The Behavioral Health Workforce in North Dakota: A Status Report

Prepared by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program
For: Division of Mental Health and Substance Abuse Services

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Executive Summary

In largely rural states, such as North Dakota, there have been historical difficulties in recruiting and retaining an effective behavioral health workforce. Additionally, the recent report of the President's *New Freedom Commission on Mental Health* described in detail the significant problems facing mental or behavioral health systems throughout the country, particularly in rural areas. These include critical gaps in accessibility to services, critical shortages in the availability of providers and programs, impaired acceptability of care due to urban-based models and strategies, and establishing mental health policy without consideration of its rural impact.

The national, regional, and state efforts currently underway indicate significant momentum behind behavioral health workforce development, particularly in rural areas. Specifically, the creation of a national behavioral health workforce development strategy is being spearheaded by the Annapolis Coalition on Behavioral Health Workforce. Rural workforce development is a major component of this effort. Regionally, western states such as Alaska, Arizona, and Nevada have undertaken their own state-level workforce initiatives with the help of the Western Interstate Commission for Higher Education (WICHE) Mental Health Program. These activities provide a context in which the State of North Dakota is now undertaking its own workforce development project.

WICHE has been asked to facilitate North Dakota's workforce development process, part of which is producing a report designed to present a picture of the current state of its behavioral health workforce. Specifically, this report will describe 1) activities at the federal, regional and state level that have set the groundwork for a more formal process of workforce development, 2) components of an effective workforce, 3) population trends and projections, 4) prevalence estimates of behavioral health disorders and unmet need, 5) the state's occupational forecast, 6) existing behavioral health training programs in higher education, including enrollment trends, and 7) a description of a Search Conference that was held in Bismarck that had the purpose of identifying preliminary recommendations for developing North Dakota's behavioral health workforce.

This Executive Summary highlights significant data, trends, and issues relevant to each of the contexts indicated above. It also provides a brief summary of the products of the Search Conference held at the end of August, 2007 in Bismarck.

National Issues for Rural Behavioral Health

- More than 60% of rural Americans live in mental health professional shortage areas.
- More than 90% of all psychologists and psychiatrists, and 80% of MSWs, work exclusively in metropolitan areas.
- More than 65% of rural Americans get mental health care from their primary care provider.
- Rural Americans travel further to provide and receive services.
- Comprehensive services are often not available.
- Few programs train professionals to work competently in rural places.

North Dakota Behavioral Health Workforce Data

- Virtually the entire state (46/53 counties, 23 geographic areas and 16 facilities) is designated as a federal Mental Health Professional Shortage Area.
    - Ranked 34th among states in psychiatrists, **2nd for psychologists** per capita and 43rd among states in social workers per capita.
    - Ranked **1st among the states in per capita health services employment** in 2000.
- The vast majority of providers are in the most densely populated areas.
- There is a significant amount of unmet need in North Dakota.

North Dakota Occupational and Population Trends and Projections

- Between 2000 and 2020, projections indicate that there will be 58,882 fewer income earners below age 55 in North Dakota. There will be also be 53,280 income earners reaching retirement age (over age 65) during that same period.
- North Dakota is projected to have far less people entering the workforce than leaving it by 2025, with a net decrease of 66,713 people.
- Health services employment in North Dakota grew 29% between 1988 and 2000, while the states population declined by 2%, resulting in a **net per capita growth of 32% in health services sector employment.**
- On average, North Dakota ranks 11th among the 15 WICHE states in actual numbers of professionals.

North Dakota University System (NDUS)

- The number of public high school graduates is expected to decrease to 5,613 in 2017-18, a 30.6% change from 2001-2.
- However, on a national level, North Dakota has the second highest high school graduation rates with 88%.
- North Dakota is the best performing state in the country with high school students enrolling in college by age 19.
- Only 48% of full-time college students complete a Bachelor's degree within six years.
- Only 28% of the state's population aged 25-65 has attained a Bachelor's degree or higher.
- There are at least 11 behavioral health programs offered in the North Dakota higher educational system (e.g., psychology, social work, etc.), with approximately 3,674 students currently enrolled.

Search Conference Products

There were six recommendations/outcomes identified by Search Conference participants that were deemed desirable and achievable to help develop the behavioral health workforce in North Dakota. Although the purpose of the meeting was simply to identify these recommendations/outcomes, participants went further and began listing strategies for achieving them. These are briefly summarized below.

Recommendation/Outcome 1: Employers provide flexible work schedules.

Strategies

1. Survey employee needs for the benefit of the organization and clients.
2. Survey other organizations which currently offer flexible schedules to determine best practices.
3. Provide training to supervisors/decision makers on the benefits to provide a flexible work schedule.
4. Develop policies which will accommodate employers' and employees' needs.

Recommendation/Outcome 2: Retiree expertise is maximized in the workforce.

Strategies

1. Research existing laws (employment and tax) and policies/practices to identify barriers and recommendations for change.
2. Conduct post-retirement planning for employees within 10 years of retirement.
3. Cost/benefit analysis.
4. Develop training courses for supervisors and staff on multi-generational workforce issues
5. Design an ongoing succession plan to fully utilize part-time retirees while developing younger workforce.
6. Consult with AARP and other groups throughout process.

Recommendation/Outcome 3: Employees anywhere serve clients everywhere in N.D. through technology.

Strategies

1. Inventory internal and external public hardware/software technology for applicability to telemedicine.
2. Research and determine technology methods to connect clients and employees (needs, costs, resources considered).
3. Research and develop confidentiality and data security needs, policies and procedures.
4. Develop stakeholder and partner relationships and form work team (primary care, insurers, reservations community leaders, etc.).
5. Determine pilot location.

6. Develop and implement pilot project (admission details; pursue use of community human resources to manage technology, hardware, client training, etc; remediating staff skills, HR issues).
7. Develop and implement ongoing, dynamic communication plan to address practice change and increase readiness of partners – change initiative.
8. Develop plan for pilot analysis and statewide applicability (include capacity analysis: increase client access and staff capacity).

Recommendation/Outcome 4: Public/private partnerships maximize workforce availability.

Strategies

1. DHS will assess workforce needs in underserved areas.
2. DHS will discuss potential partnership opportunities in defined shortage areas.
3. DHS will study insurance coverage issues and identify solutions to barriers.
4. DHS will enter into two public/private partnerships, and study outcomes.
5. DHS will develop a model framework for increasing availability of workforce in underserved areas.
6. DHS will develop methods to expand partnerships.

Recommendation/Outcome 5: DHS has competitive recruitment and retention incentives

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Strategies

1. Increase career awareness.
2. Legislative issues.
3. Identify 'hard to fill' positions through data analysis.
4. Evaluate competitiveness of wages, benefits, and incentives.
5. Communicate consequences of
6. key workforce shortages.
7. Find a champion.
8. Tell the story.
9. Funding.
10. Incentives

Recommendation/Outcome 6: Minimum qualifications to provide behavioral health services are redefined.

Strategies

1. Identify critical areas of service needs and workforce shortages.
2. Define range of specialties & scopes of practices to meet the need (job analysis).
3. Identify areas of licensure and/or certification that need to be redefined.
4. Investigate peer support & BA level best practice models.
5. Work with DHS cabinet & state practice boards to make and promote changes.

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Introduction

Rural Behavioral Health Faces Persistent and Pervasive Issues

The April 2002 report of the President's *New Freedom Commission on Mental Health* described in detail the significant problems facing mental health systems throughout the country, particularly in rural areas. These include critical gaps in accessibility to services, shortages in the availability of providers and programs, limited acceptability of care due to stigma, and establishing mental health policy without consideration of its rural impact, to name just a few.

The President's *Commission* report acknowledged that incremental reform of the mental health system is no longer a viable option; a fundamental transformation is needed. As indicated in the "Vision Statement" of the report:

> "We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports — essentials for living, working, learning, and participating fully in the community" (p. 1).

A strong and stable behavioral health workforce is necessary in order to attain and maintain this vision.

Behavioral Health Workforce Shortages are a National Issue

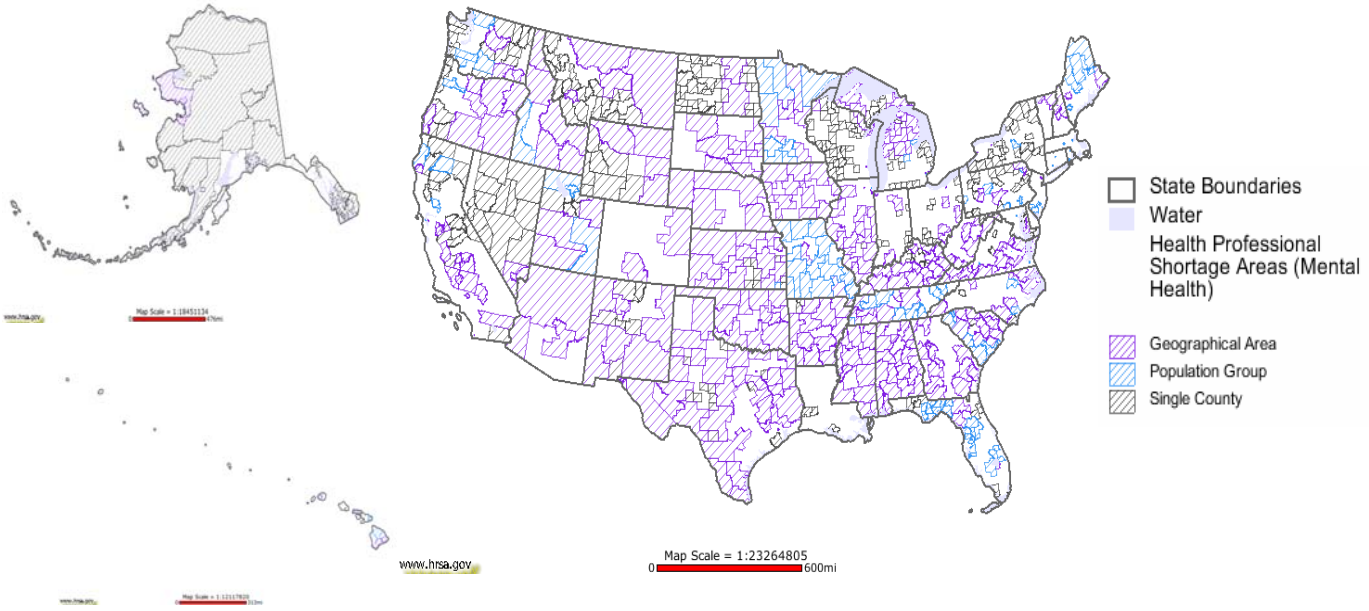
Multiple reports dating from the Eisenhower era Presidential Commission on Mental Health through today indicate that the behavioral health workforce shortage problem is persistent with little improvement.[1] This is particularly true in rural and frontier areas. For instance, the National Advisory Committee on Rural Health (1993) noted that across the 3,075 counties in the United States, 55% had no practicing psychiatrists, psychologists, or social workers, and *all* of these counties were rural. Additionally, over 85% of 1,669 federally designated Mental Health Professional Shortage Areas are rural[2] (refer to Figure 1; please see Appendix A for a definition of MHPSAs). The National Advisory Committee on Rural Health (2004) reported that the supply of psychiatrists is about 14.6 per 100,000 people in urban areas compared to 3.9 per 100,000 in rural areas. Similar shortages exist for other behavioral health professions as well, such as social work and counseling.

The ratio of behavioral health providers to the population worsens as rurality increases.[3] Holzer and colleagues studied the availability of health and mental health providers by population

[1] Bird et al., 1999; Flax et al., 1979; Larson et al., 1994; Murray & Keller, 1991
[2] Bird et al., 2001
[3] Holzer et al., 2000

density.[4] They found that only about 10% of frontier[5] counties had psychiatrists and less than 1% of very frontier[6] counties had any psychiatrists. These rates of psychiatrists per 100,000 people for frontier and very frontier counties are 1.3 and 0.1, respectively. Additionally, only 13.3% of very frontier counties had psychologists (13 per 100,000), although frontier counties had 43.1% (18.1 per 100,000). For very frontier counties, 18.5% had social workers (12.8 per 100,000), while 23.4% exist in frontier counties (9.1 per 100,000). This data shows the strong trend of sharply declining numbers of behavioral providers as one gets farther away from urban areas.

Figure 1: Designated Mental Health Professional Shortage Areas: Nationally



Federal, Regional and State Activities

Efforts to address behavioral health workforce shortages have been underway for several years. At present, there is a national endeavor to increase the workforce for all Americans, which includes rural as one of its primary focuses, as well as regional and state-level activities that have also primarily focused on rural workforce. These efforts will be briefly discussed here.

At the national level, the *Annapolis Coalition on Behavioral Health Workforce* has engaged in a multi-phase process to create a national strategic plan for behavioral health workforce development. The plan is sponsored by all SAMHSA Centers (i.e., CMHS, CSAT, CSAP) and encompasses workforce issues for a comprehensive range of specialty areas (e.g., rural, co-occurring disorders). A major goal will be to focus on common issues, while respecting the unique needs of each specialty area.

[4] http://www.du.edu/frontier-mh/letter11.html
[5] The definition of "frontier" is based on that of the Frontier Mental Health Services Resource Network, which is a county with less than 7 persons per square mile (it is slightly altered to be 2 to 6.9 persons per square mile, to include the categorization "very frontier").
[6] "Very Frontier" is a county with 0 to 1.9 persons per square mile.

The desired results from the multi-phase process include: 1) broad national consensus on mission, vision, and strategic directions; 2) a proposed plan of action for SAMHSA and its federal partners; 3) a set of high priority interventions; 4) new or strengthened partnerships to implement the interventions; 5) focused action at federal level; 6) focused action at the state and local levels; 7) focused action at the organizational level (providers, associations, educational); and 8) stimulate collective and individual action.

The phases of planning for development of the national strategy began at the start of 2005, with expert input from persons in recovery and their families, as well as specialists in the field, and consensus-building occurring from February to September 2005. A plan was created in December of 2005, and was followed by public comment. The next step in developing the national strategic plan was to build on previous workforce initiatives and seek broad input from the field to identify a core set of strategic directions, specific, achievable goals, and a set of high priority ***action*** items for strengthening the workforce.

On a regional level, the call for western states to engage in formal efforts to develop a strong and able behavioral health workforce occurred in September 2003, during a regional meeting in Reno, Nevada. The basic premise of the meeting was that behavioral health and higher education can collaborate to develop effective workforce development strategies. This required a discussion of the multilevel contexts in which workforce shortages exist, the implications of these shortages, and possible solutions.

Top educators, providers, and legislators attended the Reno Meeting from western states, including representatives from Nevada. The Western Interstate Commission (WICHE) Mental Health Program facilitated the meeting for Higher Education. WICHE's mission includes 1) assisting states in the improvement of systems of care for consumers and their families and 2) advancing the preparation of a qualified workforce in the West.

The Reno Meeting identified a number of factors and issues that confront behavioral workforce development in rural and frontier areas, including:

1. Components of a transformed rural and frontier mental health shortage initiative;
2. Strengths of the region;
3. Regional barriers/challenges;
4. Academic Assets.[7]

Following the Reno Meeting, the WICHE Mental Health Program received funding from SAMHSA to sponsor a second conference to bring together public behavioral health system and higher education stakeholders to continue the efforts of the Reno Meeting. "Building Partnerships in Rural Mental Health Workforce Development Meeting" was held in Mesa, Arizona in March 2005.[8] WICHE collaborated with the *Annapolis Coalition* to merge efforts and inform the national strategy on issues germane to rural behavioral health.

