further Assessments Needed

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Recommendations

Positive Behavior Supports

Counseling

Supervision/case management

Community Service

Hospitalization

Agency Transfer

Other treatment/training

Psychotropic medication management

Restitution

Fine

Probation
Incarceration

Other Recommendations

Anticipated Outcome

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Integration

Review of the IJP

Consent

Confidentiality

I have reviewed and agree with all components of the Individual Justice Plan document. I am aware that I have the right to request changes to this document at any time. I am aware that some components of this IJP may be court ordered and that I may not have the right to revise these components.

________________________________ _______________
Signature of Client Date

________________________________ _______________
Signature of Parent/Guardian Date

________________________________ _______________
Signature of Witness Date

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IJP Assessment Worksheet

The following domains of the individual's life should be examined to determine how they contribute to the problem or potential solutions. Note: If the answer is yes, information included should be provided to identify specifics of the situation.

Residential

Does the current residential environment have an impact on the behavior?

Does the current setting meet the individual's needs in terms of the presenting behavior?

Would a change in living environment be appropriate/recommended?

Vocational

Does the individual's current job situation contribute to the behavior?

Does it provide a source of stability and structure for the individual?

Can the behavior be controlled in this setting?

Education/Training

Does this individual have skill deficits (e.g., social skills, learning deficits, communication) that contribute to the presenting behavior?

What, if any, further education/training might eliminate the behavior?

Medical

Do medical needs or physical disabilities contribute to the behavior?

Are there needs in this area that are unmet and may contribute to the behavior?

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Are medications taken and at proper dosage?

Mental/Behavioral Health
Does the individual have a mental illness that contributes to the behavior?

Does the individual have coping deficits that impact the behavior?

Are services needed/appropriate to assist the individual?

Are psychotropic medications taken and at proper dosage?

Financial
Does the individual manage his/her own money?

Is the behavior related to lack of funds or to mismanagement of money?

Are services needed/appropriate to assist the individual?

Social/Recreation
Does the individual have excessive free time and/or lack of ability to organize free time that contributes to the behavior?
Does the individual have friends who may encourage the behavior?

What services may assist the individual in positive development of skills in this domain?

Family
Does the individual have an active and supportive family?

Do family influences contribute to the behavior?

Can family assist in appropriate behavior development?

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Cultural background
Are there cultural factors that should be included in the assessment process?

Does culture have an impact on the behavior?

Are services needed/appropriate to assist the individual?

Transportation
How mobile is the individual?

Do transportation factors contribute to the behavior?

Is there accessible transportation available in the community?

Are services needed/appropriate to assist the individual?

Advocacy
Is the individual his/her own legal decision maker?

Is the individual able to ensure his/her rights are upheld?

Is an outside advocate needed/desired?

Is a guardian needed?

If a guardian has been appointed, is the guardian able to ensure his/her ward's rights are upheld?

Further Assessment
Is there further assessment or other relevant information that would assist in identifying or addressing the behavior?

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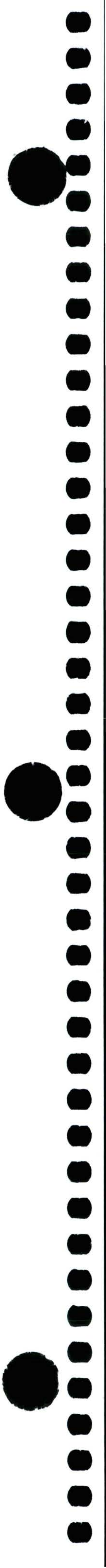
Signature of Assessor

Date



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IJP Recommendations Worksheet

Recommendations regarding resources available to the individual should be identified, clearly organized, and an integration of the CJS and community-based services. The least-restrictive, most effective services should be recommended for implementation. Specific service providers/responsible parties should be identified for each recommendation.

The following support options should be considered (see attached flowchart for reference):

Positive Behavior Supports:
Are there systematic use of reinforcements or strategies that would strengthen appropriate alternative behaviors and consequences to help suppress the illegal behavior?

Counseling
Would the individual benefit from a therapeutic effort such as one to one counseling or group therapy?

Would counseling or therapy provide a level of service or support that is not currently being met in the individual's life?

Supervision/case management
Would increased supervision or case management services assist with preventing the behavior from occurring?

Community Service
Would the option of community service (e.g. engaging in a relatively less desirable activity) serve to suppress the problem behavior?

Is this a recommendation that should be made to the courts?

Hospitalization
Is there a need for inpatient psychiatric services?

Is there a need for out-patient or partial care services?

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Agency Transfer
Would another facility be better equipped to provide more specialized treatment to address the behavior?

Other treatment/training
Is there a need for further treatment or training?

Psychotropic medication management
Are there medication management issues that need to be addressed to ensure compliance?

Are there any unaddressed questions about the appropriateness of medications being taken?

Is there a need for ongoing review by a physician?

Restitution
Is it appropriate for the individual to make some type of restitution to the victim or do some type of service for the victim?

Fine
Would the imposing of a monetary fine may have the desired impact on the individual and result in suppression of the problem?

Probation
If probation is imposed by the court, are there any recommendations regarding the level of supervision?

Incarceration
If incarceration is court-ordered, are there any risks or services that are needed to ensure the safety and well-being of the individual?

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Are there any disability-related accommodations that are needed during a period of incarceration?

Are there any alternatives that should be presented to the court in lieu of incarceration?

Are there any other recommendations that should be considered as part of this IJP?

______________________________ ________________

Signature of Assessor Date

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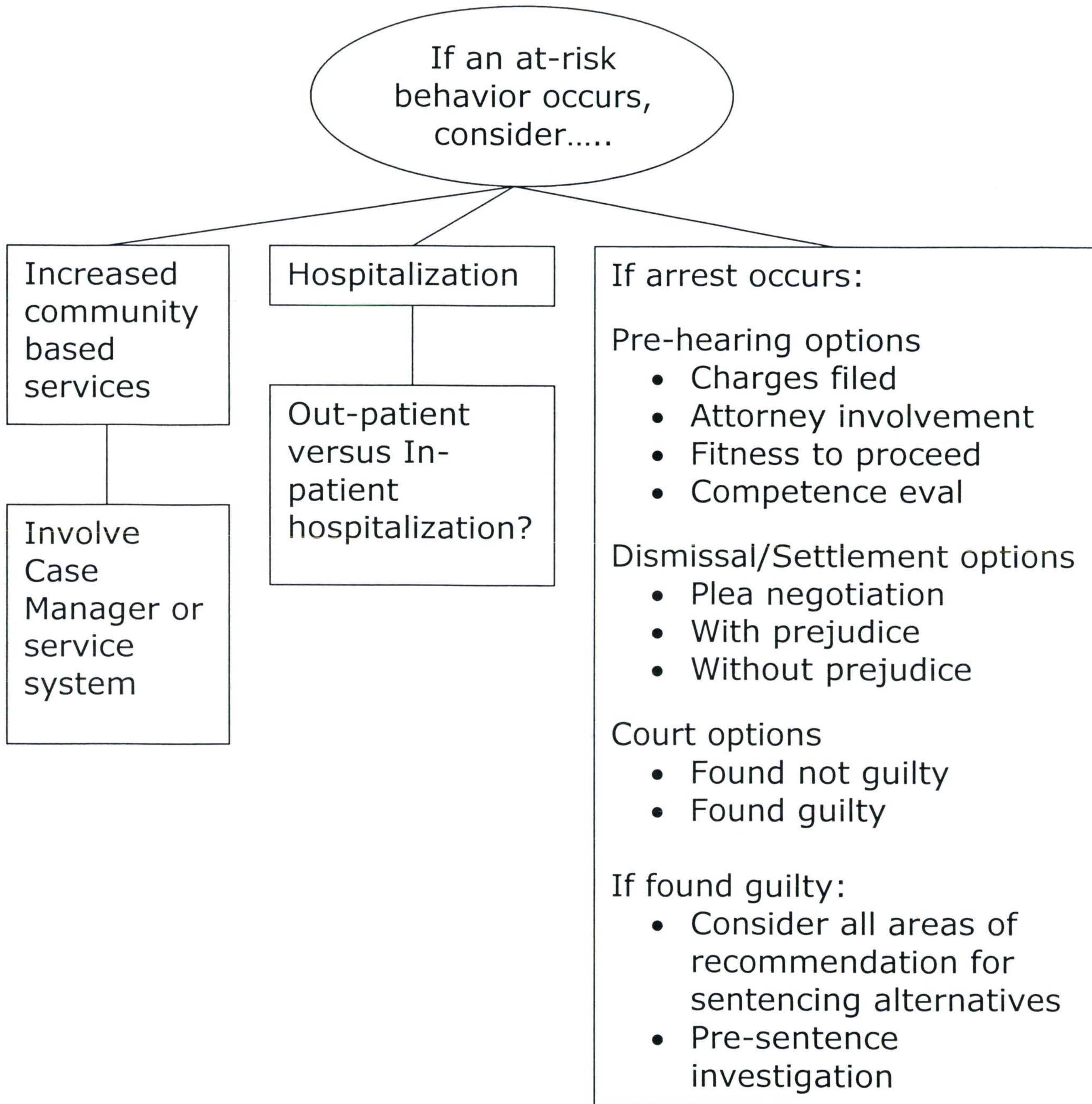
Recommendations for an IJP

The following decision process may assist with organizing recommendations relative to this section of an IJP:



Throughout this process, it is important to understand the nature of an individual's disability and what specific supports and services are needed.