[7] The "Reno Report" can be seen at http://ruralhealth.hrsa.gov/pub/WicheMH.asp
[8] The "Mesa Report" can be obtained by contacting WICHE directly at www.wiche.edu

Four specific recommendations for rural behavioral health initiatives were produced by the attendees to be included in the National Strategy for Workforce Development:

1. Distance Learning: Use Distance Education as a strategy to deliver seamless training across the rural behavioral health care career ladder. (Each State will identify their unique needs.)
2. Community-Specific Needs: Consult communities about their specific needs as defined by the community itself.
3. Include "Rural" in Cultural Competence: Determine ways to introduce "rural" and "cultural humility" into cultural competence (i.e., unique aspects of rural; no one "rural;" values of individual and community, spirituality, and linguistics).
4. Training in Model Rural Treatment Programs: Promote the adoption of rural training programs by identifying model programs and replicating and tailoring them to other rural communities.

Finally, the WICHE Mental Health Program has worked with three of its member states on projects specifically focused on developing the rural behavioral health workforce. The first project occurred in Alaska shortly after the Reno meeting. In December 2003, faculty in behavioral health disciplines from the University of Alaska, Fairbanks and Anchorage campuses met to discuss important issues and goals related to developing the workforce. The WICHE Mental Health Program conducted key informant surveys of faculty and facilitated the December meeting, then helped organize and facilitate the Alyeska summit in May 2004, which resulted in the identification of specific workforce development goals and support of 1.178 million dollars for these efforts.

A particular strength of the Alaska approach was using a data-driven decision making process. University faculty involved in the partnership, with the help of WICHE, synthesized data regarding behavioral health professional shortage areas, workforce projections, student totals in each of the behavioral health programs and projected graduates, as well as macro-level trends such as the number of people projected to enter versus leave the workforce by 2025. The use of data helped clarify areas of need, present and future workforce trends, and focused decision-making.

The State of Arizona began its behavioral health workforce development initiative in April 2004 to integrate higher education behavioral health curricula with state practice models and the reality of practice in the public behavioral health system. This partnership has involved a number of meetings of faculty, CMHC staff, consumers and consumer advocates, as well as state personnel. WICHE facilitated the meetings which focused on developing mission statements and specific, concrete, and achievable goals. In addition to the goal of integrating clinical practice models with higher education curricula, Arizona is ultimately trying to develop and recruit a workforce that is representative of the local communities, using a "grow your own" approach. Although the project continues, a major event was a one-day conference held in April 2005 to disseminate the project to university faculty and enlist their help in making it a reality.

The most current state that WICHE is working with on workforce initiatives is Nevada. Nevada is in the beginning stages of this process and recently convened an information-gathering meeting in Las Vegas. Nevada commissioners, the Director of Mental Health, and numerous

representatives from higher education institutions attended this meeting. Nevada is one of the fastest growing states in the country and is facing a severe shortage of mental health professionals. Nevada is proactively working with its colleges and universities to develop an integrated system of graduate programs based on the Alaska model and specifically tailored to meet the growing mental health needs of its diverse rural population.

* * *

The national, regional, and state efforts currently underway indicate significant momentum behind behavioral health workforce development, particularly in rural areas. These activities provide a context in which the State of North Dakota is now undertaking its own workforce development project. North Dakota already has initiated some focus on health workforce issues in rural areas. A Health Workforce Summit was held on December 5, 2006[9]. Ideas and activities produced from this summit will likely be very informative to the current behavioral health workforce project. This report presents a picture of the current state of North Dakota's behavioral health workforce. Specifically, this report will describe 1) activities at the federal, regional and state level that have set the groundwork for a more formal process of workforce development, 2) components of an effective workforce, 3) population trends and projections, 4) prevalence estimates of behavioral health disorders and unmet need, 5) the state's occupational forecast, and 6) existing behavioral health training programs in higher education, including enrollment trends.

This report is an initial step in synthesizing relevant information that can inform future discussions and activities. However, it is beyond the scope of this report to describe all possible factors that impact workforce development. Instead, it looks at four key areas that have arisen in similar work in other states that bear most directly on behavioral health workforce. It is assumed that those in North Dakota working in the system understand issues that also affect the workforce but that are not described fully here.

[9] http://www.med.und.nodak.edu/depts/rural/rhw/summit/

North Dakota Behavioral Health Workforce Shortages

North Dakota's Public Behavioral Health System

The North Dakota Department of Human Services is committed to providing their diverse population with "quality, efficient, and effective human services that improve the lives of people." To accomplish this mission, the department utilizes a strong umbrella structure, which facilitates communication and the ongoing development of a solid community-based system of mental health care throughout the state. However, the department also recognizes that there are issues present that hinder the full accomplishment of their mission. This report presents the major barriers and provides a platform for the stakeholders in the state to design and implement responses to address those barriers.

The Department of Human Services consists of two components: Program and Policy and the Human Service Centers. Program and Policy incorporates the Division of Mental Health and Substance Abuse Services (DMHSAS), which plans, develops, and implements the necessary components of the community-based mental health care delivery system. The Human Service Centers implement this system to provide a network of services across the state that encompasses the spectrum of necessary mental health care. Most centers contain an interdisciplinary team consisting of a psychologist, masters-degreed social worker, masters-degreed human relations counselor, psychiatric nurse, psychiatrist, and/or a licensed addiction counselor.

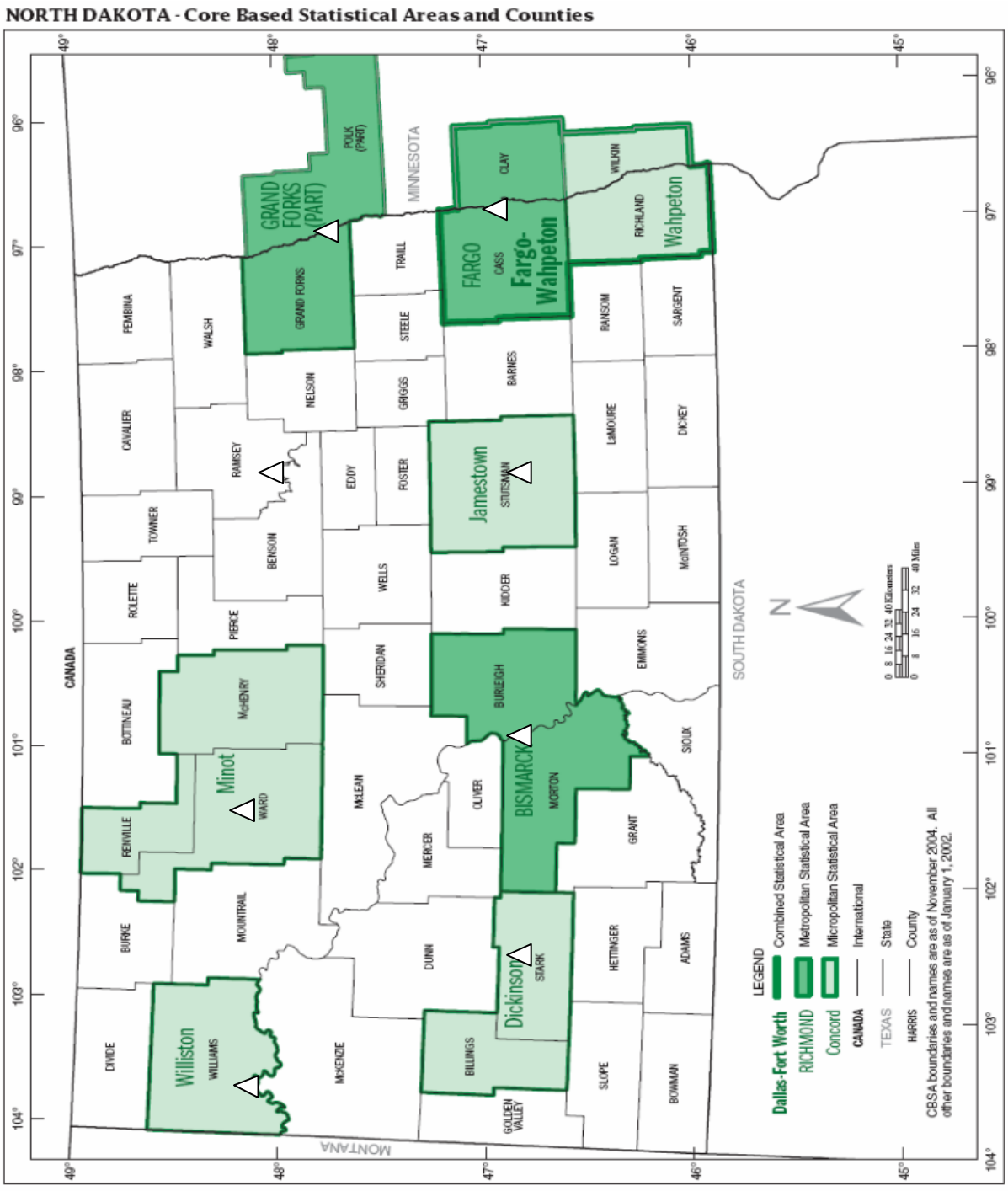
In addition to these agencies, the North Dakota State Hospital provides total care to individuals with mental illness and/or substance abuse issues consisting of physical, medical, psychological, rehabilitative, social, recreational, and spiritual services. Through the collaborative efforts of the Department, the Planning Council, consumers and family members, private providers, consumer advocate groups, tribal representatives, and many other mental health stakeholders, the community-based mental health delivery system continues to grow and thrive (please see Appendix B for highlights of recent human service center initiatives in 2006-7).

Included on Figure 2 are the locations of the eight human service centers throughout the state (see Appendix C for a complete list of the human service centers along with Appendix D for the core services provided). One can see that most clinics are located in the major population centers in the state.

Virtually the entire state (46/53 counties, 23 geographic areas, and 16 facilities) is designated as a federal Mental Health Professional Shortage Area (MHPSA; see Appendix E for current information on counties and facilities in North Dakota with MHPSA designation) with most designations based on ratios of providers to population.[10] Thirty-seven of the 53 counties have a frontier designation with densities ranging from 0.6 to seven persons per square mile. This places North Dakota 44th in the nation for the most number of MHPSAs. [11] In addition, North Dakota is ranked 48th in the nation for greatest disparity between urban and rural areas.

[10] HRSA website; http://hpsafind.hrsa.gov/HPSASearch.aspx
[11] *Development Report Card for the States, 2003 State Summaries*; Corporation for Enterprise Development.

Figure 2: Core Based Statistical Counties and Human Service Center Locations



△ - Human Service Center Locations

According to the U.S. Department of Health and Human Services,[12] North Dakota:

- Had 55 psychiatrists, 530 psychologists, and 700 social workers in 2000. This was equal to 8.6 psychiatrists, 82.7 psychologists, and 109.2 social workers per 100,000 individuals.
- Ranked 34th among states in psychiatrists, **2nd for psychologists per capita** and 43rd among states in social workers per capita.
- Ranked **1st among the states in per capita health services employment in 2000.**
- Health services employment in North Dakota grew 29% between 1988 and 2000, while the states population declined by 2%, resulting in a **net per capita growth of 32% in health services sector employment.** This exceeded the national rate of per capita growth in the health services sector of 21%.

Staff vacancies continue to present challenges in managing ever-increasing caseloads. As of March 31, 2007, the Department of Health Services reported 89 vacancies in the behavioral health sector. It notes that DHS is falling behind in its ability to keep up with the marketplace salaries paid in the private sector. Hiring staff is difficult due to low unemployment (4%). In addition, market equity issues in high demand areas such as psychology, nursing, and addiction counseling have led to extended vacancies, affecting service capacity. There is also the issue of recruiting professionals to serve in the rural and frontier areas of the state. The professionals that are hired often experience a high turnover rate due to problems of cultural and rural competence. For instance, young professionals often come from schools that do not have an appropriate curricula regarding rural or cultural competence. North Dakota would like to look at higher education to turn out students who are able to work in rural/frontier areas.

Based on the self-identified areas of unmet need selectively listed below, North Dakota is implementing or planning to implement a number of remedial actions (please see Appendix F for a complete listing of areas of unmet need and their corresponding action plans).

- Access to psychological and psychiatric services in a timely manner can be challenging in some areas of the state. Again, the challenges of recruiting and retaining clinical staff has resulted, at times, in longer waits to receive some clinical services.
- Community-based mental health and substance abuse services for adults and children are full.
- Lack of increased funding for human services is a local concern.
- There are limited resources for completion of assessments. Because of the challenges recruiting and retaining clinical staff, workloads at the regional human service centers have increased at times resulting in delays in receiving an assessment.

In addition, the North Dakota Healthy People 2010 Report (2005) identified the following priorities to be addressed:

- 18-1: Reduce suicide deaths to 5.0 per 100,000 population.
- 18-2: Reduce Adolescent Suicide Attempts Resulting in Need for Medical Attention to 1 percent or less.

[12] HRSA State Health Workforce Profiles, Highlights, North Dakota.

- 26-6: Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol to no more than 30 percent.
- 26-11a: Reduce the proportion of high school seniors engaging in binge drinking to no more than 11 percent.
- 26-11c: Reduce the proportion of adults age 18 and older engaging in binge drinking to no more than six percent.

To accomplish these and other workforce development goals in North Dakota, collaboration among the following programs will be necessary: 1) Executive Branch of state government, including the Department of Human Services (DHS), the Division of Mental Health and Substance Abuse Services (DMHSAS), and the Human Service Centers; 2) Legislative Branch of government, 3) University and Community College System of North Dakota; 4) occupational boards; and 5) the Western Interstate Commission for Higher Education. Improving recruitment and retention will improve accessibility in North Dakota. Impressing upon those who make budgetary decisions that North Dakota programs can succeed only if they are developed and evaluated with a "rural yardstick" (not urban).

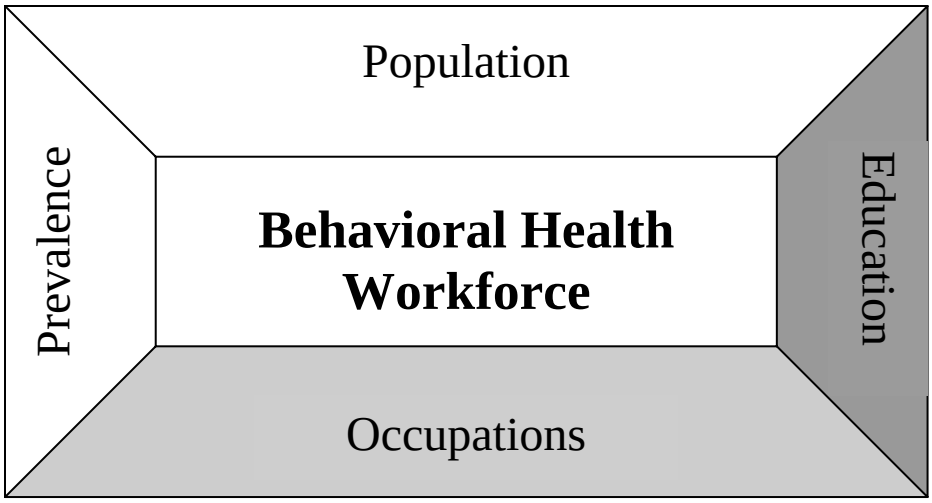
In addition to the potential strategies alluded to above, North Dakota can choose from a wide variety of methods to develop the behavioral health workforce. However, some of the best strategies come from people working in the behavioral health system or higher education in North Dakota, particularly those with training responsibilities. Thus, the WICHE Mental Health Program will help North Dakota through facilitation of processes used successfully in other states for workforce development.

Components of a Strong and Effective Workforce

At any given time, the need for workforce development in behavioral health is determined by the prevalence of behavioral health disorders and the number and location of professionals to provide services. Prevalence rates are based on epidemiological studies of populations, while the number and location of clinicians is based on the interplay of education and occupation trends. Both are estimates, and there are multiple reasons beyond limited availability why those who need treatment do not seek it (e.g., lack of awareness of a problem, stigma, etc.). Additionally, a *competent* and *adequate* workforce has the right number of experienced and skilled people in the right jobs at the right time.

Thus, establishing and sustaining an effective mental health workforce involves several components:

- A profile of present *population* and demographics;
- An estimation of the *prevalence* of mental illness;
- An analysis of the professional *occupations* available to serve the community;
- A picture of the *higher education* programs designed to supply well-trained professionals.



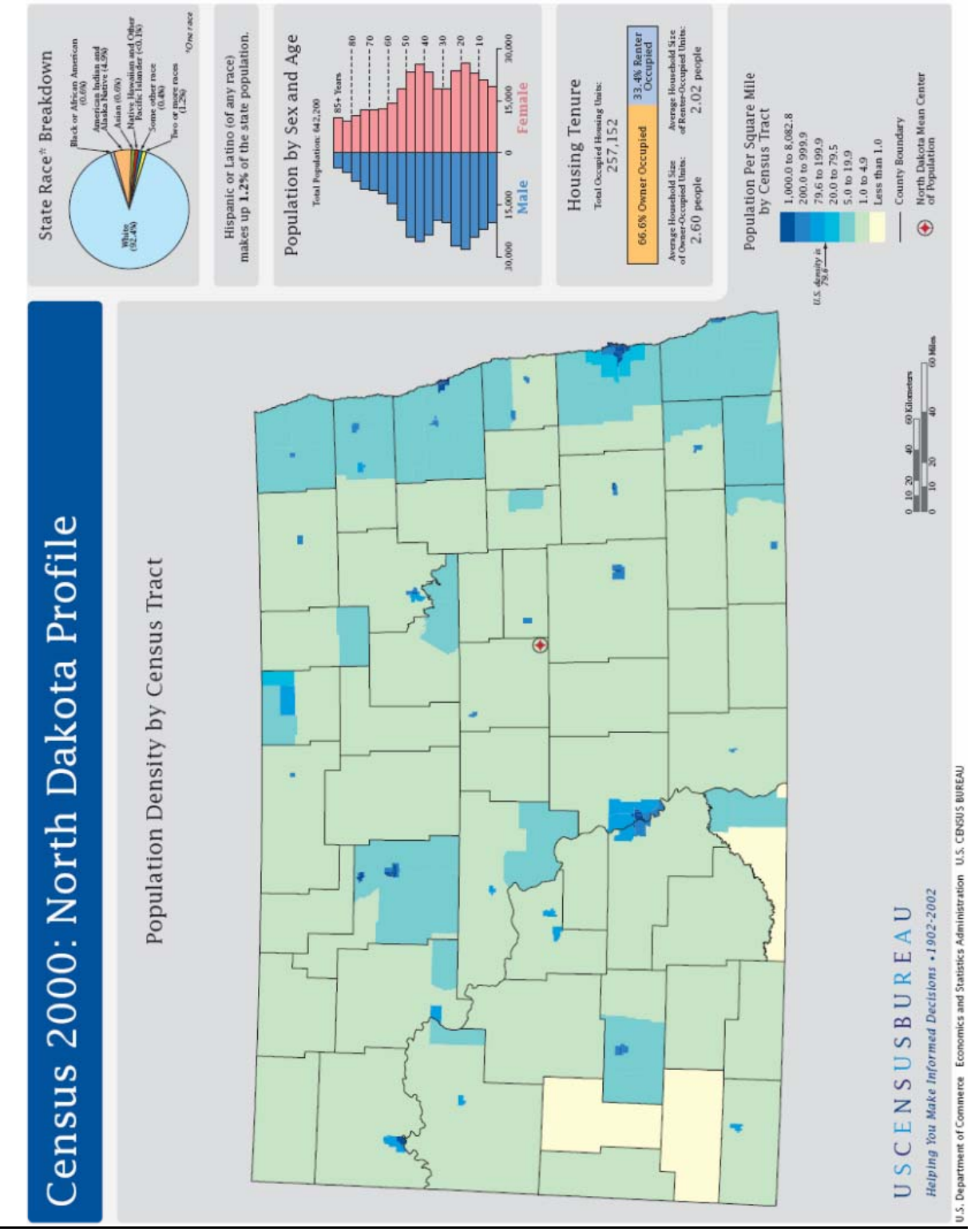
Each of these four components interrelates, and changes to one often affect the others. For instance, large and rapid increases in population can translate into greater numbers of people with a behavioral health problem (even if the percentage remains the same). Nevertheless, it can also mean more people available to enter the behavioral health field as clinicians. Thus, it is important to study previous trends to project future courses. More importantly, these projections allow decision-makers to identify potential avenues of growth, as well as barriers and means of overcoming them. The sections that follow review relevant data in each of these four areas.

North Dakota's Population Demographics

According to the Census Bureau, North Dakota has a land area of 70,762 square miles and a population of 642,200, with an average of 9.3 persons per square mile. North Dakota is one of the few states in the country experiencing a decline in population since the 1980's, particularly among younger people with university degrees. Between 1990 and 2000, North Dakota's population decreased 2.1%, while the USA's population increased 13.1%. Approximately 40% of the population lies in the eastern region bordering Minnesota and only 10% borders Montana in the western region. The urban counties of Cass, Grand Forks, Burleigh, and Ward account for half of the population (49%), with the remainder of the population spread across the remaining 90% of the state (please see Appendix G for a list of county populations and densities). Thirty-five out of 53 counties fall in the "frontier" category and two counties fall into the "very frontier" category.[13]

[13] Using the Frontier Mental Health Services Resource Network's definition described earlier, in "The Availability of Health and Mental Health Providers by Population Density," Letter to the Field No. 11.

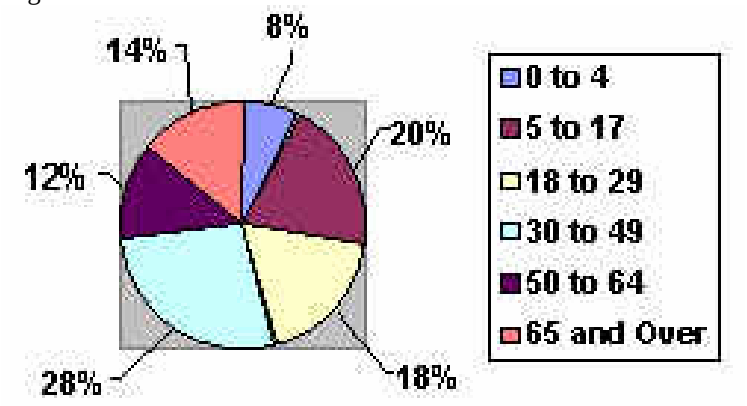
Figure 3: Census 2000 North Dakota Profile



Population by Age

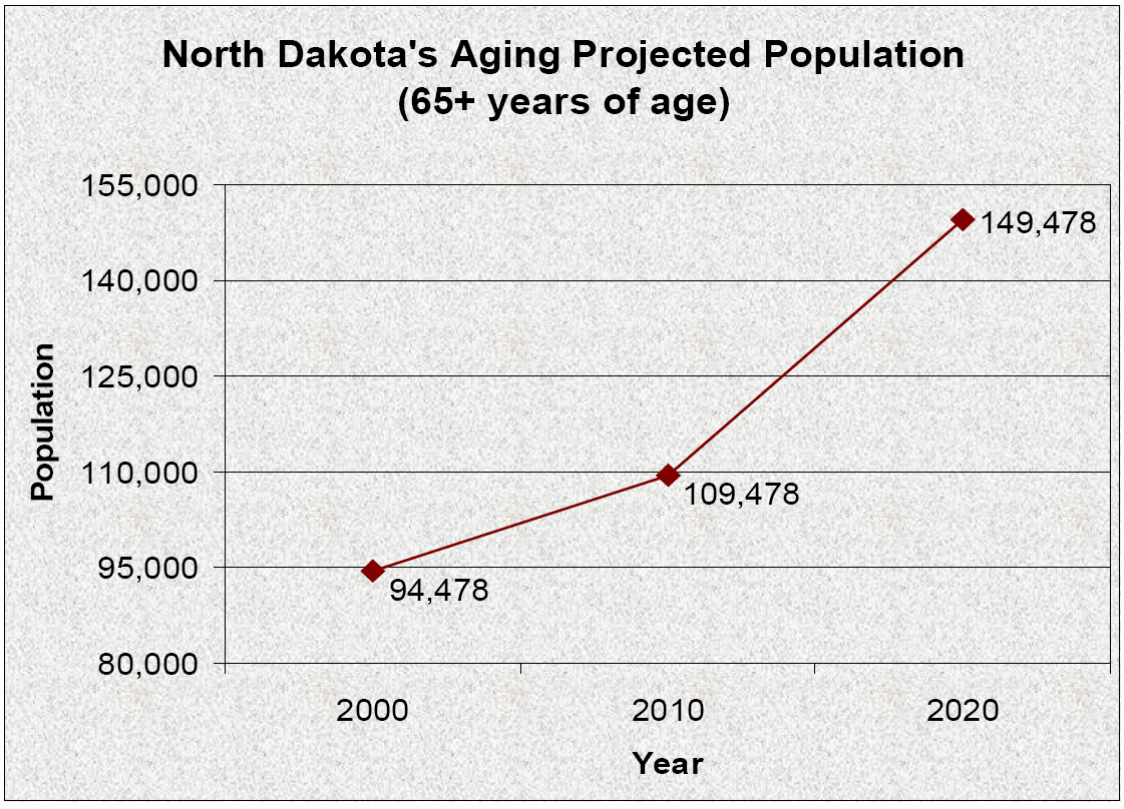
The total North Dakota estimated population for 2006 is 635,867. The greatest population density by age in the State of North Dakota is in the 30 to 49 age group, with 78,999 residents. The lowest density is in the 0 to 4 age group with 47,961 residents.

Figure 4: Population by Age[14]



According to Minot State University, North Dakota ranks first in the nation in the percentage of total population age 85 and older and fifth in the nation for ages 75 to 84.

Figure 5: North Dakota's Aging Population Projection



[14] http://www.dpi.state.nd.us/adulted/statplan/chap2.shtm

Population by Gender and Ethnicity

North Dakota's population consists of approximately 49.8% males and 50.2% females. North Dakota's largest ethnic population reported is White, which represents 91.5% of the population. The second largest ethnicity reported is American Indian, which represents 4.9% of the population. Of the remaining ethnic groups, Asians represent 0.9%, Blacks represent 0.8%, and Native Hawaiians represent 1% of the population. Those reporting 'Some Other Race" or "Two or More Races" represented 1.8% of the total population.

Table 1: North Dakota Population by Race, US Census 2000

North Dakota[15]	
Total	**642,200**
White	593,181
Black or African American	3,916
American Indian or Alaska Native	31,329
Asian	3,606
Native Hawaiian and Other Pacific Islander	230
Other	2,540
Two or More Races	7,398

Population Trends

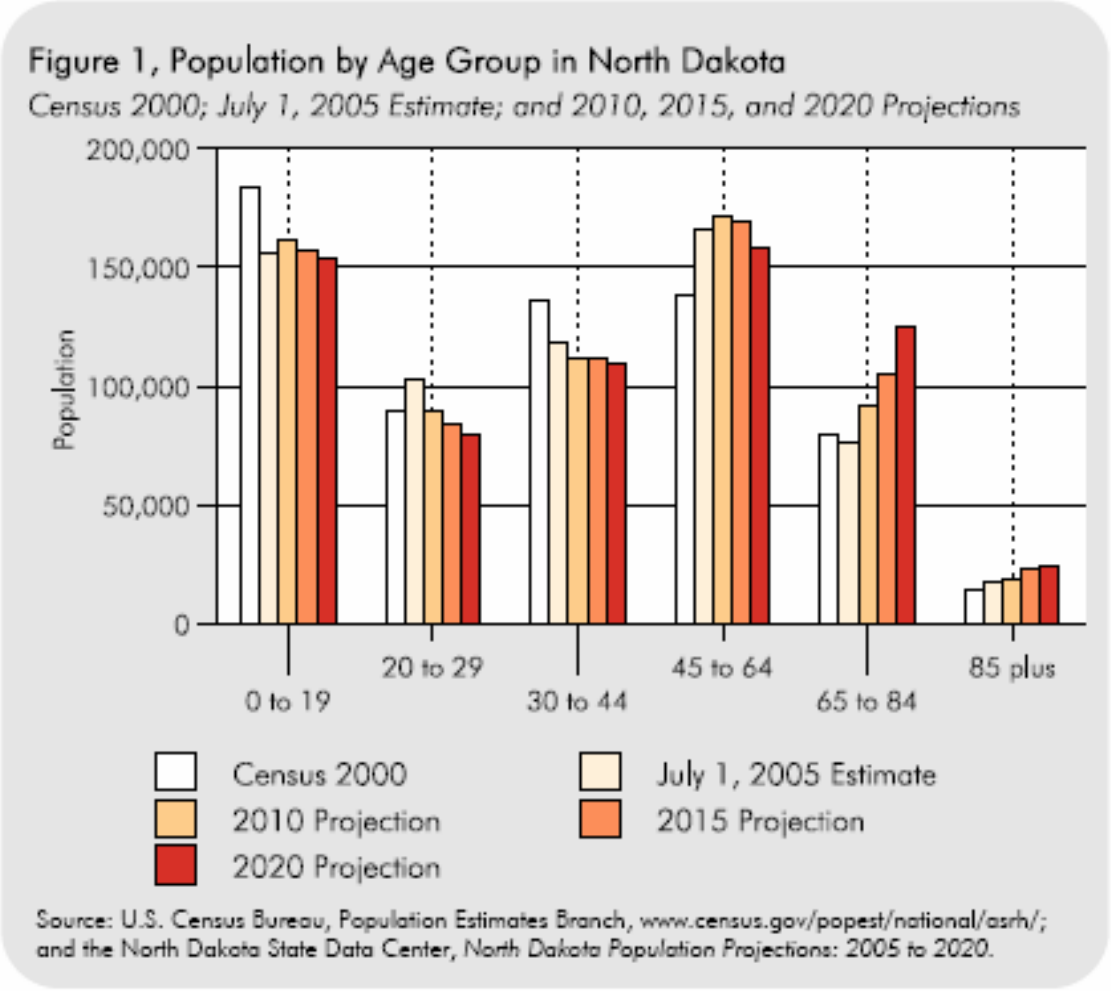
According to estimates released by the U.S. Census Bureau, the number of North Dakotans ages 45 to 64 increased by 27,032 people or 19.5 percent between 2000 and 2005.[16] The US Census projects that over the next ten years significant increases will occur in the 45+ age group while the 45 and under age group will likely see declines in numbers. This places an increasing burden on the working cohort to provide for a proportionately larger retirement group. The state is also experiencing a steady decline in birthrates. In addition, many of the young adults, especially those with college educations, are leaving the state to find opportunities elsewhere.

The combination of these two trends, the increase in the 65+ age group and the decrease in the 0-44 age group, creates a serious unbalance. It will become increasingly difficult to find caregivers to offset the increasing mental health needs of the elderly. The North Dakota Center for Persons with Disabilities is addressing this serious trend in conjunction with the eight regional Human Service Centers and numerous stakeholders.