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APPENDIX 5-IJP EXAMPLES

Joe-Case Scenario #1
Individual Justice Plan

I. Presenting Problems

Joe is an 18 year old male with a diagnosis of mild mental retardation and depression. He recently graduated from high school with a modified diploma and is trying to find a job. He lives by himself in an apartment in the community. Joe began dating and is very happy because this is his first girlfriend. Joe and his girlfriend decide that they were going to have intimate relationships. Later, police arrive on Joe's doorstep and take him to the police station for questioning. Joe tells the police officer that he has been dating this girl for the summer and that they had intimate relations. Joe is now being charged with committing a sexual offense because of the age of his girlfriend. Joe has no idea what he did wrong; he does not understand that this was a criminal act.

II. Assessment

Residential

Joe currently resides in his own apartment with minimal support services. Because he chose to graduate at the age of 18, his ability to access adult Developmental Disabilities Services was hindered. As a result of this decision, Joe receives two hours per week of support and assistance. This time is spent budgeting and shopping as these are his most significant needs.

Vocational

Joe has been looking for a job, however, his job search has been slow because he is not able to read or write. Joe is dependent on his VR counselor and limited staff time to assist with filling out job applications. Joe is very interested in working and would like to earn money.

Education/Training

Joe graduated from high school when he turned eighteen. Joe did not like school as he didn't ever feel that he fit in. Joe has limited skills and it is thought that his transition plan did not prepare him well for life after graduation.

Medical

Joe is very healthy medically. He does not currently take any medications. Joe does require assistance with setting up medical appointments for routine medical exams as he does initiate this without reminders.

Mental/Behavioral Health

He has experienced some episodes of depression over the past few years and has taken medication in the past. Joe is not able to self-medicate as he doesn't always remember to take his medications. Joe does not take any other medications at this time.

Financial

Joe's only source of income at this time is his Social Security money. One of Joe's greatest needs when he entered community services was budgeting and money management. Joe does not have a clear understanding of how to manage his money and is not able to budget and pay his bills. When Joe first entered the community he experienced some difficulties with his landlord because he was not paying his rent on time. Joe does have difficulties with making sure that his bills are paid and on time.

Social/Recreation

Joe does a lot of things socially; however, he tends to gravitate towards people that are not always a good influence. Joe often looks for people that will pay attention to him. He also tends to find friendships with people that are quite a bit older and that have a greater understanding of life than he currently has. A great deal of staff time is spent coaching Joe on how to make decisions in relation to people that he is spending time with.

Family

Joe has family that lives in the community that he lives in. He spends a great deal of time with them, however, is quite adamant about not wanting to be dependent on them for support and assistance.

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Cultural background
Joe was born and raised in a small town in Minnesota. His family moved to this community about 12 years ago when his dad was relocated through the armed services. Joe likes living in this community has chosen to stay here.

Transportation
Joe walks or rides bike to pretty much everywhere that he goes. If not, he often will "bum" rides from friends. It is speculated that one reason that he tends to choose the friends that he does is because they will take him with them wherever they go. Joe has stated that he would like to someday get his driver's license. This may be compromised by his lack of ability to read and write.

Advocacy
Joe has been attending the local self-advocacy group in his home community. One thing that has been identified in this process is Joe's lack of understanding in social situations. Joe often will voice his frustration with advice or information that he is given. Joe has been educated on how to contact the local Protection & Advocacy office and he will do so if he has concerns or questions. Often times Joe does so with complaints about advice or guidance that has been given to him. Most often, the advice given to him is sound and his desires could potentially get him into trouble.

Further Assessments Needed
Social Skills Assessment
Updated Psychiatric Evaluation

Recommendations

Positive Behavior Supports
Joe does not exhibit any behavioral issues that would warrant follow-up in this area.

Counseling
Joe has benefited from counseling in the past when his depression has been significant. With some of the currently stressful situations that Joe is going through right now, it is recommended that this be considered if the need arises. It is recommended that compliance

with Psychiatric care be included in any court orders that are put in place for Joe.

Supervision/case management

Joe currently is receiving case management services through the Developmental Disabilities system. Joe states that he likes his Case Manager and also that she is helpful when needed.

One issue in this area is Joe's need for more staffing intervention. There are significant life skills that Joe is lacking in and his ability to be successful in the community will be impacted by staff intervention at this point in his life.

Community Service

With the nature of the alleged crime and Joe's current situation, it isn't recommended that community service be included in Joe's plan. If probation is ordered, Joe will be limited in his ability to pay for the related fees. If this arises, community services may be a viable option in lieu of payment for these services.

Hospitalization

Joe does not have any history of hospitalization for medical or mental health. This aspect of services does not appear to be necessary or recommended.

Agency Transfer

Joe is doing well with his current service provider; however, there is a definite need for an increase in service hours. This would further allow for skill development to ensure that Joe has the supports and services to live independently.

Other treatment/training

None are recommended at this time.

Psychotropic medication management

Joe has not been taking medications for his depression for approximately 8 months. He has not seen his Psychiatrist in that timeframe either. It is recommended that Joe see his physician and that compliance with medication recommendations are adhered to. Past review of Joe's attendance at appointments and compliance with

medication is not consistent. This may be an area for increased service and response.

Restitution
The crime that Joe is being charged with typically does not have a component of restitution involved. As a future reference, money is very important to Joe and if payments could be arranged with the court, restitution may be a feasible consequence.

Fine
Due to Joe's limited monetary income, any fine assessed would need to be paid in increments. A fine may have a powerful impact on Joe as money is important to him.

Probation
Probation for Joe would be a recommended option because it may provide support and learning. It is recommended that probation be supervised.

Incarceration
If Joe is found guilty, incarceration is a sentence attached to this crime. Joe would be very vulnerable and would be an at-risk client as he does not understand social situations. He would be influenced negatively by others and would become an easy target. He also has limited ability to advocate for himself, which is compounded by his inability to read and write.

Other Recommendations
As these legal proceedings continue, it is imperative that those working with Joe provide ongoing, good information to Joe's attorney so that he can develop and understand Joe's limitations and skills.

Anticipated Outcome
In talking with Joe's attorney, he is optimistic that the addition of an IJP to Joe's case would be beneficial. Joe's attorney has indicated that he will provide Joe's IJP to the States Attorney for consideration.

Integration
Joe's current Program Coordinator within his service provider has developed goals, objectives and supports that are consistent with this IJP. She will also be arranging for the other assessments that are recommended.

Review of the IJP
Joe's Program Coordinator and DD Case Manager will oversee and review/revise his IJP and service plan on an ongoing basis. Throughout the criminal proceedings, ongoing updates and changes may be needed. As updates occur, copies will be provided to Joe's defense attorney so that they can be presented during the criminal proceedings. P&A advocacy staff will also be involved in the ongoing review of this document throughout the criminal proceedings.

Confidentiality
Joe was educated on his right to confidentiality and he was informed that this document will be kept confidential, as all his records are. A release was obtained and signed by Joe that allows his Program Coordinator to provide copies of the IJP to his defense attorney.

Consent
Joe is currently his own legal decision maker. This document has been developed with him and he is in agreement with all components. As changes are made, they will be done so with Joe and an updated consent form completed.

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INDIVIDUAL JUSTICE PLAN (IJP)
CLIENT/LEGAL DECISION MAKER CONSENT FORM

I have reviewed and agree with all components of the Individual Justice Plan document. I am aware that I have the right to request changes to this document at any time. I am aware that some components of this IJP may be court ordered and that I may not have the right to revise these components.

Signature of Client	**Date**
Signature of Parent/Guardian	**Date**
Signature of Witness	**Date**

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Jim-Case Scenario #2
Individual Justice Plan

I. Presenting Problems

Jim is a 38 year old male who has moderate mental retardation and a diagnosed impulse control disorder. He has struggled with community placements for many years because of physical aggression related to his diagnosis of impulse control disorder. When in community placements, he has had behavioral programming that has focused on maintaining an environment where he maintains control. This has at times been paired with medications to assist with his anxiety and impulse difficulties, however, he has experienced side effects from medications and changes in medications have taken place. During these periods of instability, he has "struck" the staff members who work with him, typically when they have made requests of him that he perceives as frustrating.

II. Assessment

Residential

Jim has spent a great deal of his years living at the state institution for developmental disabilities. He has lived in the community numerous times, but these have not always been successful placements. Jim has currently been living in the community for four years and this placement has been relatively successful. Only recently, when a medication change occurred, did Jim become more unstable. He recently has had weekly incidents of striking staff who are working with him.

Vocational

Jim attends the local sheltered workshop and does perform some paid work through contracts. If kept busy, behavioral issues are not seen at work.

Education/Training

Jim does not have any education or training beyond his modified diploma that he received from his high school. Jim is capable of performing work with a job coach and does have a desire to do so.

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Medical
Jim does have a few medical issues that affect him on a regular basis. He does have ulcer difficulties and high cholesterol and takes medications for both conditions.

Mental/Behavioral Health
Jim does see a Psychiatrist who monitors his behavioral issues and his medications. Jim has experienced side effects as a result of some psychotropic medications, so changes have recently been implemented. Unfortunately, changes of meds often lead to periods of instability that have resulted in Jim losing community placements.