[15] http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=DEC_2000_SF1_U&-mt_name=DEC_2000_SF1_U_P003&-CONTEXT=dt&-tree_id=4001&-all_geo_types=N&-geo_id=04000US38&-search_results=01000US&-format=&-_lang=en

[16] http://www.ndsu.edu/sdc/publications/population/PB_22_10press.pdf

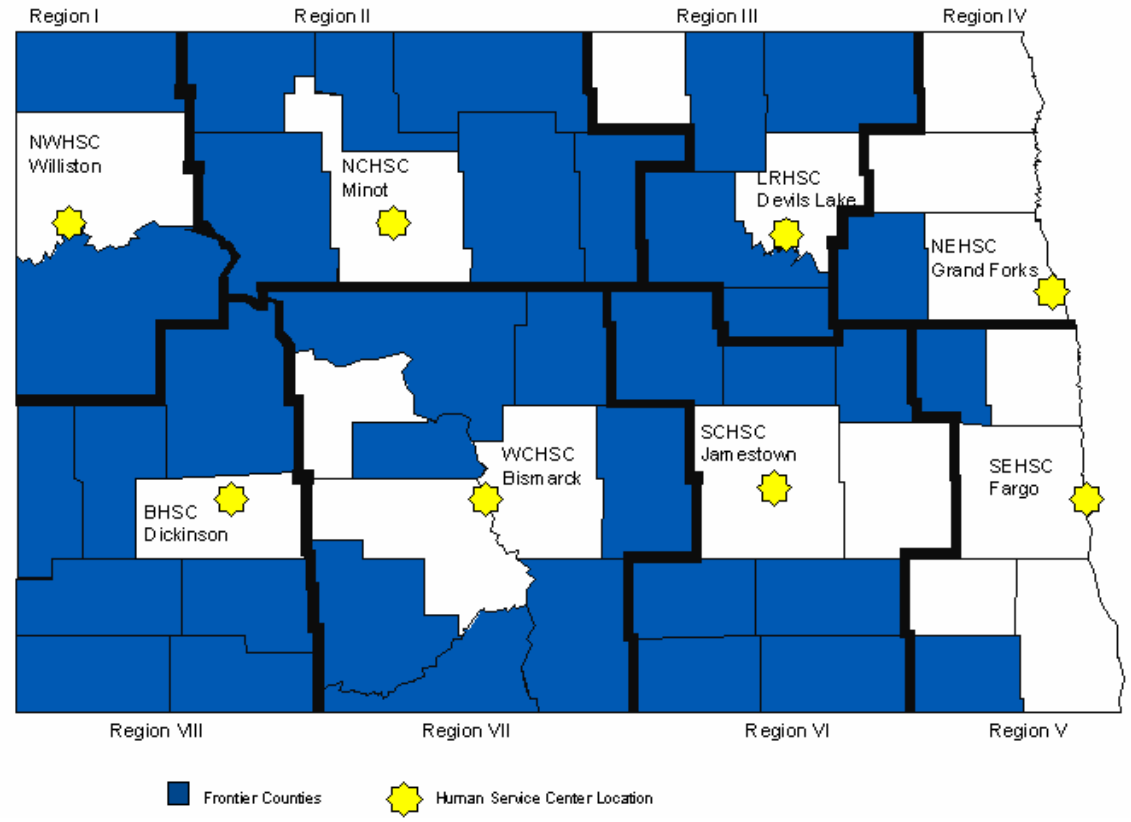
Figure 6: Population Trends by Age Group



Behavioral Health Disorder Prevalence Data for North Dakota

North Dakota does not collect formal estimates of prevalence of Serious Mental Illness (SMI) or of Serious Emotional Disturbances (SED) for the state. Thus, the following information is based upon the established prevalence percentages provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). According to SAMHSA, the prevalence rate for SMI is 5.4% of the population and the population with SMI in serious need of services is 2%. Tables 2 and 3 are printed in the FY 2008 North Dakota Mental Health Block Grant and provide estimated prevalences and actual numbers served within the state. The following map is provided as a reference to the eight North Dakota regions.

Figure 7: Map of North Dakota Regions



In the two largest regions of North Dakota (Region V and VII), there are an estimated 12,630 adults with SMI. Of these adults, only 3,371 received services in 2006 (see Table 2). This represents a potential gap of 9,259 adults not receiving services through the state. The penetration rate was 26.7%, with a remaining unmet need of 73.3%. Across the other regions, the penetration rate ranges from a low of 16.3% (Region II) to a high of 35.4% (Region I). At present, there are no data gathered to indicate the numbers of consumers receiving mental health services outside of the public mental health service system. However, the Office of Applied Studies estimates that the prevalence of Serious Psychological Distress in North Dakotan adults is 57,000 (11.82% of the population).

Table 2: Estimate of Prevalence, Need, and Numbers Served for Adults with SMI at HSCs

REGION	Population >17 (2004 Census)	Population with a SMI (1)	Population with SMI in Need of Services (2)	Actual # Served at the HSC (FY 2006) (3)	Actual # Served at the HSC (FY 2007) (3)	Estimated # to be Served at the HSC (FY 2008) (4)
I	20,995	1,134	420	402		0
II	64,716	3,495	1,294	570		0
III	30,544	1,649	611	374		0
IV	69,546	3,755	1,391	1,224		0
V	130,779	7,062	2,616	2,199		0
VI	46,582	2,515	932	645		0
VII	103,112	5,568	2,062	1,172		0
VIII	29,137	1,573	583	377		0
TOTAL	**495,411**	**26,752**	**9,908**	**6,963**		**0**

(1) & (2) Estimation based on 5.4% and 2%, respectively, of total State Adult Population as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121).
(3) From ROAP adults with PopCode 37. FFY2004 data were gathered during a year of transition from one statewide computer system (ARIS) to the new one (ROAP). This was done in increments with regions, phasing in ROAP while ARIS stayed on line until all regions had ROAP. SFY2005 data came directly out of the new system (ROAP).
(4) Estimation based on anticipated 2% growth.

In the two major regions of North Dakota (Region V and VII) 2,644 children and youths are under the purview of the Division of Child and Family Services. The penetration rate was 25%, with a remaining unmet need of 75%. Across the other regions, the penetration rate ranges from a low of 7.8% (Region III) to a high of 62.9 (Region VIII). The number of people served is based only upon those people who received services at a regional HSC and does not reflect services that may have been provided by other agencies or private providers.

Table 3: Estimate of Prevalence, Need, and Numbers Served for Children with SED at HSCs[17]

REGION	Population <18 (2004 Census)	Population with a SED (1)	Population with SED in Need of Services (2)	Actual # Served at the HSC (FY 2006) (3)	Actual # Served at the HSC (FY 2007) (3)	Estimated # to be Served at the HSC (FY 2008) (4)
I	5,990	246	120	101		0
II	19,422	796	388	123		0
III	11,249	461	225	36		0
IV	18,658	765	373	243		0
V	35,828	1,469	717	375		0
VI	11,332	465	227	172		0
VII	28,652	1,175	573	286		0
VIII	7,824	321	156	202		0
TOTAL	**138,955**	**5,697**	**2,779**	**1,538**		**0**

(1) & (2) Estimation based on 4.1% and 2%, respectively, of total State Population under age 18 as specified for North Dakota by CMHS "Estimate of Prevalence for Adults with Serious Mental Illness (SMI)" (Federal Register, Vol. 64, No. 121)
(3) From ROAP children and adolescents with PopCode 22.
(4) Estimation based on anticipated 2% growth.

As figure 8 shows, the preponderance of presenting problems served at the regional HSCs is substance use at 41%, followed by Depression at 21%. However, it is important to note the numerous other presenting issues, which demonstrates the spectrum of treatment the HSCs must perform utilizing shrinking resources. In addition, approximately 15% of consumers present with co-occurring disorders that require complex levels of care and services.

[17] http://www.nd.gov/dhs/info/pubs/docs/mhsa/draft-2008-mh-block-grant-applic.pdf

Figure 8: Top 10 Presenting Problems at the Eight Regional Human Service Centers

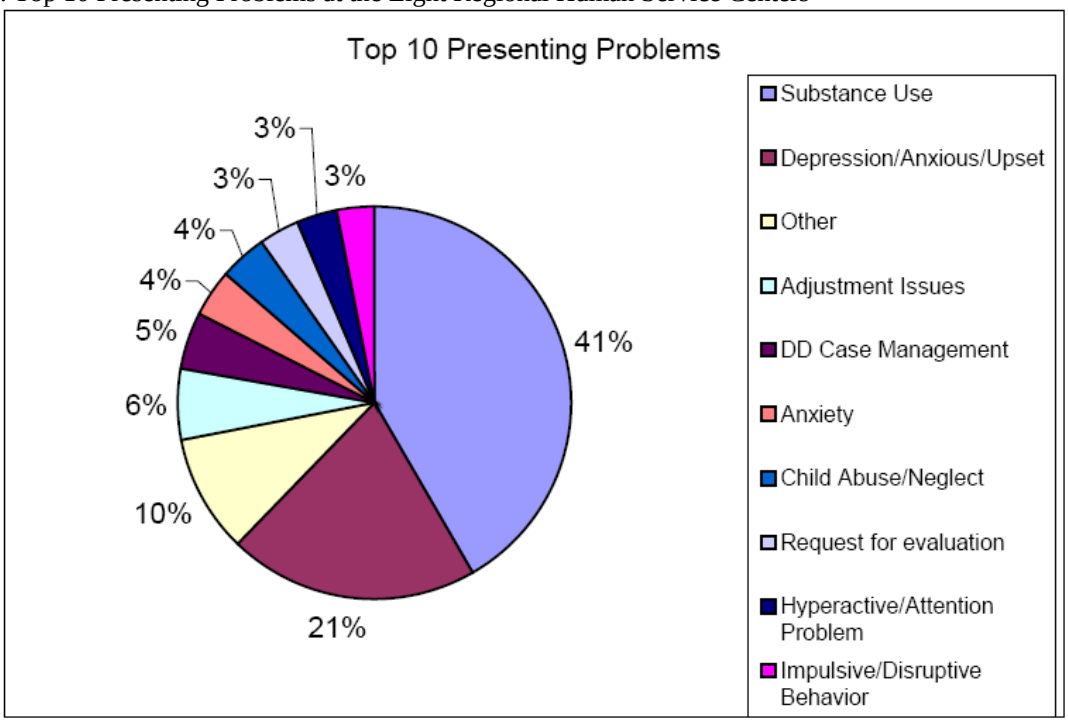
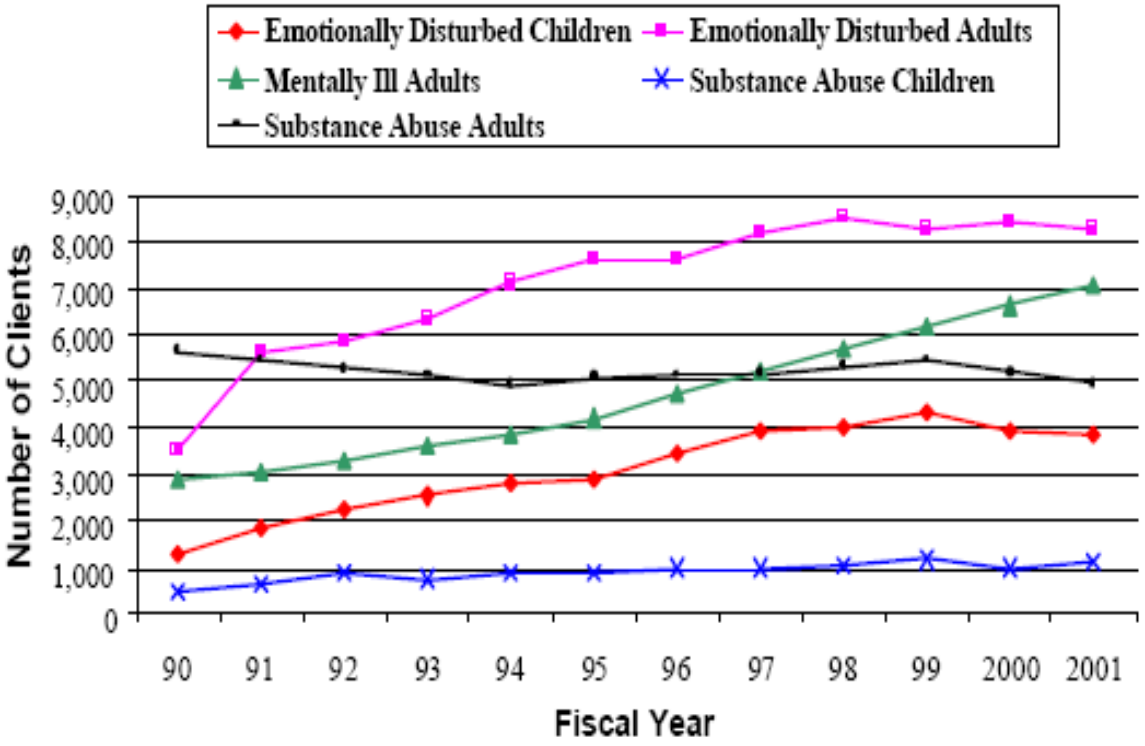


Figure 9 shows the treatment trends from 1990 to 2001. There have been increases in all treatment types provided, except for adults abusing substances. The number of people accessing services at the human service centers has increased 82% to 25,124. Particularly, the number of adults with mental illness has increased 144%. This increase in service demand has not been met by an increase in funding. Since 1997, the general fund expenditures of the North Dakota mental health system has increased by only 12%. The impact of this disparity is discussed in further detail in a later section.

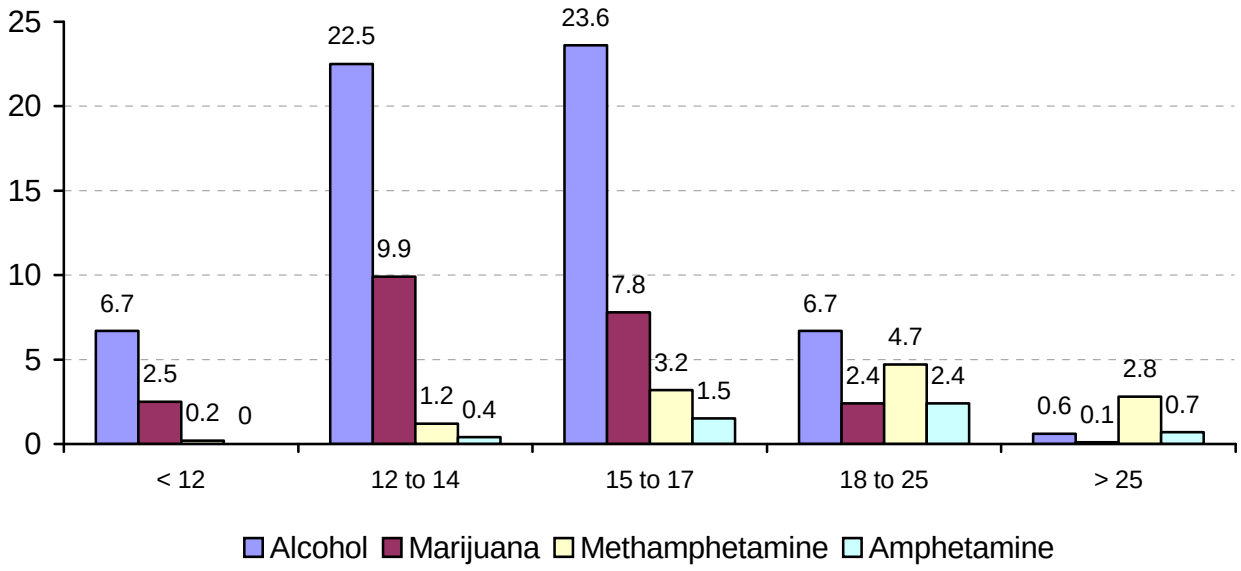
Figure 9: North Dakota Regional Human Service Center Clients Served by Treatment Type[18]



The following information addresses the substance abuse prevalence and trends. According to an in-depth needs analysis conducted by North Dakota in 2002[19], alcohol abuse is the State's major substance abuse problem. There was a significant discrepancy between rural and urban rates, with rural areas generally reporting higher alcohol abuse rates and urban areas reporting higher drug abuse rates. According to Figure 10, in the 17 and under age group, alcohol abuse has the highest treatment percentage in the human service centers, followed by marijuana abuse. In the 18 to 25 age group, alcohol remains the highest percentage, however, methamphetamine abuse moves to second place. In the 25+ age group, the percentages fall to very low usage in all substances except for methamphetamines. The increasing use of substances by children is a growing trend in North Dakota. As shown on Figure 9 above, between 1990 and 2001, the number of children who have received substance abuse treatment services at a human service center increased by 137%, while the number of adults decreased by 13%.[20]

[18] http://www.nd.gov/humanservices/info/pubs/docs/services-for-people-with-disabilities.pdf
[19] http://www.nd.gov/humanservices/info/pubs/docs/nd-chartbook-second-edition.pdf
[20] http://www.nd.gov/humanservices/info/pubs/docs/services-for-people-with-disabilities.pdf

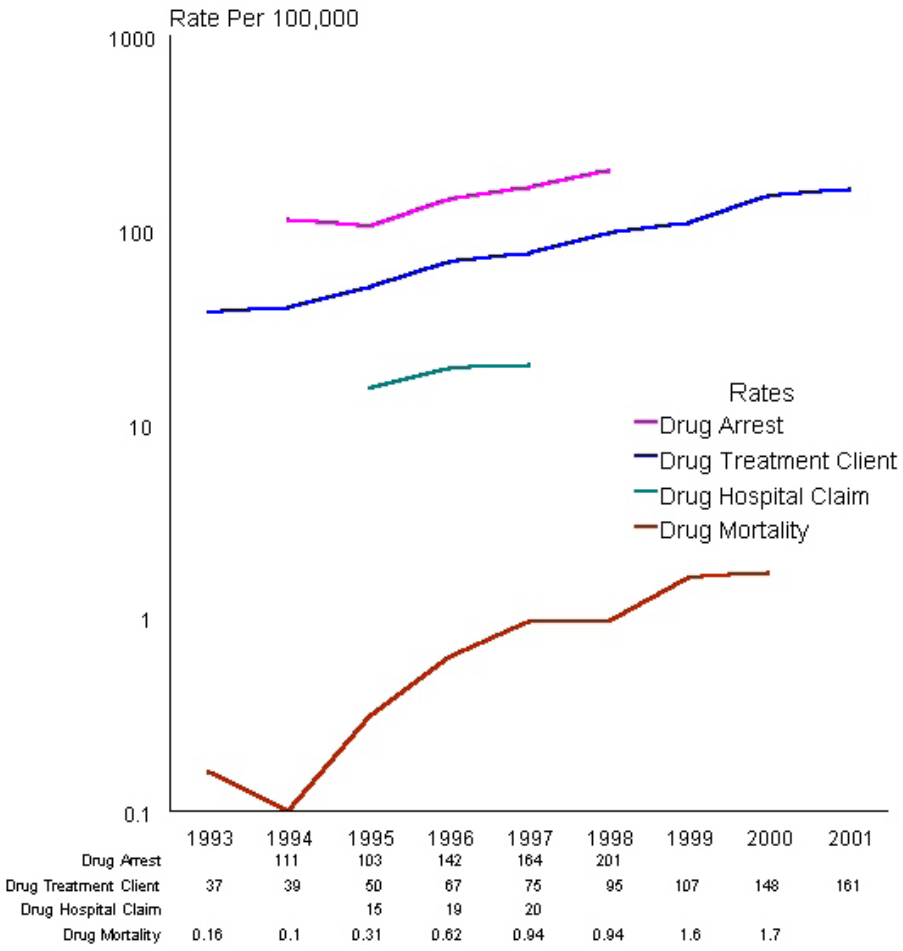
Figure 10: Percent of Persons Receiving Substance Abuse Services at Regional Human Service Centers by Substance and Age – CY 2005[21]



North Dakota's drug abuse indicators are among the lowest in the nation. However, one alarming trend found by the need analysis is the state's drug mortality rate jumped sharply from 1993 to 2000. Figure 11 demonstrates that rates have gone up in all areas of drug-related indicators.

[21] http://www.nd.gov/humanservices/info/pubs/docs/2006-06-20-alt-to-incarceration-powerpoint.ppt

Figure 11: Drug-Related Indicators in North Dakota



The overall behavioral health data indicate that children and youths are served at relatively the same rate compared to adults. While 27% of adults receive mental health services statewide, 26% of children and youths are receiving needed services. There is some variation among counties, with some counties providing more services to one population or the other. One significant trend in the Department of Public Health is the large increases of children and youth qualifying for services, qualifying at younger ages, and presenting with multiple and more complex issues in both mental health and substance abuse. In addition, approximately 15% of clients present with both mental health and substance abuse diagnoses and many substance abusers abuse multiple substances. These clients need community wrap-around services to support their stability, minimize symptoms, and decrease hospitalizations.

Although American Indians are a relatively small percentage of the population, they are the primary racial minority in North Dakota. Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing health care, including mental health services, to American Indians living on or near the reservation.

IHS is responsible for the delivery of health services to federally recognized American Indian and Alaska Natives through a system of IHS, tribal, and urban (ITU) operated facilities and programs that are based on treaties, judicial determinations, and Acts of Congress.

Two major pieces of legislation are at the core of the federal government's responsibility for meeting the health needs of AI/AN: The Snyder Act of 1921 and the Indian Health Care Improvement Act, Public Law 94-437. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of AI/AN. The IHCIA of 1976 was enacted "to implement the federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs[22]."

IHS is complicated and is often believed to be similar to an insurance program, but IHS is a provider of care. IHS has a finite category of funds known as Contract Health Service (CHS). CHS dollars are available to pay for critical care that IHS cannot directly provide, thus the dollars are contracted out to other health care providers[23].

In North Dakota, IHS offers mental health services. If the individual is in need of psychiatric hospitalization and is without health insurance or Medicaid, options become limited when accessing private care. A referral can always be made to a state institution. IHS refers individuals to the state hospital and human service centers with a sliding fee.

State funded services are not readily accessible to people living on the reservations due to distance and lack of transportation. Ten miles may not seem a great distance if you have a car and gas money, but if you are without both and are struggling with your mental health, it might as well be a 100 miles[24].

There is a significant amount of unmet need in North Dakota. The statewide penetration rate is 26.2%. There is some notable variation among counties. Most counties fall within the 15 to 35% range. However, in adult services Region II shows a low penetration rate of 16.3% and Region I shows a penetration rate of 35.4%. In child services, the variation ranges from a low of 7.8 to a high of 62.9%. There are numerous possible explanations for this range of penetration rates, including non-standard data collection, availability of private services, funding, geographical barriers, and accessibility. An in-depth review is recommended to determine the causational factors.

Analysis of North Dakota's Occupational Forecast

The data presented above indicates that North Dakota is currently experiencing a significant mental health workforce shortage. To gain a better picture of the state of the workforce, it is important to look at not only the present state of the workforce and how it compares to nearby states, but also how it may evolve over time. Presented here are overviews and projections for the general workforce in North Dakota, as well as a detailed focus on behavioral health professions.

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[22] Taken from a statement made by Dr. Trujillo, Director of the Indian Health Services: http://info.ihs.gov/TreatiesLaws/3-IHCIA_ReauthorizationAct-Jan2005.doc

[23] http://info.ihs.gov/Files/CHS_Profile-Jan2007.doc

[24] Thank you to Theresa Snyder, Tribal Liaison and Program Civil Rights Officer, ND Department of Human Services for clarification and resources on the American Indian section.

Overview and Projections of the General Workforce

In 2000, 92 percent of North Dakota residents aged 15 and older earned income and nearly 2/3 received wages or salary.[25] Between 2000 and 2020, projections indicate that there will be 58,882 fewer income earners below age 55 in North Dakota. However, there will be 53,280 more income earners over age 65 during that same period. There is little data available on North Dakota indicating specific employment trends and projections for the behavioral professions.

North Dakota is projected to have far less people entering the workforce than leaving it by 2025 (see Table 4 below). In the WICHE states surrounding North Dakota (marked in italics), only Montana is losing more of their workforce. North Dakota's retirement population is growing at a much higher rate than its workforce population.

Table 4: Projections of the Working and Retirement Age Populations from 2000 to 2025.26

State	Actual Pop. Ages 18-64 (2000)	Projected Pop. Ages 18-64 (2025)	% Change 2000 to 2025	Actual Pop. Ages 65+ (2000)	Projected Pop. Ages 65+ (2025)	% Change 2000 to (2025)	Entering (+) vs. Leaving (-) workforce by 2025
CA	21,026,161	28,352,207	34.8	3,595,658	6,424,090	78.7	+4,497,614
HI	755,169	1,040,295	37.8	160,601	288,581	79.7	+157,146
NM	1,098,247	1,458,993	32.8	212,225	440,582	107.6	+132,389
AK	400,516	516,611	29.0	35,699	92,235	158.4	+59,559
WY	*307,216*	*380,192*	*23.8*	*57,693*	*144,843*	*151.1*	*-14,174*
SD	*444,064*	*469,081*	*5.6*	*108,131*	*186,629*	*72.6*	*-53,481*
ND	**386,873**	**392,293**	**1.4**	**94,478**	**166,611**	**76.3**	**-66,713**
ID	779,007	940,187	20.7	145,916	374,410	156.6	-67,314
UT	1,324,249	1,559,168	17.7	190,222	494,003	159.7	-68,862
MT	*551,184*	*599,757*	*8.8*	*120,949*	*274,424*	*126.9*	*-104,902*
WA	3,718,130	4,477,116	20.4	662,148	1,580,554	138.7	-159,420
NV	1,267,529	13,44,107	6.0	218,929	486,854	122.4	-191,347
AZ	3,095,846	3,468,872	12.0	667,839	1,368,129	104.9	-327,264
OR	2,136,696	2,387,747	11.7	438,177	1,054,368	140.6	-365,140
CO	2,784,393	2,971,381	6.7	416,073	1,043,918	150.9	-440,857

[25] http://www.ndsu.edu/sdc/publications/reports/2007EconImpactSeniorPop.pdf
[26] http://www.higheredinfo.org/

Overview of Behavioral Health Professions

The states composing the Midwestern Region are some of the most rural in the nation. Data for comparing the states are drawn from the Bureau of Labor Statistics (BLS) website. The BLS maintains data for each of the 50 states regarding 11 behavioral health disciplines, including Clinical, Counseling, and School Psychologists; Substance Abuse and Behavioral Disorder Counselors; Educational, Vocational, and School Counselors; Marriage and Family Therapists; Mental Health Counselors; Child, Family, and School Social Workers; Medical and Public Health Social Workers; Mental Health and Substance Abuse Social Workers; Psychiatrists; Psychiatric Technicians; and Psychiatric Aides. Some professionals are grouped together even though they may have some differences in professional focus or activities (e.g., Clinical, Counseling, and School Psychologists). There was no data for North Dakota regarding four professions, Psychologists, All Other, Marriage and Family Therapist, Mental Health Counselors, and Psychiatric Aides, and so these will not be included in the table.

Table 5 below presents data from the Bureau of Labor Statistics for each of these disciplines in North Dakota for 2006, including the number of employed professionals, number of professionals per 100,000 persons in the state, as well as the ranking of a given profession among the 12 Midwestern states. In terms of professionals per 100,000, North Dakota ranks, on average, 3rd in the Midwest on professions with available data. The best rankings (1st) are for Educational, Vocational, and School Counselors, Medical and Public Health Social Workers, and Psychiatrists, while the lowest ranking (7th) were for Child, Family, and School Social Workers and Psychiatric Technicians. Additionally, six of the eight (75%) professional groups with available data ranked between 1st and 4th in number of professionals.

Table 5: Midwestern Regional Comparison of North Dakota's Behavioral Health Occupations[27]

	Total Employment[a]	**Employment Per 100,000**	**Rank Among 12 Midwestern Regional States[b]**
Clinical, Counseling, and School Psychologists*	310	48.8	2
Psychologists, All Other	N/A	N/A	N/A
Substance Abuse and Behavioral Disorder Counselors	220	34.6	4
Educational, Vocational, and School Counselors	670	105.4	1
Marriage and Family Therapists	N/A	N/A	N/A
Mental Health Counselors	N/A	N/A	N/A
Child, Family, and School Social Workers	630	99.1	7
Medical and Public Health Social Workers	460	72.3	1
Mental Health and Substance Abuse Social Workers	310	48.8	4
Psychiatrists*	60	9.4	1
Psychiatric Technicians	80	12.6	7
Psychiatric Aides	N/A	N/A	N/A

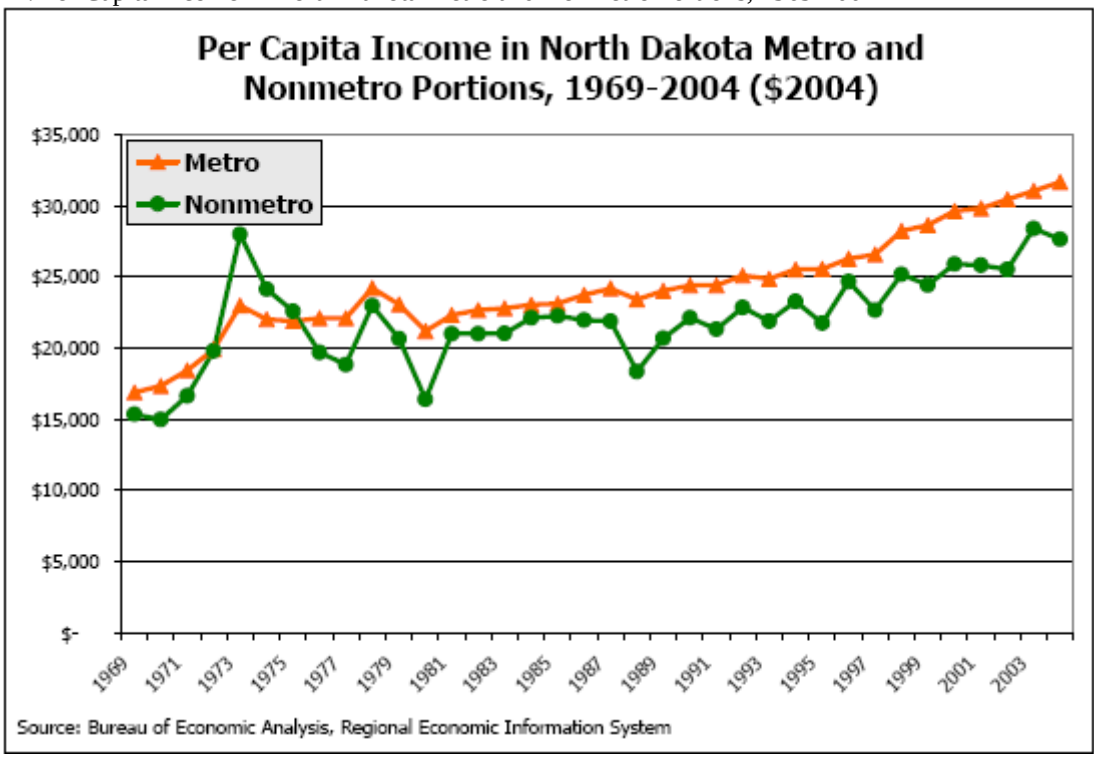
Note. Data were not available for all states.
[a]Estimates do not include self-employed workers. [b]Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.
* Data from the state licensing board indicates that there are 193 licensed psychologists (which includes clinical, counseling, industrial-organizational, or independent educational psychologists). Additionally, the state indicates having 92 licensed psychiatrists. Thus, there is some inconsistency between federal and state data. We assume that there are fewer psychologists, but more psychiatrists, than indicated by BLS data.

[27] http://stats.bls.gov/oes/current/oes_nd.htm

Several caveats should be kept in mind when considering these rankings. First, these comparisons are among the 12 Midwestern states and rankings might be different if looking at the whole country. Second, data was not available for given professions (e.g., Marriage and Family Therapists) in all states, which could also affect rankings. Additionally, although North Dakota may rank highly for a given behavioral health clinician within the Midwestern region, the trends of the state (based on data presented in earlier sections) suggests a decreasing workforce, increasing number of people with mental health and/or substance use problems, and a fairly large percent of unmet need (i.e., the number of those estimated to have a given mental health problem vs. those being served). Thus, these trends strongly suggest the need to boost the state's workforce to meet growing demand.