Financial
Jim does have some basic concepts of money and can manage small amounts. Money is very motivating to him, so this is often something that he works hard for. Jim's sister is his guardian and Representative payee. Jim does receive assistance from his staff to manage a checkbook in which his spending money is deposited in to. If Jim receives a paycheck from the shelter workshop, this is also deposited into his personal checkbook. Jim's sister maintains his checkbook that is used to pay his bills.

Social/Recreation
Jim enjoys spending time in the community, but he requires one-on-one supervision. Jim also has a history of making bomb threat calls through the 911 system, so supervision in the community is very important. Jim enjoys going out to eat and is known very well in his small, local community.

Family
Jim's parents are still living, however, they spend their winters in Arizona. As a result, his contact with them during this time is somewhat limited. Jim's sister does live about 30 miles from his home community, so he is able to see her on a regular basis. Visits and contact with her is very important to her. Jim also enjoys visiting her rural farm and spending time with her kids.

Cultural background
Jim's parents have lived in North Dakota all of their life. They have lived in their community for many years and this is beneficial to Jim.

There are not any further cultural issues that should be considered in the development of this plan.

Transportation
Jim's staff transport him to where he needs to go. Jim does pay 50 cents for each ride that he receives. This has allowed for flexibility with Jim's activities.

Advocacy
Jim does have limited abilities in regard to his understanding of how to advocate for himself. It is quite typical for Jim to do whatever is told to him, even if this is not a good choice. His sister/guardian does a nice job of including Jim in decision making and often will contact advocacy staff for support and assistance.

Further Assessments Needed
No further assessments are recommended at this time.

Recommendations

Positive Behavior Supports
Jim does have a behavior support plan that addresses his assaultive behaviors, his phone calls to 911 with bomb threats. This plan includes a positive reinforcement program and techniques for staff to implement to de-escalate Jim if he becomes anxious. Allowing Jim to maintain control of his environments is very important. This plan is included in his agency support plan and is reviewed on a monthly basis by the agency's behavior specialist.

Counseling
Jim has not had counseling in the past and this has not been recommended by any professionals working with him.

Supervision/case management
Jim's agency case manager will implement, monitor and review his IJP in conjunction with his service plan on a monthly basis. Adjustments and updates will be made on an as needed basis. Jim's DD Case Manager and his P&A advocate are also involved in the revision process as needed.

Community Service
Jim has performed community service work in the past in relation to criminal charges of assault. This has been fairly successful, but does require one-on-one agency staff supervision to ensure the safety of Jim and others that may be in the community service environment. This is a recommended option for sentencing in the future if seen fit by the court.

Hospitalization
Jim has not been hospitalized in a Psychiatric Unit, however, has had numerous placements at the state institution. This high level of structure has been successful for Jim. A key to a community placement is to allow Jim independence while providing a foundation of structure.

Agency Transfer
Jim's current placement is the most successful placement that he has experienced. It is not recommended that any changes be made relative to this placement or the agency that is serving Jim.

Other treatment/training
Jim's team has placed his name on the waiting list for the social skills group at the local Human Service Center. It is thought that an increased understanding of social situations may help Jim learn alternative ways to deal with interactions with staff that are frustrating to him. It is estimated that Jim should be able to begin these classes within the next three months.

Psychotropic medication management
Jim currently takes two Psychotropic medications and is dependent on staff for medications administration. If not provided by staff, Jim would not take any of his medications. When provided with assistance, Jim is very cooperative with taking his medications. It is recommended that this level of support be provided and that ongoing training regarding his medications and side effects be done as the meds are being administered.

Restitution
Due to Jim's limited understanding of his money, restitution has not had an impact on Jim in the past. If restitution is ordered by the

court in the future, it is recommended that a payment plan be arranged and that Jim use his work paycheck for this purpose. This may create a greater understanding of the consequence versus his sister/rep payee making these payments. Non-monetary restitution something that would be considered on a case by case basis and may have a level of validity.

Fine
As with the issue of monetary restitution, careful consideration should be given to how this is handled.

Probation
Jim has been involved in unsupervised probation in the past and he does not have an understanding of this process. The compliance issue of probation was built into his community services and he did not understand their intent. An aspect of supervised probation may create an increased level of learning and accountability if ordered by the court.

Incarceration
Jim has not experienced incarceration in the past and it is not recommended that this take place. Jim is very vulnerable and would be at a very high level of risk in the criminal justice system.

Other Recommendations
None at this time.

Anticipated Outcome
The desired outcome of Jim's IJP is to outline appropriate responses that should be maintained to ensure that support and supervision is maintained. With a consistent level of support, it is the intent of Jim's IJP to ensure that he can remain in the community. The IJP also identifies potential at-risk behaviors and how future involvement in the CJS can be avoided.

Integration
There is a strong integration of Jim's IJP and his agency support plan. Many components of Jim's behavior support plan are outlined in his IJP. Jim's behavior support plan is also very descriptive as to the level of supervision that should be provided to Jim at all times.

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Review of the IJP

Jim's agency case manager reviews his support plan and his IJP on a monthly basis. His DD Case Manager does complete a quarterly service review and an overview of his IJP is included in this process also.

Confidentiality

Jim and his sister have been provided information regarding the agency's policy on confidentiality. Jim's IJP is kept in his agency file and all records are kept confidential. Releases of information were obtained by the agency to release his IJP to his defense attorney, DD case manager and P&A advocate.

Consent

Jim and his sister/guardian were involved in the development and ongoing monitoring of the IJP. All aspects of the IJP were clearly written with their involvement and consent. See signed consent attached.

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INDIVIDUAL JUSTICE PLAN (IJP)
CLIENT/LEGAL DECISION MAKER CONSENT FORM

I have reviewed and agree with all components of the Individual Justice Plan document. I am aware that I have the right to request changes to this document at any time. I am aware that some components of this IJP may be court ordered and that I may not have the right to revise these components.

______________________________	______________
Signature of Client	**Date**
______________________________	______________
Signature of Parent/Guardian	**Date**
______________________________	______________
Signature of Witness	**Date**

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Marie-Case Scenario #3
Individual Justice Plan

[P]resenting Problem

Marie is a 24-year old female who recently sustained a closed head injury as a result of a motorcycle accident. Marie has experienced a great deal of difficulty with impulse control since the accident. She has also experienced difficulties with memory recall. This affects her ability to take her medications, attend appointments as required and maintain her services. Marie has assaulted people within her home and community, and law enforcement personnel. Marie has also had difficulty with parenting her children and has been verbally and physically abusive toward them. Marie is currently facing three counts of assault and felony child abuse charges.

Assessment

Residential

Marie currently resides within her family home with her husband and their two kids, ages 5 and 2. Marie has been back in her family home for the past 7 months, following rehabilitation services for a period of 17 months.

Vocational

Marie does not currently receive any vocational services and is not interested in working outside of her home. Marie was a part-time hair dresser prior to her accident and does not wish to return to that profession. At this point in time Marie chooses to stay home. Marie has completed interest surveys with Vocational Rehabilitation and is aware that this is a resource for her should be want assistance with returning to work.

Education/Training

Upon graduation from high school Marie went to beauty school in New York City. She lived there for a period of time before returning to her home community. Marie then married her high school sweetheart and began working part-time for a local salon. Marie's goal was to be a hairdresser and she enjoyed this career a great deal. Marie has not been interested in any further education or training since her accident.

Medical

Marie has spent a great deal of time with physicians and medical personnel over the past two years. Beyond the neurological and psychiatric issues that she currently faces, there are not any other health issues that require treatment or services. Marie has continued to receive outpatient Occupational Therapy that is focusing on memory recall and information maintenance.

Mental/Behavioral Health

Marie does have a diagnosis of severe depression and impulse control disorder. Both of these diagnoses occurred within three months of her accident. Marie does currently take psychotropic medication, however, is depending on others to ensure compliance with this as she does not have the memory capabilities to remember to take her medications. Marie does have a medication reminder, however, when it sounds, she at times cannot recall what the sound is for. At this time, Marie's family ensures her medication compliance. This does make Marie angry a great deal of the time and thus power struggles occur between her and her husband.

Financial

Marie currently receives Social Security Disability benefits and her husband assists with the management of these funds. Marie's husband is a local physician and supports the family financially. Marie has not developed skills in the area of money management since her accident.

Social/Recreation

Marie is dependent on her staff for socialization and recreation. She does spend time interacting with her children, but does require supervision if this is for longer periods of time. Marie has been observed to be quiet verbally vocal towards the kids and has also been observed to have physical interactions that are of concern.

Family

Marie's extended family live about 5 hours from her. Her husband's family does live within the same community and are very helpful. Marie's mother-in-law provides daycare for them during the daytime and whenever needed. This provides support for Marie when she needs to attend therapies and medical appointments.

Cultural background
Marie's family is American Indian and is very involved in their culture. Marie's husband's family is Caucasian and have lived in North Dakota for many years. Understanding the family dynamics that play roles in both families is important. There have been conflicts as Marie's parents would like to care for the children. These are important things to consider when arranging for services and supports for Marie.

Transportation
Marie has not renewed her driver's license since her accident. She is dependent on others for transportation, which typically is not a problem. Marie does use a cane with walking and her gait is somewhat unsteady. Walking long distances is also difficult as she tires easily.

Advocacy
Marie's husband sought services from Protection & Advocacy as they were not aware of what Marie's right to services was following her discharge from the rehab facility. Assistance was provided to ensure that County Qualified Service Provider (QSP) services were established along with the supports to ensure that Marie could return to her family home. Criminal Justice involvement also occurred when Marie was assaultive to two women that were in her yard. Advocacy services are currently being provided to ensure that Marie and her family understand the legal system and to ensure that her right to due process is protected.

Further Assessments Needed
No further assessment are recommended at this time, however, it is imperative that Marie receive assistance with maintaining her appointments with her neurologist and psychiatrist.

Recommendations

Positive Behavior Supports
Training and information has been provided to Marie's husband and the extended family on how a Traumatic Brian Injury affects a person. In addition, specific information and reaction strategies for Marie's depression and impulse control have been provided. De-escalation of

stressful situations has been successful in diffusing situations with Marie.

Counseling

Marie has seen a counselor on a sporadic basis since her accident. This is not something that Marie has been compliant with at time. Marie has experienced difficulties with remembering information that is shared in these appointments and thus, the use of coping strategies has not been successful. It is unknown whether Marie will be able to develop further strategies in regard to memory recall.

Supervision/case management

Marie does have a case manager through the County that monitors and oversees the in-home care services. This has been helpful in ensuring that Marie is able to remain in her family home.

Community Service

Due to Marie's TBI, she would not be able to independently perform community service work, therefore, this is not a recommended sentencing alternative. Marie's brain injury is significant enough that she would not understand the correlation between community service and the legal charges.

Hospitalization

Marie has not required any further hospitalization since her accident nor has she needed hospitalization for medical or mental health reasons.

Agency Transfer

Marie currently does not have an agency involved in her care. Her family has hired their in-home care staff on their own and has chosen to maintain this arrangement. The County does provide the financial support for the staffing that Marie receives through the TBI waiver program.

Other treatment/training

It is recommended that Marie continue with her out-patient Occupational therapy as this does seem to be improving her memory recall and ability to communicate without frustration. There is concern that funding for her therapy may become an issue in the near

future. Marie and her husband have been made aware that P&A may be able to assist with this issue.

Psychotropic medication management

Marie does take psychotropic medication two times per day. Her husband and/or in-home staff assist her with using the medication organizer that she has. There are frequent situations when Marie can not identify what the sound is when her medication organizer goes off. It is hopeful that through some repetition, this may be improved.

Restitution

Imposing financial restitution is not a recommend option as Marie no longer understands concepts of money or that this would be imposed as a consequence for her actions. The legal charges that have occurred have not resulted in financial loss to the other parties, nor have they created emotional difficulties. This should be thoroughly discussed with Marie's attorney before further recommendations are made.

Fine

If a fine is imposed as a result of legal charges, Marie would have the financial ability to pay the fine. The question would be however, would this create a level of understanding for Marie that would prevent future behavior from occurring. As noted previously, Marie's brain injury would impact her ability to understand the consequence of the fine.

Probation

None at this time.

Incarceration

The legal charges that Marie is currently facing do not carry the penalty of incarceration. Should future issues arise, careful consideration should be given to this issue as Marie would be very vulnerable in this type of situation.

Other Recommendations

None at this time.

Anticipated Outcome
The purpose of Marie's IJP is to create a level of understanding of how Marie's TBI affects her along with the inclusion of her other disabilities. With an increased awareness of these issues and the potential issues that exist regarding Marie's involvement in the CJS, this plan can provide a level of structure for those providing care to Marie.

Integration
Marie does have a care plan document that is developed by the County that outlines her in-home services. There is overlap of this document with Marie's care plan and thus both should be recognized as important documents that drive Marie's care and services.

Review of the IJP
Marie's husband, family and the County Case Manager have agreed to review and monitor the effectiveness of her IJP on an ongoing basis. The County plan is reviewed on a quarterly basis and thus the IJP review will formally occur with this. If legal charges continue to move forward, a copy of Marie's IJP will be provided to her attorney to ensure that it is provided to the courts. Marie's husband is also aware of his ability to request advocacy services from P&A if needed.

Confidentiality
Marie and her husband/family were carefully informed of the confidentiality of County records. Releases of information for Marie's attorney, P&A and the County are on record in all places.

Consent
Marie's husband does currently have guardianship over legal, medical and financial issues for Marie. This was first obtained on a temporary basis after Marie's accident and following that, a permanent order was obtained. Marie's husband involves her in all decision making and thus consent was reviewed with both of them. Marie and her husband both have agreed that the IJP have provided an increased understanding of Marie's disabilities and how they affect her in the community.

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INDIVIDUAL JUSTICE PLAN (IJP)
CLIENT/LEGAL DECISION MAKER CONSENT FORM

I have reviewed and agree with all components of the Individual Justice Plan document. I am aware that I have the right to request changes to this document at any time. I am aware that some components of this IJP may be court ordered and that I may not have the right to revise these components.

______________________________ ______________
Signature of Client **Date**

______________________________ ______________
Signature of Parent/Guardian **Date**

______________________________ ______________
Signature of Witness **Date**

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APPENDIX 6
SAMPLE FORMS

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Authorization to Disclose Information

(Disclosure of the Social Security Number is optional and voluntary. It is requested for the purpose of accurate identification)

Client:	Social Security Number	Date of Birth	
Address	City	State	Zip code

I authorize:

Person/Agency to Release Information	Address		
City	State	Zip Code	Phone

To disclose information only if the recipient agrees to keep the information confidential, to:

Person/Agency to Release Information	Address		
City	State	Zip Code	Phone

Information to be disclosed: (Be specific)

Information will be used for: (List each purpose)

Consideration/Development of an Individual Justice Plan and other supports and services.
Other:

I authorize the disclosure of information between both listed parties to the extent necessary to obtain rights and services. ☐ **Yes** ☐ **No** ☐ **Not Applicable**

This authorization is in effect until: (Specify date OR event which ends this authorization)

Client consent:

This authorization was not obtained as a condition of obtaining insurance coverage. This authorization is voluntary and I understand that I can revoke this authorization at any time by providing written notice to the involved parties. Any information disclosed before I revoke this authorization is not a breach of confidentiality. A photocopy of this authorization is as effective as the original. This authorization allows disclosure of information in any form.

I understand that information disclosed might be re-disclosed and no longer protected by federal law covering privacy of medical information (HIPPA). I explicitly require that anyone, who receives information pursuant to this authorization, must protect the information as confidential. Addiction records can be re-disclosed only as permitted by federal law (42 C.F. R. Part 2). I have received and understand the information regarding confidentiality.

Signature: ______________________ **Date:** ______________________

Check One: ☐ Client ☐ Guardian/Custodian ☐ Parent

Signature of Witness (If needed) ______________________

Disclosure of Information - Addiction Records: (Please Check if Applicable)

☐ This information may be disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit further disclosure, unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. Part 2. A general disclosure of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature: ______________________ **Date:** ______________________

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INDIVIDUAL JUSTICE PLAN (IJP)
CLIENT/LEGAL DECISION MAKER CONSENT FORM

I have reviewed and agree with all components of the Individual Justice Plan document. I am aware that I have the right to request changes to this document at any time. I am aware that some components of this IJP may be court ordered and that I may not have the right to revise these components.

______________________________ ______________

Signature of Client **Date**

______________________________ ______________

Signature of Parent/Guardian **Date**

______________________________ ______________

Signature of Witness **Date**

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Individual Justice Plan (IJP)
Law Enforcement Referral Form

The following person has become involved in the law enforcement/criminal justice system. Through initial contact by law enforcement, it appears that this person may have a disability.

Based upon the potential for involvement in the criminal justice system, I believe that this person may benefit from an Individual Justice Plan (IJP).

Date:____________________ Case Number:______________

Person's Name:______________________________________

Officer's Name:______________________________________

Note to Law Enforcement Personnel:

If you suspect any involvement of a disability, fax this form to an entity listed on the back of this form. The receiving party will then provide screening and support for this process.