Of particular concern to North Dakota is the per capita income statewide and for behavioral health in particular. For most of the past several decades, North Dakota per capita income has lagged behind the nation and nonmetro has lagged behind that of the metro population.

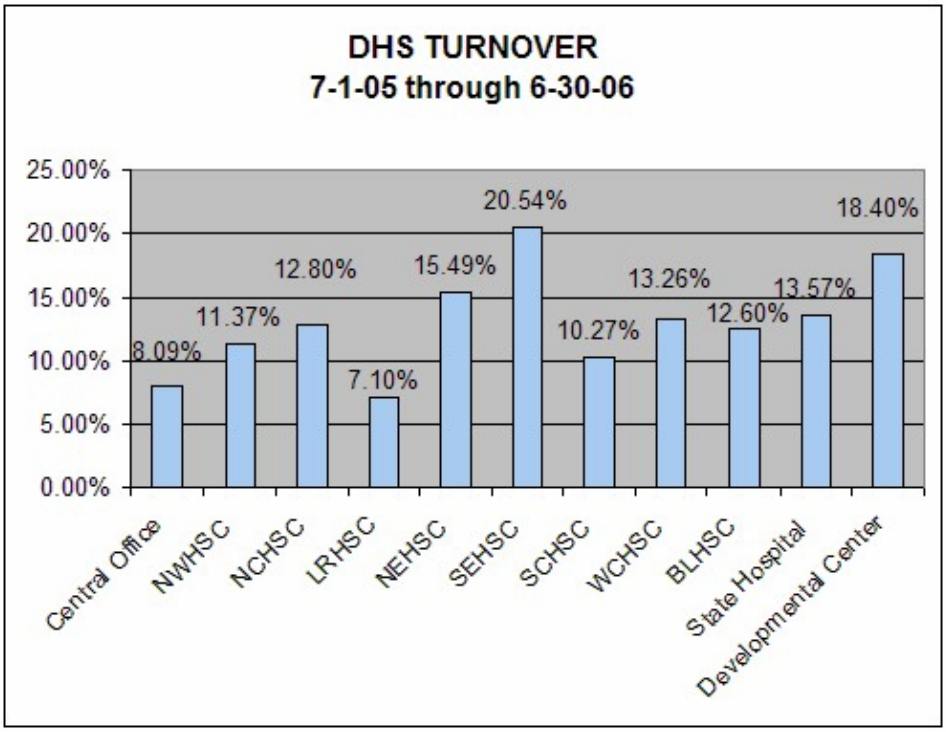
Figure 12: Per Capita Income in North Dakota Metro and Nonmetro Portions, 1969-2004



Within the behavioral health field, the DMHSAS recognizes that state professional positions are not competitive with the broader job market. Clinical positions in the state compete with private positions that pay anywhere from $5-50,000 more per year depending on the specific occupation. One striking example is the psychologist who left one of the HSCs to take a job in the private service sector for $120,000 per year. At the HSC, that individual was earning $54,516 per year. In addition, there are only minor differences in salaries for positions that have noticeably different lengths of employment, suggesting a low rate of pay increase over time. This income discrepancy combined with low pay increases contribute to serious recruitment and turnover

issues (e.g. 21% staff turnover rate in Fargo in FY2006), resulting in 89 currently unfilled positions in the state. Figure 13 shows the turnover rate for each of the eight regional HSCs, the Central office, the state hospital and the developmental center. In 2005-2006, the turnover rates ranged from 7.10% to 20.54%, with an average of 13.04%. Unfortunately, the impact of prolonged vacancies is more powerful in rural areas of the state where there are fewer private providers.

Figure 13 : Utah DHS Turnover Rates



North Dakota has taken a number of steps to address the vacancy issues, including numerous presentations to the ND Legislature, contracting with private providers, and working with the Employee Benefits Programs Committee (EBPC) on improving clinical staff benefits. The DHS also has an optional professional development program to assist with coursework completion. Reimbursement is up to 80% of the cost of the course(s).

On March 5, 2007, the House passed a bill relaxing the requirements for addictions counselors' licensure to encourage more counselors to attain licensure and apply for state positions. The following excerpt is a statement made by Marcie Wuitschick, HR Director for the North Dakota Department of Human Services:

> In terms of administrative changes, one example that happens frequently is when we fill a position of Advanced Clinical Specialist, we recruit for two levels of licensure; one being the LICSW/LPCC and the other being LCSW/LPC. We then can attempt to attract applicants who might qualify at either level, so as not to box ourselves into a corner of accepting only one or the other.
>
> The other most frequent example is the use of underfilling. For example, if there is an option for an Addiction Counselor II, we will put a modification in the job announcement, which states that if we cannot obtain a suitable applicant at the Addiction Counselor II level, we will "under fill" the position at the

> Addiction Counselor I level. In recent years, we have also needed to under fill that level with the Addiction Counselor Intern or Addiction Counselor Trainee level. That allows us to attract applicants who can work towards qualification at that higher level.
>
> The third thing we do frequently is offer paid internships to staff. In the past we found that there were plenty of applicants willing to work on an unpaid basis; this is not the case any longer. We are finding that in order to get them in our facility in the first place, we need to pay them a minimum of $10 per hour, and that number continues to rise.

Loan repayment programs do provide a reason for many young professionals to live and practice in rural areas, but the period of repayment tends to be limited and it is unclear to what extent those participating in the program are trained in rural behavioral health. In addition, North Dakota has lost its National Health Service Corps designation for loan repayment, due to stricter parameters by NHSC. This might have a significant impact on recruitment of psychologists, nurse practitioners, physician's assistants and physicians.

In some cases, DHS has worked with colleges to modify coursework offerings to tailor them to the needs of the state. However, these are not legislative changes, but more administrative changes. There has been some legislative work done to change licensing requirements in the areas of addiction counseling and nursing. These changes will allow for smoother entry for applicants into these professions and more applicants for jobs in these areas in DHS. Combined, these measures are a positive first step and provide stakeholders in the state a foundation for continuing the process of addressing the workforce challenge.

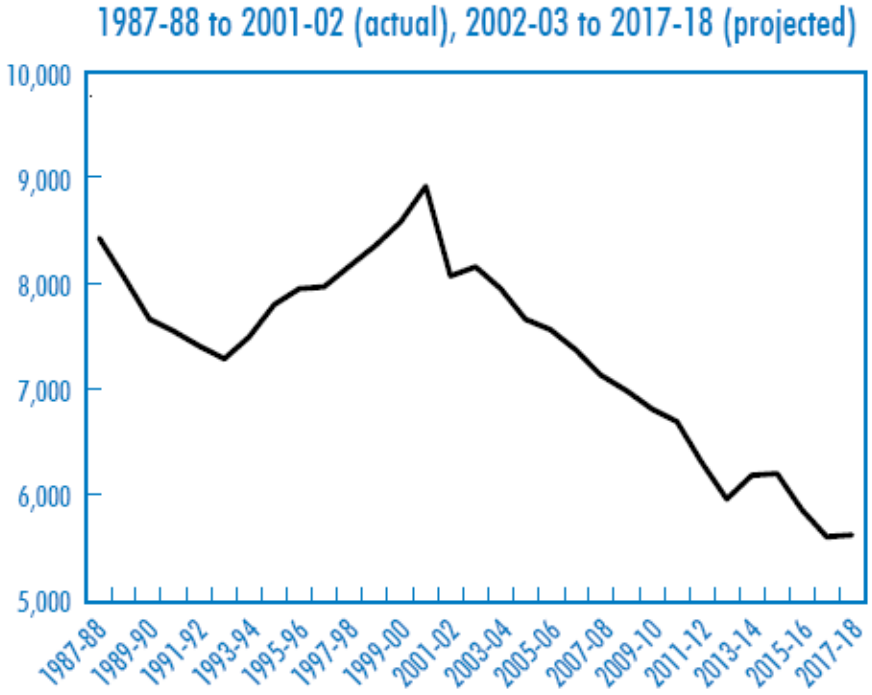
North Dakota Higher Education

In order to meet the current and future unmet needs of those with behavioral health problems, a large number of professional positions in behavioral health need to be filled. Additionally, those trained to become behavioral health clinicians require exposure to issues facing rural residents. Higher education behavioral health programs are a logical and important part of achieving these goals.

Recent research by the National Center for Public Policy and Higher Education suggests that demographic changes to the country's population could lead to decreases in high school and college diplomas, as well as personal income in the next 15 years.[28] Specifically, there are projected to be "substantial increases in America's young population with the lowest level of education, combined with the coming retirement of the baby boomers—the most highly educated generation in U.S. history..." (p. 1). The number of public high school graduates in North Dakota is expected to decrease to 5,613 in 2017-18, a 30.6% change from 2001-02, as shown by Figure 14.

[28] http://www.highereducation.org/reports/pa_decline/index.shtml

Figure 14: North Dakota Public High School Graduates[29]



Despite this projected decline, the Manhattan Institute reports that North Dakota has the second highest high school graduation rate in the country with 88%.[30] The National Center for Public Policy and Higher Education also notes that North Dakota is the best performing state in the country with high school students enrolling in college by age 19.[31]

According to a WICHE Workforce Brief on North Dakota:[32]

> Between 2002 and 2012, the rate of job growth in North Dakota will be modest: under 1 percent annually. However, a large number of positions– close to a quarter of all jobs in the state – will open up for hiring due to retirements and separations. In addition, the demand for well-educated employees will only increase over the next several years. In the decade leading up to 2012, healthcare occupations will see growth of 14 percent. The growth of these sectors is good news for North Dakota's citizens, since wages for jobs in these areas are significantly higher than the average for North Dakota in general. But entry into these jobs comes with a price tag: most positions in these fields will require a bachelor's degree or higher. The question for North Dakota and other states is how, in a time of tight budgets, to meet the increasing demands on higher education and thereby meet the needs of an increasingly sophisticated economy.

The percent of the population that has earned a Bachelor's Degree or higher in the United States is 24.4 percent and 22 percent in North Dakota. Figure 15 shows the educational attainment between metro and nonmetro populations in the state.[33] While the graduation rates are higher for nonmetro students at the high school level, more students in metro areas go on to complete some level of college.

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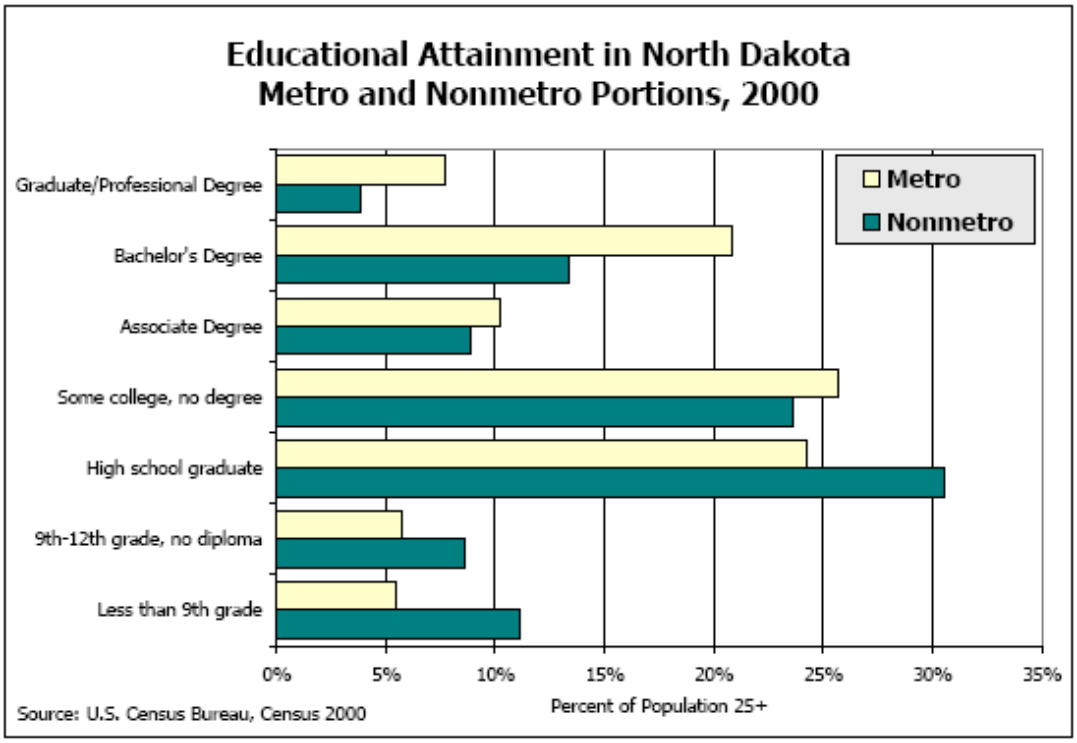
[29] http://www.wiche.edu/policy/Knocking/1988-2018/profiles/nd.pdf
[30] http://www.manhattan-institute.org/html/cr_baeo.htm
[31] http://measuringup.highereducation.org/_docs/2006/statereports/ND06.pdf
[32] http://wiche.edu/Workforce/nv.pdf
[33] http://www.cdktest.com/rupri/Forms/NorthDakota.pdf

Only 48% of full-time college students complete a bachelor's degree within six years. In addition, only 28% of the state's population aged 25 to 65 has attained a bachelor's degree or higher. This places residents at a disadvantage when applying for the increasing number of jobs that require a higher education, weakening the state's economy.

Figure 15: Educational Attainment in North Dakota, Metro and Nonmetro Portions, 2000



The North Dakota University System notes the following disturbing trends in the state:

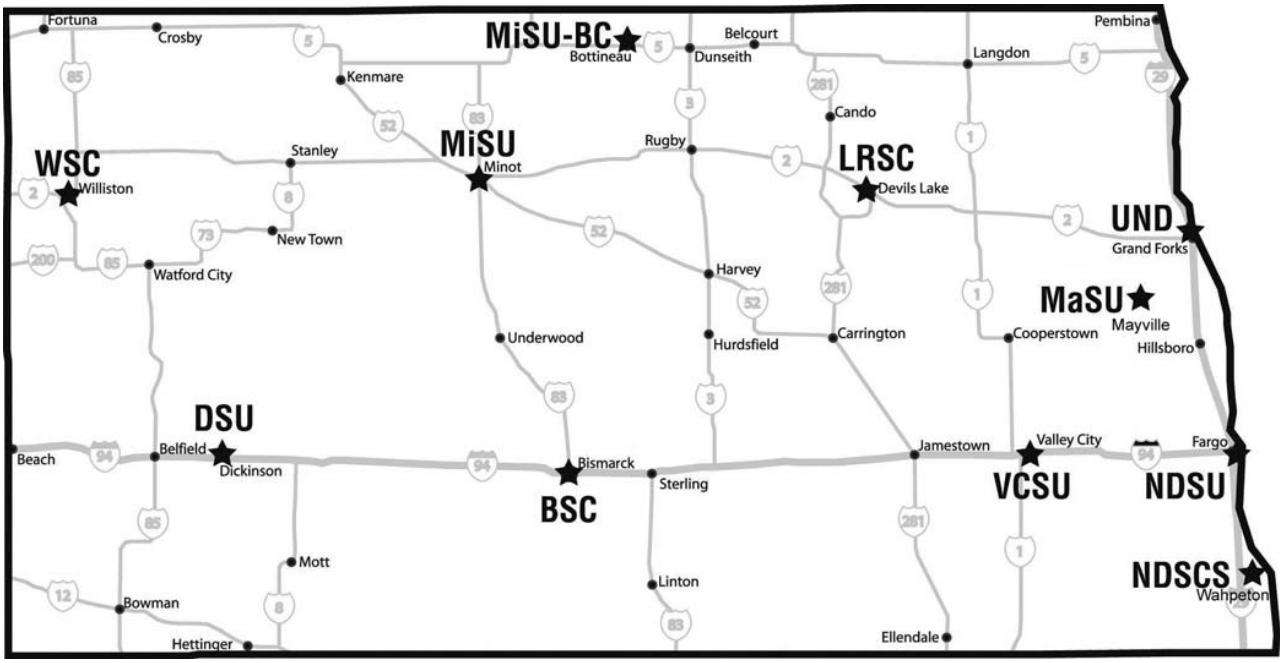
- Declining population, especially young people and adults in the prime working years of their lives.
- Falling further and further behind the rest of the country in per capita income, threatening the ability of its citizens to maintain their quality of life.
- Being increasingly unable to compete in the new information-based economy.