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State Human Service Center Agencies

Region I (Serving the Counties of Divide, McKenzie & Williams)
Northwest Human Service Center
Phone: (701) 774-4600 or 1-800-231-7724
Fax: (701) 774-4620

Region II (Serving the Counties of Bottineau, McHenry, Peirce, Mountrail, Burke, Renville & Ward)
North Central Human Service Center
Phone: (701) 857-8500 or 1-888-470-6968
Fax: (701) 857-8555

Region III (Serving the Counties of Bensen, Cavalier, Eddy, Ramsey, Rolette & Towner)
Lake Region Human Service Center
Phone: (701) 665-2200 or 1-888-607-8610
Fax: (701) 665-2300

Region IV (Serving the Counties of Grand Forks, Nelson, Pembina & Walsh)
Northeast Human Service Center
Phone: (701) 795-3000 or 1-800-845-3731
Fax: (701) 795-3050

Region V (Serving the Counties of Cass, Ransom, Richland, Sargent, Steele & Traill)
Southeast Human Service Center
Phone: (701) 298-4500 or 1-888-342-4900
Fax: (701) 298-4400

Region VI (Serving the Counties of Barnes, Dickey, Roster, Griggs, LaMoure, Logan, McIntosh, Stutsman & Wells)
South Central Human Service Center
Phone: (701) 253-6300 or 1-800-260-1310
Fax: (701) 253-3033

Region VII (Serving the Counties of Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan & Sioux)
West Central Human Service Center
Phone: (701) 328-8888 or 1-888-328-2662
Fax: (701) 328-8900

Region VIII (Serving the Counties of Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope & Stark)
Badlands Human Service Center
Phone: (701) 227-7500 or 1-888-227-7525
Fax: (701) 227-7575

ND Protection & Advocacy Project
Any county in the state of North Dakota:
Protection & Advocacy Project-State office
Phone: (701) 328-2950, 1-800-472-2670
Fax: (701) 328-3934

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APPENDIX 7
DISABILITY AWARENESS

(Taken from Disability Justice Initiative Materials-NDCPD)

Characteristics of Mental Retardation or a Developmental Disability

- Limited vocabulary, may have speech defect.
- Difficulty understanding or answering questions.
- Inability to read or write.
- Mimics responses or answers.
- Easily influenced by and anxious to please others.
- Difficulty making change, using the telephone, telling time, etc.
- Low frustration tolerance.
- Doesn't understand the seriousness of the situation.
- May not consider the consequences of her/his actions; acts impulsively.
- May not understand her/his rights.
- May be overly willing to confess.
- Difficulty recalling facts in detail.
- Tendency to be overwhelmed by police authority.
- May not admit having a disability.
- Says what she/he thinks others want to hear.

Tips on How To Interact With A Person who Has Mental Retardation

- Use People First Language - avoid words or phrases like "retarded" or "disabled person", instead use "person with a disability".
- Speak directly to the person, even if someone else is with them.
- Be patient; give ample time to respond to questions and process information.
- Keep sentences short and simple; speak slowly and clearly.
- Avoid "yes" or "no" questions; ask open-ended questions.
- Ask the person to repeat information back to you.
- Avoid questions about time, complex sequences, or reasons for behavior.
- Be age appropriate - treat adults as adults.
- When possible, say it and show it-use pictures, symbols, or actions to convey meaning.

Identifying The Presence of Mental Illness-Characteristics May Include

- Accelerated speaking or hyperactivity.
- Delusions and paranoia, such as false beliefs that she/he is famous person or that others are trying to harm them.
- Hallucination, such as hearing voices or seeing, feeling, or smelling imaginary things.
- Depression.
- Inappropriate emotional response.
- Unintelligible conversation.
- Loss of memory, such as inability to remember the day, year, or where they are.
- Catatonia, indicated by lack of movement, activity, or expression.
- Unfounded anxiety, panic, or fright.
- Confusion.

Tips On How To Interact With A Person Who Has Mental Illness

- Approach in a non-threatening and reassuring manner. Make them feel they are in control.
- Introduce yourself by name first, then your authority.
- Determine if the person has a support system such as family, guardian, or mental health provider you can contact. If necessary, contact the local mental health crisis center.
- Keep interviews simple and brief. Be aware that rational discussion may not be possible on all topics.
- Be aware that the person may be experiencing delusions, paranoia, or hallucinations. However, they still may be able to provide information on details related to victimization.
- Avoid standing too close or surrounding the person. Do not touch, even to offer reassurance unless absolutely necessary.
- Do not whisper, joke, or laugh in the presence of the person.
- Avoid direct eye contact, forced conversation, or indications of impatience.
- When possible, back off and allow the person to calm down if they are agitated.
- Break into nonstop talking by interrupting with simple questions, such as asking their name.
- Don't assume that victims who are unresponsive do not hear you or are being uncooperative. They may be experiencing hallucinations.

- Never try to convince victims that their hallucinations do not exist. Rather, reassure victims that the hallucinations will not harm them and may disappear if they calm. Acknowledge paranoia and delusions by emphasizing with them, but do not disagree or agree with their statements.
- Be honest. Well intentioned deception will only increase fear and suspicion.

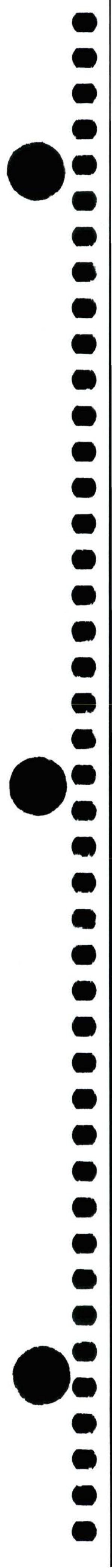
Distinguishing Mental Retardation from Mental Illness

Mental retardation and mental illness are often thought of as the same. However, they are two distinct, separate conditions. Sometimes a person may have both conditions (dual diagnosis). People with mental illness are usually of normal intelligence but may have difficulty functioning at normal levels. People with mental retardation are more likely than others to experience mental health problems. Reasons for this include: environmental factors, lack of learning opportunities, decreased coping skills, and the impact of the central nervous system on their disability. Some indicators of mental illness are also observed in people with developmental disabilities. The following table differentiates between mental retardation and mental illness.

Mental Retardation	Mental Illness
• Not an illness. • A permanent condition, there is no cure. • Functioning can be improved through training and habilitation.	• It IS an illness • Usually temporary and often reversible. • There is no cure, but it can often be successfully treated with medications.
• Person has below average intelligence with deficits in adaptive behaviors.	• Person has normal intelligence, but difficulty functioning because of the illness.
• Becomes evident at birth or during childhood.	• May occur at any age. Episodes may occur and then subside.
• Affects approximately 3% of the population.	• Affects 16-20% of the population.
• It is not a disturbance of thought. • Behavior is consistent with the person's level of	• Involves disturbances in thought processes and emotions. • Behavior may be irrational and

intellectual functioning.	change often.

(Mercer, 1997)



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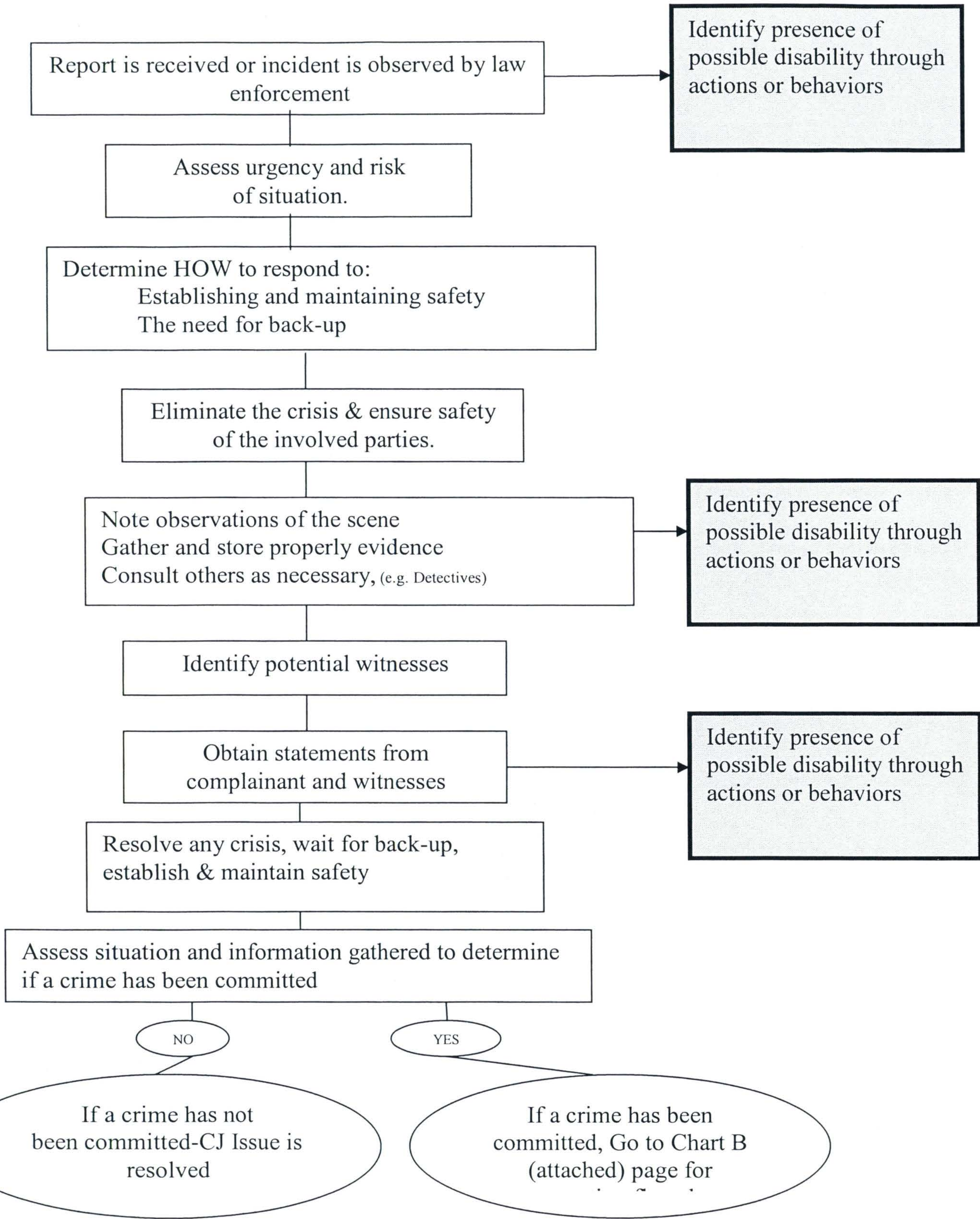
APPENDIX 8

ND LAW ENFORCEMENT INVESTIGATORY FLOW CHART (Chart A)



There may be a need to involve Human Service personnel, mental health professionals, treatment services or providers at any time in this process.

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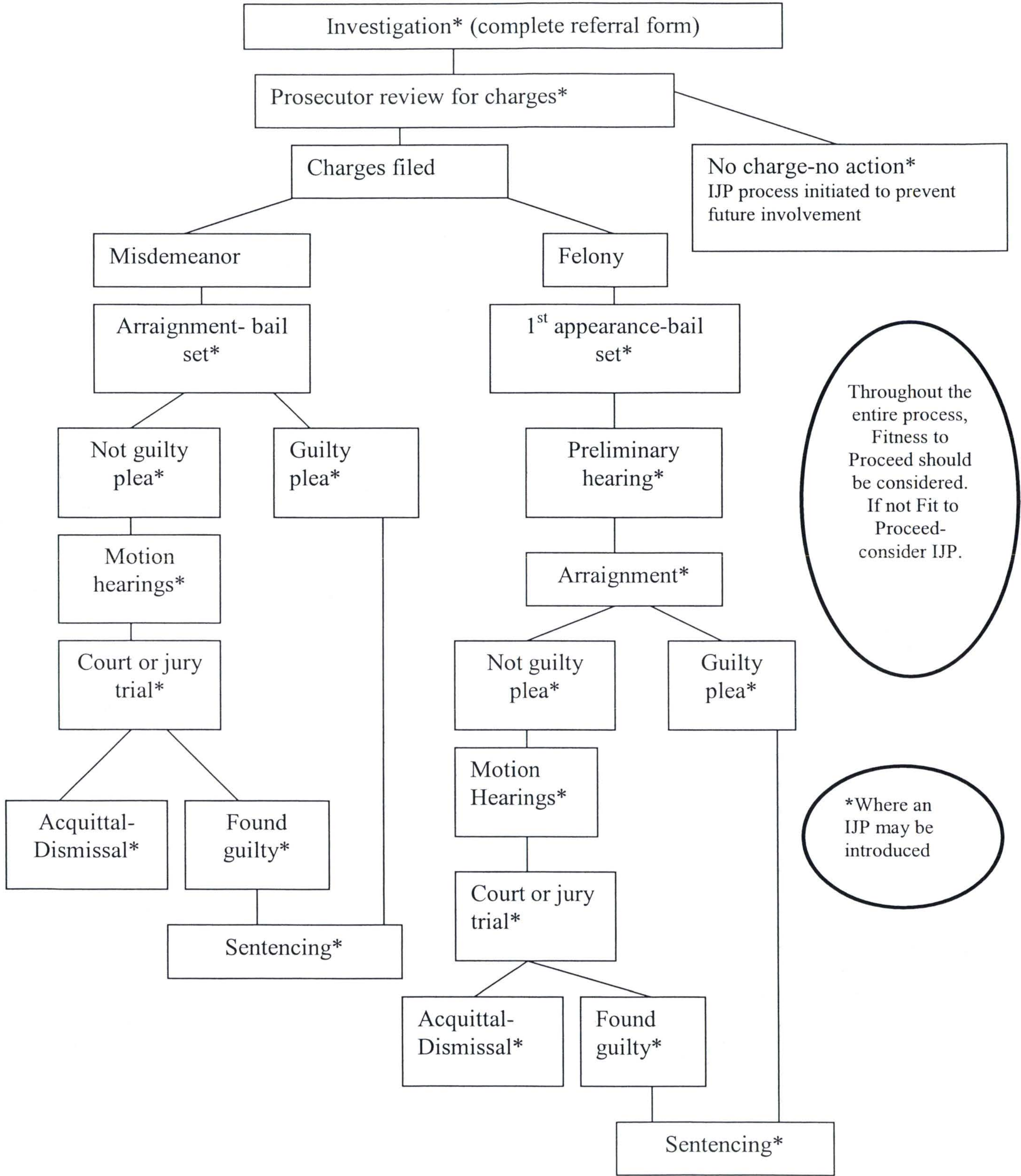
ND CRIMINAL PROSECUTION FLOW CHART (Chart B)



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Please sign me up to receive any revisions made to the IJP manual.

Name: ______________________________

Organization: ______________________________

Address: ______________________________

City/State: ______________________________

Zip Code: ______________________________

E-mail: ______________________________

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PROTECTION AND ADVOCACY PROJECT
400 EAST BROADWAY SUITE 409
BISMARCK ND 58501-4071

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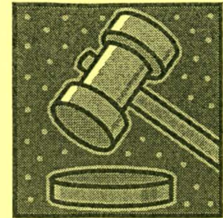
Individual Justice Planning in North Dakota



Training Evaluation

Date of Training:________________ Location:___________________________

Professional occupation:____

Prior to this training, my level of understanding of people with disabilities and their involvement in the Criminal Justice system was:___________
(4 = Strong, 3 = Average, 2 = Weak, 1 = None)

After this training, my level of understanding of the IJP process and how it may be used for people with disabilities that are involved in the Criminal Justice System has improved.

True **False**

As a result of this training, I have learned more about the rights of people with disabilities.

True **False**

As a result of this training I have learned skills or strategies that will help me perform my job or will help someone that I know.

True **False**

Suggestions for future IJP trainings:

____

____

____

____

____

8.1.07

SB 2274
Attach #9
1/25

Senate Human Services Committee
Senator Judy Lee, Chairman

Lisa Peterson, PhD
Clinical Director
North Dakota Department of Corrections and Rehabilitation
Presenting Neutral Testimony on Senate Bill 2274
Wednesday, January 25, 2017

Good morning Chairman Lee and members of the committee. My name is Dr. Lisa Peterson. I am a licensed psychologist and Clinical Director with the Department of Corrections and Rehabilitation (DOCR). I am here on behalf of the DOCR to provide neutral testimony on Senate Bill 2247.

First, I would like to thank you for undertaking the difficult task of improving behavioral healthcare services, specifically for people involved with the criminal justice system who have serious behavioral health needs. This bill is a significant step in the right direction in terms of addressing the gaps identified by the interim health, human services, and incarceration issues committees over the past several years. The DOCR supports efforts to expand community behavioral healthcare with the goal of reducing incarceration and corrections costs.

I appreciate the emphasis this bill places on funding services shown to be effective and meet the goals they have set forth. To that end, I suggest considering a pilot project perhaps in one region of the state and including one larger and one smaller community within the region. A pilot would allow high-fidelity implementation of evidence-based interventions over the next two years and meaningful outcome measurement. It would further allow the opportunity to ensure the design of these services are effective and make any changes necessary to improve the effectiveness before investing in statewide resources.

In closing, the DOCR acknowledges the fiscal impact of this bill in light of the current budget circumstances. Initiatives such as these represent investments that may realize future cost-savings, but there will be no immediate cost-savings within the DOCR budget. Our Director of Administration, Dave Krabbenhoft, prepared the fiscal note and he is present today to address any concerns related to the financial aspects of this bill. If there is not a way to fund this bill in its entirety, please find a way to fund a portion and move forward in reducing the incarceration of individuals with serious behavioral health needs in our state. Thank you and I am happy to respond to any questions you may have.

SB 2274
Attach #10
1/25

ND Senate Human Services Committee

January 25, 2017

Testimony presented by

Nate Medhus

President/CEO

ShareHouse, Inc.

Chairwoman Lee and members of the Senate Human Services Committee, my name is Nate Medhus, President and CEO of ShareHouse, a licensed treatment provider for Substance Use Disorder. ShareHouse provides both outpatient and residential treatment services, with locations in Fargo, ND and New York Mills, MN. I also serve as the President of the North Dakota Addition Treatment Providers Coalition. I am here today to provide testimony on behalf of ShareHouse.

I am requesting your full support for Senate Bill 2274. This important bill will provide greatly needed assistance for those who are suffering from a Substance Use Disorder and are intertwined in our Correctional system.

Treatment improves the lives of those who directly receive it, their families and friends, and our society and State as a whole. The estimated 55,000 citizens of North Dakota who suffer from Substance Use Disorder need your continued support. Thank you for your time today, and consideration of my request. I would be happy to address any questions you might have at this time.