Further exacerbating these issues is the lack of affordable colleges in the state. North Dakota's investment in need-based financial aid is very low compared to the rest of the nation. Attracting people to higher education will be a significant challenge for educators and crucial to building a stronger workforce. In response, the North Dakota Roundtable on Higher Education was created by the legislature in 1999 to monitor the status of higher education and to ensure that higher education policy is closely linked to state priorities.

North Dakota University System (NDUS)

The North Dakota University System (NDUS) encompasses 11 public colleges and universities governed by the State Board of Higher Education. The NDUS is composed of two doctoral-granting institutions, two masters-granting institutions, two universities that offer baccalaureate degrees and five campuses that offer associate and trade/technical degrees (Please see Appendix H for a list of the institutions). The map below shows the locations of each of the institutions. Despite the lack of affordability, one of the strengths of the NDUS system is there are 1,766 more students entering the state than leaving for college. In addition to the NDUS institutions, there are five tribal colleges and four private schools (please see Appendix I for a complete listing).

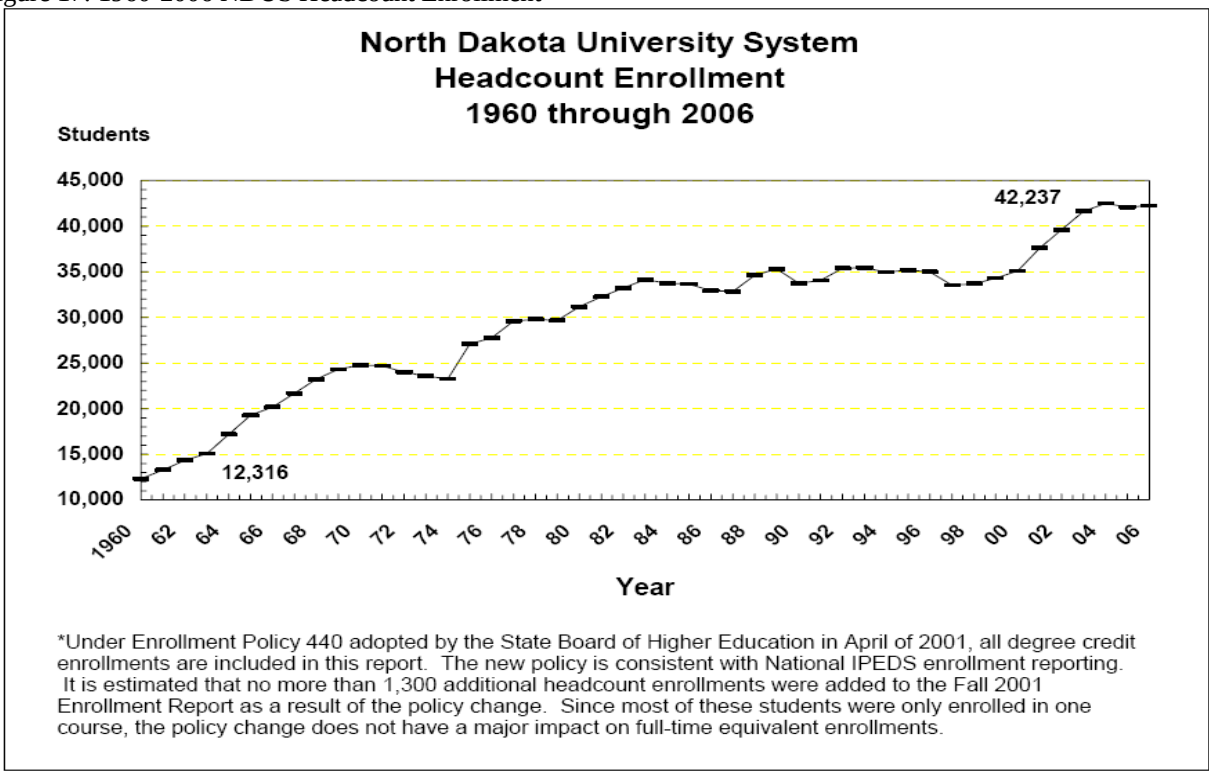
Figure 16: Location of Schools in the North Dakota University System



Type of Institution:
Doctoral Universities: UND, NDSU
Masters Universities: MiSU, VCSU
Bachelor's Universities: DSU, MaSU
Community Colleges: BSC, LRSC, MiSU-B, NDSCS, WSC Research Extension Agronomy Seed Farm-Casselton, Carrington, Central Grasslands- Centers: Streeter, Dickinson, Hettinger, Langdon, North Central-Minot, and Williston

According to the NDUS 2007 Resource Guide, overall enrollment in the NDUS system has increased from 12,316 in 1960 to 42,237 in 2006.

Figure 17: 1960-2006 NDUS Headcount Enrollment



NDUS Behavioral Health Programs

The North Dakota University System offers programs that range from certificates to doctoral and professional degrees. There are at least 11 behavioral health programs offered in the public higher educational system (e.g., psychology, social work, etc.). There is no indication of degreed programs offered in psychiatry or psychiatric aides. Table 6 provides a breakdown of the programs offered by institution.

Table 6: Program and Degrees Offered by Institution

	BSC	DSU	LRSC	MaSU	MiSU	MiSU-B	NDSCS	NDSU	UND	VCSU	WSC
Addiction Studies	4*				4						1-2
Mental Health Care							2				
Counseling and Guidance								G	G		
Forensic Psychology									G		
Mental Health/Addiction Technician											1-2*
Nursing		2,4			4						1-2
Psychology/Applied Psychology/Experimental		4		4	4			4G	4G	4	
Psychology, Clinical	4								G		
Psychology, Counseling									G		
School Psychology					G						
Social Work	4*	2			4		2		4G		

1 = less than one year, 1-2 = one - two years, 2 = two years, 4 = four years, 4+ = more than 4 years, G = graduate school, 4G = four years or a graduate program, C = upper-level certificate programs, * = indicates the program may also be offered through distance education.

Table 7 presents detailed enrollment rates by degree and institution. Not all institutions reported the degree of enrollment for their student body, nor were all the behavioral health degrees tabulated. According to the table, there were 2191 students enrolled in Nursing, 311 in Social Work, 996 in Psychology, 80 in Counseling, 86 in Addiction Studies, and 10 in Mental Health Care. This is a grand total of 3,674 students enrolled in behavioral health related degrees. In addition, the human service centers and the state hospital work together with the behavioral health programs to provide internships and teaching opportunities (please see Appendix J for a listing of internships available at each center).

Table 7: College/University Enrollments - Spring 2007

	Nursing	**Social Work**	**Psychology**	**Counseling**	**Addiction Studies**	**Mental Health Care**
BSC	16-PN 16-ADN					
DSU	144		82			
Jamestown College	146		26		7	
MiSU	256-PrN/Major	100-Major	118-Major 12-Minor		36-Major 5-Minor	
NDSU	418 – BA 12- MA		285-BA 20-MA 18-PhD			
United Tribes Technical College	17-BA					
UND	306-BA 69-MA 17-PhD 321-PrN	55-PSW 83-BA 41-MA	304- BA 69-MA 24-PhD	80	4	
University of Mary	273-BA 45-MA	32	38-BA		16	
WSC	100-PN 35-RN				12- AA 6-Cert.	
NDSCS						10-AA
Total	**2159**	**311**	**996**	**80**	**86**	**10**

AA – Associates, BA – Bachelor's, MA – Masters, PhD – Doctoral, PN – Practical Nursing, RN (ADN) – Associate Degree Nursing, and Cert – Certificate.

Search Conference

A process for identifying goals and strategies for behavioral health workforce development called a "Search Conference" was conducted August 28th - 29th, 2007. The North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services sponsored this event. As described below, this process looks at a "System" to identify important and influential factors, strengths, weaknesses, trends, and, ultimately, solutions. In this case, the System was defined as "People with a clear and direct interest in accessible quality behavioral health care from North Dakota's Department of Human Services."

A Search Conference also has a theme. The theme of this Search Conference was, "The future of behavioral health care work force development in the North Dakota Department of Human Services – recruitment, retention, and preparation for serving North Dakota's demographics." Finally, the purpose of the Search Conference was to create "A list of preliminary recommendations for recruitment and retention of North Dakota's Department of Human Services' behavioral health care work force."

Richard Mettler, an expert on and facilitator of the Search Conference, and consultant with WICHE, provided a definition and description of this process (paraphrased here): The Search Conference is a group process designed for any organization or community of people uniting around the common purpose of the most desirable and achievable future of the organization or community. It involves open systems strategic planning, problem solving, and issue/conflict resolution for effective active-adaptive implementation and diffusion. It is an integrated process of data collection and community agreement, whereby each move in the agenda sets the foundation for the community to move forward.

Collaborative endeavors can be undermined by hidden agendas, attempts to dominate discussion or the direction of the work, insincere agreement, or failure to take responsibility by not following through on agreements. For these reasons, there are a number of important Ground Rules to the Search Conference to ensure dialogue and activities move forward in the most productive manner possible. These are:

1. The work of the search conference is open and public—everything is as it appears.
2. Participation is free and equal—everyone participates; no one dominates.
3. Listen for understanding.
4. It's okay to disagree.
5. Concentrate on areas of agreement.
6. You are responsible for the search conference work products.
7. Everyone brings some of the puzzle pieces; no one has the entire puzzle picture.
8. Work hard for *sincere* agreements and honor all such agreements.

These Ground Rules are effective only to the extent that participants adhere to them and the facilitator(s) effectively manage the process in both the large and small group formats. In this regard, there are a number of phases to the Search Conference, each of which builds upon the previous one and moves the discussion forward. The following sections describe these phases.

Search Conference Phases

The Search Conference has three phases:

- ***During the first third of the Search Conference*** participants examine important events and trends in the external environment that surrounds the System, the turbulent and unpredictable nature of this environment, and the forces that changes in this environment exert on the System. Participants then reach agreement on *the most desirable and achievable future of the world,* and agreement on *the most probable future of the world* if key themes, trends, and patterns, noticed in changes in the world continue without intervention. This generates a stronger sense of interdependence and mutual fate among participants, creating in turn a deeper awareness that System survival and growth are dependent upon ever-greater levels of meaningful collaboration.

- ***During the second third of the Search Conference*** participants analyze their System, learning of its history and as it is currently. Participants then reach agreement on *the most desirable and achievable future their System*, and *the most probable future of their System* without concerted intervention. Participants identify key constraints to this future, along with ways to overcome these constraints. Participants then formulate strategic goals to realize the most desirable and achievable future of their System.

- ***During the final third of the Search Conference*** participants conduct strategic goal implementation planning to realize the *most desirable and achievable future of their System.*

Throughout the Search Conference, participants ***search*** for congruence (*ecological balance*) between the System's desired future and realities in the System's external environment—***active adaptation*** to the environment. It ***searches*** through the environment and the System, collecting, analyzing, and synthesizing data as it goes. It is a community dialogue that builds common experience, shared meaning, and united action.

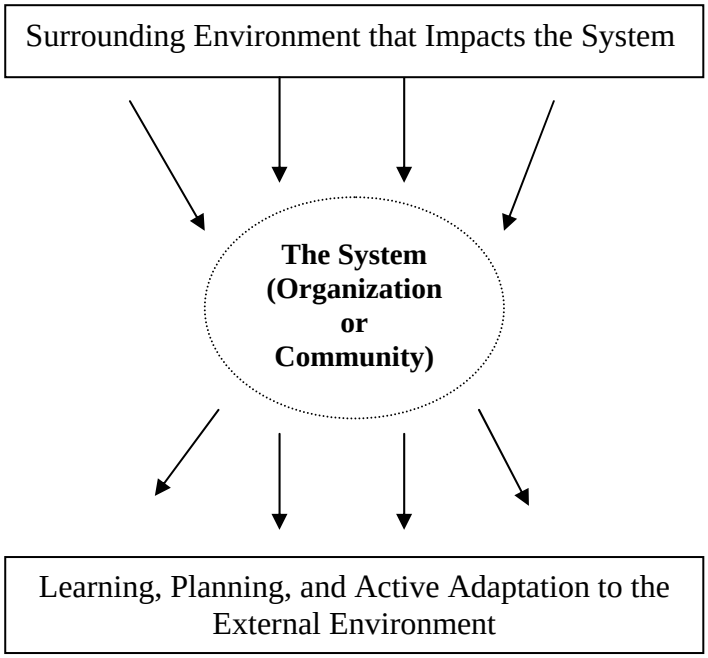
Although the above phases describe the general process of the Search Conference, these may be slightly altered depending on the needs, desires, and readiness of a given group to move forward. For instance, the purpose of North Dakota's conference was to generate a list of preliminary recommendations, and not necessarily in-depth strategic planning of how to accomplish those recommendations. Therefore, subsequent sections that describe the results of each of these phases reflect the processes deemed important to North Dakota and their particular task.

Open Systems Thinking & Planning

Specific systems exist within a larger context—be it society, a country, or the world. As resilient as a given system may be, events in the larger context nevertheless impact what occurs in the system, sometimes negatively. Recent examples are the terrorist attacks of 9/11 and subsequent wars in the Middle East. Whether it is economically, politically, or emotionally, people across the nation and the world have experienced, directly or indirectly, the impact of these events. However, productive systems and the people of which they are composed find ways to learn

from and adapt to events over which they have no control yet with which they must contend. The ability to do this is an example of "open systems thinking and planning." The relationship of the system to external environment and resulting reaction is illustrated in the diagram below.

OPEN SYSTEMS THINKING & PLANNING



Phase I: Environmental Analysis

1. Important events and trends in the world during the past 4-6 years important to the future.

In a large group format, conference participants were asked to identify significant or important events that have occurred in the world during the past 4-6 years in terms of their impact on current and future circumstances. The purpose of this exercise was to recognize that important factors outside the System impact the persons and processes therein. Attendees called out their responses, which were recorded on large poster paper at the front of the room.

Participants identified a number of significant events and trends in the past few years that ranged from the international to the local level. The areas covered were extensive, including national and state politics, the war, economics, population trends, healthcare, the media, and positive and negative aspects of the culture. Generating and seeing such a list is a powerful way to demonstrate the turbulence of the environment in the past few years. The list below indicates these events as identified by participants.

Significant Events in the World

- Returning veterans – various needs
- Young workforce leaving N.D.
- Globalization – offshore jobs (China)
- In-migration – people leaving small towns
- Cultural shift – people moving, changing jobs
- Pools of untapped labor
- Necessity for life-long learning in the work environment
- Greater division between income groups – "haves" and "have nots"
- Cost of living rising to a greater rate than income – gas, milk, etc.
- Graying of America – people looking at rural opportunities
- More people taking care of parents, grandchildren, etc.
- Increasing cultural diversity
- High suicide rate continues
- Medical advances – people living longer, babies surviving
- Involvement of consumers in their own healthcare
- Access to post-secondary education in the form of distance education
- People want to be independent, in their communities longer

Phase Two: Internal Analysis

People living in a particular place in the same time have a shared history—a history that could involve productive relationships or conflict, depending on different factors. Furthermore, that history is influenced by events external to the place (such as those listed above) and events at a state or local level. Participants were asked to identify significant events or issues in North Dakota that influence their system. Like the list generated in the first exercise, the topics covered were wide-ranging. Below is a table that includes the events/issues identified by participants, organized into larger themes. Some of these were positive things, while others were viewed as negative or challenging.