SB 2274
2-9-17
#1

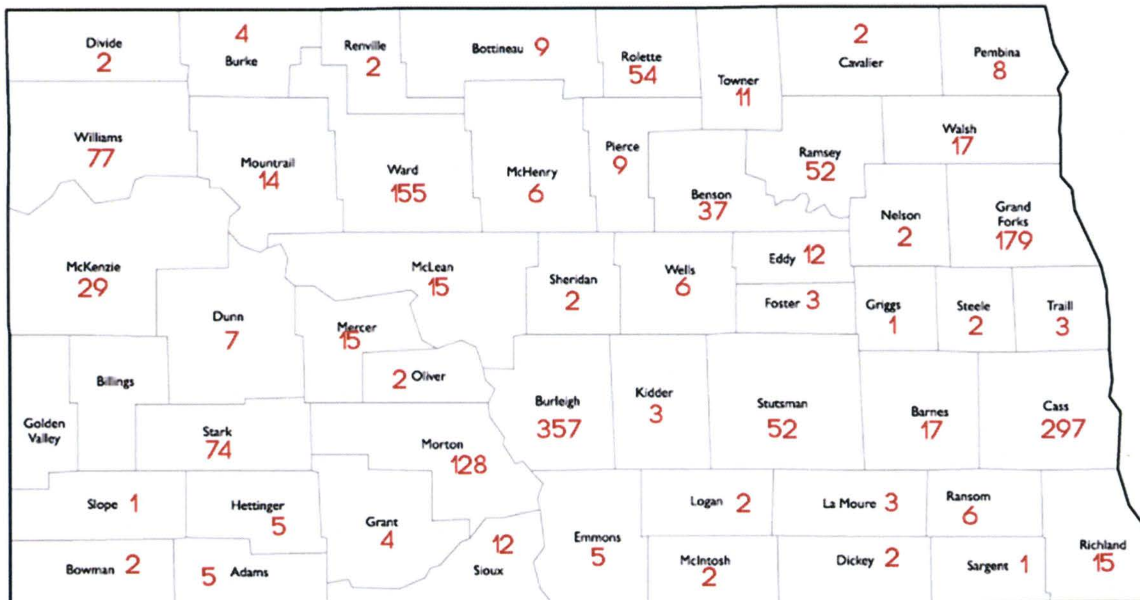
Senate Bill 2274 increases access to high-quality community behavioral health treatment that, when combined with effective supervision, is shown to reduce recidivism. The bill proposes funding to DOCR to partner with DHS, who will contract services with behavioral health providers in the state.

Participants will be identified by both the criminogenic risk (LSI-R) and behavioral health disorder (DSM 5 & Functional Status). Once identified, participants will be assessed for and provided access to the appropriate tiered service (Page 2).

The Level of Service Inventory–Revised™ (LSI-R™) is a quantitative survey of offender attributes and their situations relevant to level of supervision and treatment decisions. The LSI–R helps predict parole outcome, success in correctional halfway houses, institutional misconducts, and recidivism.

Total 30 LSI-R & SUD/SMI - 2059
(334 no county identified – 16%)

38% of the 2059 live in 2 urban areas of ND.



Variables include:

- # of participants
- # of participants per tier
- Rate ($) per tier
- Rate ($) per provider/location
- Reimbursement returned to state ($)

Considerations:

- Oversight and training are vital components to this proposal.
- Types and volume of service vary by need (individualized).
- Each tier would have a monthly rate.

North Dakota's Justice Reinvestment Approach
Behavioral Health Policy and Reinvestment Package

Expand Provider Workforce

Rationale: Lower correction costs and reduce recidivism by cultivating a network of community behavioral health providers to help meet treatment needs of people in the criminal justice system

Strengthen Para-Professional Workforce

Case Management: Providing assessment, case planning, referrals, care coordination and monitoring in collaboration with clinical services and probation or parole

Peer Support Specialists: People with lived experience of a mental illness or addiction in sustained recovery who are trained to support others

Create Strategic Plan

Establish committee to create a strategic plan to increase number of community behavioral health providers in the state, especially in rural areas

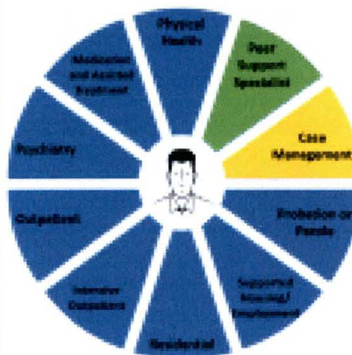
Fund and Implement Plan

Begin investing to implement strategic behavioral health workforce plans for items such as:

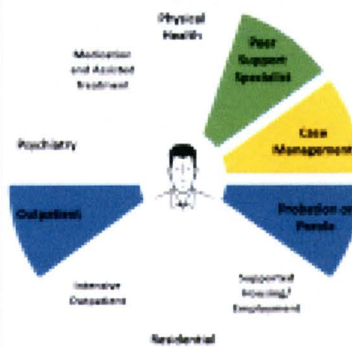
- Scholarships and loan forgiveness
- Outreach to develop interest in professions in rural areas
- Strengthening of "distance learning" opportunities
- Strengthening of behavioral health career ladders
- Supports for clinical supervision services
- Strategies for out of state recruitment and retention
- Psychiatric fellowships

Increase Access to Services

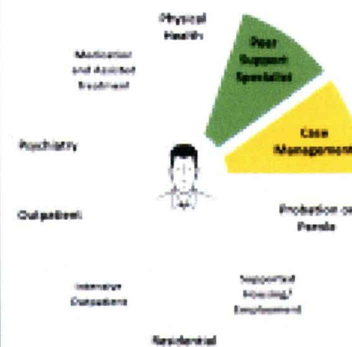
Rationale: Improve healthcare outcomes and reduce recidivism by 20 to 30 percent by delivering high-quality community behavioral health treatment with effective supervision *



Tier 1: Comprehensive and intensive services for target population to stabilize behavioral health conditions and reduce criminal justice involvement



Tier 2: Moderate array of services designed to help people sustain and strengthen their early recovery and reduce their risk for recidivism



Tier 3: Minimal services for people to help sustain full recovery, monitor for relapse and minimize additional justice involvement

* Washington State Institute for Public Policy, Evidence-Based Adult Corrections Programs: What Works and What Does Not, January 2006 ; D. A. Andrews and James Bonta, The Psychology of Criminal Conduct, 5th ed. (New Providence, NJ: Matthew Bender & Company, Inc., 2010).

from Council of State Goverments

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Fraser, Ltd.
Individual Consumers & Families

SB 2274
2-9-17
#2

Testimony
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
February 9, 2017

Chairman Holmberg and members of the committee, my name is Carlotta McCleary. I am the Executive Director for both North Dakota Federation of Families for Children's Mental Health (NDFFCMH) and Mental Health America of North Dakota (MHAND). Today I speak on behalf of the Mental Health Advocacy Network (MHAN) in support of Senate Bill 2274 and how this effort can be the start that we need to address the behavioral health crisis in the state of North Dakota. MHAN advocates for a consumer/family driven mental health system of care that provides an array of service choices that are timely, responsive, and effective.

MHAN has provided testimony throughout the interim human service committee meetings regarding our priorities. We argue that peer to peer and family support, consumer choice, diversion from corrections, a core services zero-reject model, and conflict free grievance and appeals processes, and the access to a full and functional continuum of care serve as the backbone to correcting the crisis in North Dakota's behavioral health system.

In the time since MHAN started testifying on these issues, there has been a growing consensus that the status-quo must not be tolerated. The Interim Incarceration Issues Committee had been notified that more than two thirds of North Dakota judges have sentenced someone to prison—even if they were not a high-risk offender—in order to receive behavioral health services.

For years the crisis was brewing, but in 2013 the North Dakota legislature chose to address the growing problem regarding the lack of services in North Dakota's mental health system. The legislature most notably commissioned the Schulte Report in 2013, which was

released the following July. The Schulte Report made it resoundingly clear that this system is in crisis and drastic action must be taken. Hopes were high for the 2015 legislative session, and while progress was very modest, progress was being made. Then the allotment came. Nearly all of the gains that were made were taken away.

The Schulte Report delivered a warning to the state of North Dakota when it said, "Lawsuits are happening across the country in states which are not offering a choice of services to individuals or requiring that they seek only institutional care." This is in reference to the *Olmstead* decision of 1999, regarding the Americans with Disabilities Act. MHAN is often asked if we will pursue litigation against the state of North Dakota. To that we respond: all options are on the table. We would like the North Dakota legislature to lead in developing the state's policy for community mental health services, not the courts or the federal government. You have opportunity here. Schulte did say that the state of North Dakota was well-equipped to tackle the crisis. "North Dakota has all the resources and experience it needs to turn things around."

That is why Senate Bill 2274 is important. MHAN believes diversion from the North Dakota Corrections System is a top priority in systemic planning efforts through prevention, early intervention and treatment. While this bill does not address all of the behavioral health needs in North Dakota, it does address alternatives to incarceration as well as prevent recidivism for those with behavioral health needs. We urge you to support Senate Bill 2274.

Thank you for your time and I would be happy to take any questions you have.

Carlotta McCleary, Spokesperson
Mental Health Advocacy Network
523 North 4th Street
Bismarck ND 58501
Email: cmccleary@mhand.org
Phone: (701)255-3692

The Mental Health Advocacy Network (MHAN)

A coalition for North Dakota

Mission: MHAN advocates for a consumer/family driven mental health system of care that provides an array of service choices that are timely, responsive and effective.

Members of MHAN have long recognized the lack of mental health care and treatment in the state. With the release of the Schulte Report* in the summer of 2014, policymakers, including the North Dakota legislature, also became keenly aware of the crisis in mental health - and the associated risks of maintaining the status quo. Following the release of the Schulte Report, legislators also heard from the Bazelon Center for Mental Health Law, relative to the State's legal obligations for behavioral health services. MHAN was formed to assure that consumer and family voices are included in recommendations for improvements and in decision-making.

Values: MHAN values the work done by many in this arena including the ND Department of Human Services and County Social Service agencies, legislators, public and private sector providers and the Behavioral Health Stakeholder group. However, these efforts do not go far enough – or respond quickly enough to solve the critical nature of the gaps in service, the lack of access and, ultimately, to the prevention of loss of life. Additionally, there has not been an intentional effort to engage consumers and obtain family input for these deliberations. For those reasons, MHAN shares the following values, upon which we build a case for leadership and action for policymakers and the public to consider.

1. **Peer-to-Peer and Family-to-family Support:** MHAN believes that these services should be included and adequately funded (not volunteer, but with fair wages and benefits) in every region of the state through Regional Recovery Centers, family and consumer run non-profits, or other appropriate outlets. Schulte agrees: ***"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 services."***

2. **Consumer Choice:** When someone with a mental health disorder is poor, or uninsured in North Dakota, one is captive to the services made available through the Regional Human Service Center. While these services are intended to be effective, they are not available equitably in all regions, nor are they adequate to meet the need. MHAN believes that the state should redirect funding through a voucher system or like model, to allow consumers choice and access to services in the private sector. Such choice can foster results driven accountability. Schulte agrees: ***"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. The HSCs are the sole provider of many services not giving consumers any options. 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. 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 was noted."***

3. **Diversion from Corrections Systems:** Too many North Dakotans are ending up in youth or adult corrections systems due to lack of mental health care, both inpatient and outpatient. MHAN believes that diversion needs to be a top priority in systemic planning efforts through prevention, early intervention and treatment. A recent report from the ND Department of Corrections and Rehabilitation supports this premise: ***In ND 63% of youth in juvenile corrections have mental health concerns that require a medication that must be managed by psychiatry staff. 41% of female inmates have mental health concerns that are being treated by DOCR psychiatry staff.***

4. **Core Services, Zero Reject Model and Adequate Funding for Public and Private Services:** MHAN believes that consumers and families are key to defining the core services they need to maintain good mental health and productivity. MHAN believes that a state system of care requires a zero- reject model rather than turning people away because of waiting lists, wait times, non-cooperation or being too sick or not sick enough. Adequate funding for mental health services is a federal requirement that is not being met by the State of North Dakota, thus exposing the state to legal action. Schulte agrees. The Schulte Report said another goal is to: ***"Increase funding options for youth and adults" as "There is a large gap in funding options for services in North Dakota." The study judged that, "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."***

5. **Conflict Free Grievance and Appeals Processes**: When consumers and families are faced with a concern about DHS services, they have nowhere, other than the DHS, to turn. Schulte states it best and MHAN agrees: ***"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."***

6. <u>**Access to a Full and Functional Continuum of Care**</u> that provides people with disabilities the rights to receive services in the most integrated setting appropriate, as described by the Olmstead decision (1999). People with mental disabilities, and those at risk, must also be afforded community-based treatment when appropriate, as indicated in the Americans with Disabilities Act (ADA – 1990). Community-based supports might include mobile crisis intervention, crisis residential placement, recovery centers, supportive housing, employment training and opportunities, and benefits planning for money management. Schulte agrees: ***"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 Mental Health Advocacy Network stands in support of the efforts of people and organizations that work to improve services for those who live with mental illnesses. However, MHAN insists on the direct involvement of consumers and families, including those from tribal and rural areas, as well as Veterans, in prevention, education, service planning and delivery - nothing about us without us.

The Mental Health Advocacy Network supports a responsive and immediate solution to the existing gaps in mental health services in North Dakota and rejects the notion of a phased-in, years-long approach to service development. For many North Dakotans, this is a matter of life and death. To quote Schulte again, the ***"...system is in crisis."***

1/22/17

5

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#3

SCHULTE Report

In the summer of 2014, the Shulte Report* made policymakers and legislators keenly aware of the mental health crisis in North Dakota — and the associated risks of maintaining the status quo. MHAN was formed to assure consumer and family voices are included in recommendations for improvements and in decision-making.

*For the full report, go to: http://www.mhan.org

MENTAL HEALTH ADVOCACY NETWORK
A DIVISION OF MENTAL HEALTH AMERICA NORTH DAKOTA
5[illegible]th 4th Street | Bismarck, ND 58501
[illegible]g | mhand.org

A North Dakota Coalition advocating for consumer driven mental health services. MHAN calls for immediate solutions to gaps in services.

Mental Health Advocacy Network

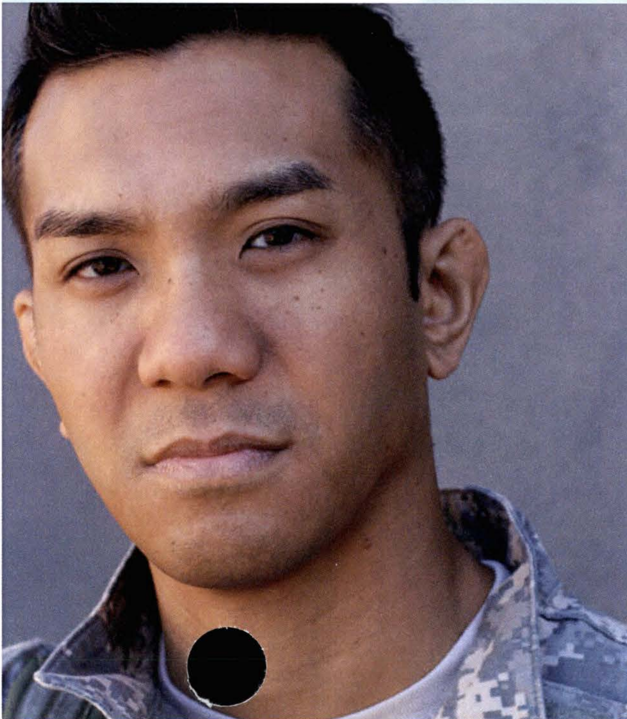
WE Support

- **PEER TO PEER AND FAMILY TO FAMILY SUPPORT:** These are evidenced-based mutual support programs proven highly effective and fiscally efficient.
- **CONSUMER CHOICE:** A voucher system or like model to allow consumer choice and access to services in the private sector.
- **DIVERSION FROM CORRECTION SYSTEMS:** A top priority in systemic planning efforts, prevention, early intervention, and treatment are important.
- **A ZERO REJECT MODEL.** Consumers and families can provide solid input to core services, but adequate state funding is needed.
- **INDEPENDENT AND IMPARTIAL GRIEVANCE AND APPEAL PROCEDURES.** Mental health providers should not review themselves.
- **ACCESS TO A FULL AND FUNCTIONAL CONTINUUM OF CARE THAT PROVIDES OPTIONS FOR SERVICES IN OUR COMMUNITIES.**

MHAN
Believes

Nothing about us—without us...

- Direct involvement of consumers and families, veterans and those from rural and tribal communities in shaping prevention and intervention, service planning, and delivery.
- There is value in the work being done by individuals, communities, and legislators to improve services. However, these efforts do not go nearly far enough to prevent the loss of life.
- We believe the North Dakota Mental Health System is in crisis.



THE NEED IS
Immediate

- 18.1% of adult North Dakotans (roughly 105,523) have experienced some form of mental illness.
(SAMHSA's 2014 National Survey on Drug Use and Health and Kids Count's 2015 Population Estimates for North Dakota.)
- Between 13 to 20% of children in North Dakota (between 22,610 and 34,785) have a mental disorder.
(Center for Disease Control and Prevention "Mental Health Surveillance Among Children-United States, 2005-2011" and North Dakota Kids Count's 2015).
- F-M Ambulance Services in North Dakota report that 1/3 of their calls are behavioral health related, including depression, suicidal ideation, anxiety and depression.
Sherm Syverson, F-M Ambulance Service Testimony (March 8, 2016).
- 70% of North Dakota judges have sentenced at least one person to prison (even if they were not considered high-risk) to receive mental health, alcohol, or drug addiction treatment.
("Justice Reinvestment in North Dakota: Interim Report," (April 20, 2016.)
- 89% of youth in juvenile corrections have mental health problems.
Director of Division of Juvenile Services, North Dakota Department of Corrections and Rehabilitation Testimony (January 6, 2016).
- 75% of youth in juvenile corrections have a serious emotional disorder.
Director of Division of Juvenile Services, North Dakota Department of Corrections and Rehabilitation Testimony (January 6, 2016).
- 56% of youth in juvenile corrections have a mental health issue that requires medication which must be monitored by psychiatry.
Director of Division of Juvenile Services, North Dakota Department of Corrections and Rehabilitation Testimony (January 6, 2016).
- Approximately 44% of the inmate population is diagnosed with a mental illne[illegible]nd 30% are prescribed psychiatric medicati[illegible]
North Dakota Departm[illegible]orrections and Rehabilitation, 2011-2013 Biennial Report.

Together

Individuals, families, professionals, and legislators can positively effect change.

- Peer and family supports should be adequately funded.
- Consumer choice should be equitable in all regions of the state by developing a model to access private services through individual vouchers.
- Avoid overuse of correction systems due to lack of mental health care.
- Treatment should be recovery-focused.
- A proper checks and balances model.
- A choice of home and community-based services to avoid institutional care.

Mental Health Advocacy Network (MHAN) is a grassroots organization created to highlight issues and bring awareness to mental health service needs in North Dakota. You may also go to www.mhan.org to make an online contribution or for more information.