As can be seen in the table, some things that were identified as positive also had downsides. For instance, although the rural nature of North Dakota creates a closeness of community members and quality of life, it can be a drawback in terms of recruiting or retaining a workforce, especially from outside the state. Additionally, although participants identified many positive qualities of North Dakota residents (e.g., hard-working), they also identified problems such as high drug use and unhealthy lifestyles. Finally, although the comments were categorized into larger themes, one can see the interrelationship of these issues across categories, which speaks to how an impact on one aspect of the System can have repercussions for other parts.

Global Events	Problems for Some Populations
▪ Increased federal spending on military, decrease on domestic ▪ Constant threat of terrorism ▪ Global interconnection to internet	▪ Lifestyle choices – eating, drinking, etc. – chronic diseases will take over ▪ High use of illegal & legal drugs ▪ Growth in meth use equals fear from folks regarding working with persons needing treatment/services ▪ Prison population with mental health and/or substance abuse problems ▪ Visibility of sex offenders in N.D. ▪ Homelessness, progress being made
Quality of Life & Demographics	**Workforce**
▪ Good place to live – hunting, good schools, safety and security, clean air, etc. (need to keep people in N.D.) ▪ Positive, well-being of N.D.'s children ▪ Low crime and other positive, quality of life factors in N.D. ▪ Promote quality of life not just tourism – and it's well wired ▪ People from N.D. are hard-working – workforce is already here ▪ Do want more people to come here & people who leave to come back ▪ Capitalize on the excitement of transplants to N.D. ▪ Diminishing number of K-12 students ▪ Aging baby-boomers ▪ Decrease in extended families ▪ Perception of state and ruralness is a challenge (cold, etc.) ▪ How prevalent is attitude of "let's stay the same?"	▪ Ruralness of N.D. impacts utilization of workforce ▪ Uncertainty of agricultural industry ▪ Oil boom possibly here to stay ▪ Strong business environment affects career choices ▪ Changes in career expectations – people want a life, shorter hours, balance of work & family, spouse employment ▪ Work schedules are different, more flexible – this affects how people want to be served ▪ High number of two-income households, but also single parents ▪ Increased workforce ▪ Lack of people going into behavioral health ▪ High percentage of people working multiple jobs ▪ Increased pressure to streamline, partner – easier in N.D. with small communities and state population ▪ Four generations in the workforce ▪ Raising our own regarding healthcare careers
Healthcare	
▪ Increased use and development of best practices ▪ Advent of medication that assists in maintaining functional level ▪ Uncertainty of nature of healthcare funding	

1. North Dakota's Most Probable Future

Given the issues identified by participants indicated above, they were asked to project what the future of the state will be like should these trends continue without intervention in some way. A large group format was again used to identify these probabilities, with the results indicated below. As can be seen in the table, most predictions were formulated in the context of population and workforce trends.

Workforce	Population: Rural vs. Urban
▪ Without flexible workforce, population will look outside state ▪ Continue to have low unemployment ▪ Continuation of low wages & problems attracting workers ▪ Imbalance of job opportunities & work sources, resulting in unemployment ▪ Shortage in overall workforce ▪ Residents leaving state for jobs/services ▪ N.D. will have workforce crisis	▪ Rural will decrease in population, urban will grow ▪ Active recruiting of our population by other states ▪ Out-migration will continue ▪ Continued migration from rural to urban
	Quality of Life: Healthcare, Higher Education
	▪ More institutionalization of elderly and problems accessing services ▪ Increase in those without healthcare/coverage ▪ Diminished higher education enrollment requiring maintenance strategies/ fewer students to fill schools ▪ Quality of life decreases, values threatened

2. North Dakota's Most Desirable and Achievable Future

The next activity in the Search Conference that logically followed those that preceded it was for the group to identify the most *desirable* and *achievable* future for the state. It should be noted that this task requires a realistic conceptualization of what can be done. For instance, it is desirable to have world peace; but it is likely not achievable. Therefore, it was necessary for participants to temper their identified desires by asking whether or not a given desire was achievable. In this way the exercise is most likely to create a foundation for identifying goals and strategies that can be realistically pursued and achieved. The table below indicates four general areas and specific outcomes participants identified.

Quality of Life
▪ Promote the N.D. lifestyle (keep and recruit) ▪ Rural communities thrive and maintain what they have ▪ Improve airline services to N.D. ▪ Develop 10-year plan to end homelessness in N.D.
Healthcare
▪ Everyone who wants treatment is able to receive it ▪ Everyone has healthcare coverage ▪ Strategic plan for comprehensive healthcare services ▪ Technology to implement best practices & behavioral health care ▪ Integration of healthcare services ▪ Increasing wrap-based services for people with mental health/substance abuse–out of institutions–especially with aging
Workforce and Economy
▪ Increase flexibility in jobs ▪ Growing and diversified economy ▪ Organized state and industry-wide recruitment and retention
Education
▪ Educational incentives – esp. in healthcare – loan incentives ▪ Highly educated workforce committed to lifelong learning ▪ Loan forgiveness – incentives to retain professionals

3. North Dakota's Most Desirable and Achievable Future for Behavioral Health Workforce

As one further step toward achieving the conference purpose of identifying a preliminary list of recommendations for behavioral health workforce development in North Dakota, participants were asked to further refine their thinking by identifying the most desirable and achievable future for the behavioral health system in particular. Again, the task was not to identify desires that were beyond the realm of possibility, but to use data from preceding activities (e.g., strengths, weaknesses, etc.) to indicate those goals that were most likely to be achieved. Small groups were convened for this purpose, but the data will be presented in aggregate below. The results are presented in the order they were given by participants and not grouped here, as the activity following this one was for participants to identify particular areas, based on the list below, that seemed to naturally group together or that they saw as being worthy of focusing on as a recommendation. The section that follows this shows how participants identified those areas from this list, as well as further work they did to clarify some particular strategies for achieving the recommendation.

Most Desirable and Achievable Behavioral Health Workforce

- Increase labor pool of behavioral workforce
- Utilize technology for continuity of care staff efficiency, peer support, specialization, dealing with rurality & training
- Assure student loan incentives for all licensed professionals
- Funding including increase in salaries, mental health/substance abuse services & parity
- Flexible work schedule and situations
- Use technology to reach rural areas
- Partnership between higher ed & services for training
- Partnership between mental health and primary care especially in rural
- Achieve strong private/public partnerships that get us:
  - Staff sharing
  - Training
  - Career preparation and promotion
  - Mentoring
  - Retention
- Retention of behavioral health workers – retain retirement and work too
- Combine education and awareness of behavioral health consumer and the need for behavioral health workers (mental health issues = career opportunities)
- More flexible benefit packages for healthcare workers
- Rich base of mentors… use them to help with mentoring program, supervision, training and real world connections
- Flexible opportunities for retiring and with re-hiring
- Find ways to include untapped workforce (technology)
- Use technology to broaden and integrate behavioral and primary healthcare

Phase Three: Identifying Recommendations and Strategies

As indicated above, participants reviewed the data to determine if there were items that naturally grouped together and/or seemed to be important to pursue in terms of recommendations and related strategies. It was not considered necessary at this point in the process to create action plans that participants would immediately start pursuing once they returned to their respective agencies, organizations, or other places of employment. Instead, this phase of the conference was merely to begin the process of identifying such goals and strategies, with the understanding that these may change or be revised once the information is taken to other stakeholders.

Based on the work from the previous activities, the group as a whole chose six areas of focus (or "themes") to formulate recommendations and related strategies. It was agreed that these were preliminary and need not be the final or only recommendations. The first task was then to identify strengths and limitations related to each theme so that any strategies identified could capitalize on a strength or overcome a weakness. Subsequent to this large group activity, participants self-selected one of the six areas and worked in small groups. The primary objective was to formulate a solid recommendation/outcome and preliminary strategies for achieving it (based on strengths or weaknesses in the current system). The themes, their related strengths and challenges, recommendations, and related strategies are presented in the tables below.

Theme 1: Flexible Work Schedules (As long as the work gets done and clients are served)

Challenges	Strengths
Requires a high level team	HIPAA I.T information protections are in place in the VA system
Will require original flexibility	Technology capabilities are in place
Current metrics for achievement	People don't have to work in Bismark, thus expanding the pool of applicants
Work availability	Placing workers in an outlying area where they live
Cost containment	The culture is family-friendly
Supervision will be more difficult	Recruitment and retention strategies
Computer/IT support	Towns growing their own workers to serve the town
Infrastructures	

Recommendation/Outcome: Employers provide flexible work schedules.

Strategies

1. Survey employee needs for the benefit of the organization and clients.
2. Survey other organizations which currently offer flexible schedules to determine best practices.
3. Provide training to supervisors/decision makers on the benefits to provide a flexible work schedule.
4. Develop policies which will accommodate employers' and employees' needs.

Theme 2: Part-Time Retirees

Challenges	Strengths
Loss of benefits	Pool of skilled workers
Staffing–will want less traditional hours–more flexibility	Skill transfers
Tax laws	Working pool
Retirement plan restrictions	Examples in place with teachers in N.D.
Keeping the age diversity balance between new and old worker	$ saved in recruitment and training
	Lower administrative costs

Recommendation/Outcome: Retiree expertise is maximized in the workforce.

Strategies

1. Research existing laws (employment and tax) and policies/practices to identify barriers and recommendations for change.
2. Conduct post-retirement planning for employees within 10 years of retirement. Include:
   - Interest level in training, mentoring, part-time employment.
   - Strategies to achieve post-retirement goals.
   - Compile interest roster of post-retirement candidates.
3. Cost/benefit analysis.
   - Medical benefits.
   - Money paid to retirement plan.
   - Training.
   - Recruitment.
   - Multi-generational workforce training.

4. Develop training courses for supervisors and staff on multi-generational workforce issues
5. Design an ongoing succession plan to fully utilize part-time retirees while developing younger workforce
6. Consult with AARP and other groups throughout process

Theme 3: Technology [Increase employee pool (e.g. living in Fargo, but serving clients in Dickinson)]

Challenges	Strengths
Tapping employees in rural	Using existing resources
Some infrastructure limitations * I.T. problems down the road * Confidentiality of data	Technology is there
Managing technology	Increase saving in professional fees
Cultural shift re: doing work differently	Decrease windshield time
Questions/challenges to reimbursement	Workplace flexibility
Client & staff technology skills	Tapping existing employees in rural

Recommendation/Outcome: Employees anywhere serve clients everywhere in N.D. through technology.

Strategies

1. Inventory internal and external public hardware/software technology for applicability to telemedicine.
2. Research and determine technology methods to connect clients and employees (needs, costs, resources considered).
3. Research and develop confidentiality and data security needs, policies and procedures.
4. Develop stakeholder and partner relationships and form work team (primary care, insurers, reservations community leaders, etc.).
5. Determine pilot location.
   - Factors:
     - Client service demand.
     - Existing infrastructure.
     - Client readiness.
6. Develop and implement pilot project (admission details; pursue use of community human resources to manage technology, hardware, client training, etc; remediating staff skills, HR issues).
7. Develop and implement ongoing, dynamic communication plan to address practice change and increase readiness of partners – change initiative.
8. Develop plan for pilot analysis and statewide applicability (include capacity analysis: increase client access and staff capacity).

Theme 4: Public/Private Partnerships (e.g. co-location in primary care facilities)

Challenges	Strengths
Culture/practice differences	Cost sharing
Cost sharing	True integration of care
Medicare/Medicaid payment concerns depending on service setting	Reduce stigma of behavioral health care
Turf guarding	Training & mentoring potential
Trust issues	Increase early intervention
	Save DHS $$
	Less deterioration
	Ease of access for clients
	Retention potential

Recommendation/Outcome: Public/private partnerships maximize workforce availability.

Strategies

1. DHS will assess workforce needs in underserved areas.
2. DHS will discuss potential partnership opportunities in defined shortage areas.
3. DHS will study insurance coverage issues and identify solutions to barriers.
4. DHS will enter into two public/private partnerships, and study outcomes.
5. DHS will develop a model framework for increasing availability of workforce in underserved areas.
6. DHS will develop methods to expand partnerships.

Theme 5: Recruitment and Retention Incentives (e.g. financial incentives, increase salaries, loan forgiveness, educational opportunities)

Challenges	Strengths
Funding	Career awareness
Legislative issues	Keep competitive with the external market
Determining application formula (# of people, kinds of positions)	
Career awareness (promotion/marketing)	

Recommendation/Outcome: DHS has competitive recruitment and retention incentives

Strategies

1. Increase career awareness.
   - Establish mentoring programs.
   - Develop talent pipeline mapping.
2. Legislative issues.
3. Identify 'hard to fill' positions through data analysis.
4. Evaluate competitiveness of wages, benefits, and incentives.
5. Communicate consequences of key workforce shortages.
6. Find a champion.
7. Tell the story.
8. Funding.

- Secure adequate funding
  - Legislative appropriations
  - Blended funding

9. Incentives
   - Do research on most effective incentive methods (i.e. benefits, loan repayments, educational opportunities, cafeteria plan) – to arrive @ most "band for the buck"

Theme 6: Redefine and Realign Scopes of Practice

Challenges	Strengths
Turf protection	Development of peer-based services in areas
Statutory challenges (eg. Licensure)	Peer supported & peer-delivered services
Reimbursement	Extend the work force via cross-training
Cultural shift in doing work differently	Increase in availability of qualified applicants
Supervision and quality control	Human capital to its highest investment
Worker expectations: new ways of doing work must be explained clearly	Less costly – save $$
	Job enrichment roll for existing employees
	Increased flexibility to attract a new pool of applicants
	Contributes inclusion of people with disabilities in the workforce
	Intentionally providing opportunities
	Decreases stigma

Recommendation/Outcome: Minimum qualifications to provide behavioral health services are redefined.

Strategies

1. Identify critical areas of service needs and workforce shortages.
2. Define range of specialties & scopes of practices to meet the need (job analysis).
3. Identify areas of licensure and/or certification that need to be redefined.
4. Investigate peer support & BA level best practice models.
5. Work with DHS cabinet & state practice boards to make and promote changes.

Summary

Over the past several years, significant momentum has formed behind behavioral health workforce development, particularly in rural areas. It is important to capitalize on this momentum, as largely rural states, such as North Dakota, have had ongoing difficulties recruiting and retaining an effective behavioral health workforce. A limited workforce translates into critical gaps in the availability and, to some extent, accessibility of services. North Dakota's Department of Human Services (DHS) is undertaking a project to address these issues within the state. A successful workforce development project will increase the number of professionals available to provide services, thereby reducing the significant unmet need in the state.

At present, most of North Dakota is designated as a mental health professional shortage area and demand for services outstrips current capacity. There are high turnover rates among mental health professionals, particularly in rural areas. Most clinics have positions that have been open and difficult to fill for a long time. The result is that those seeking services often have to wait longer and/or may have inconsistent treatment due to staff changes (see Appendix K for a list of wait times for each region). As they wait, the severity of their problems often worsens, which can lead to mental health crises. Fortunately, the DHS has already been talking with various state officials, higher education training programs, and administrators in provider agencies to identify solutions to a range of these problems.
Data regarding prevalence of mental health problems, number served, and unmet need, as well as population shifts and increasing numbers of people with mental health/and or substance use disorders indicate that North Dakota should increase their behavioral health workforce. While the state currently has a fair number of particular types of behavioral health clinicians (relative to other states in the region), the trends indicated by the aforementioned data suggest that a workforce shortage in multiple kinds of clinicians is on the horizon.

Although the state ranks very high in terms of the percent of students either graduating high school or going on to college, the sheer numbers of young people leaving the state means a smaller pool of potential clinicians. Workforce development strategies can take this data into account as they target the future generations of clinicians that will replace a now-aging healthcare workforce.

The DHS can also work with higher education institutions to ensure that training curricula reflects the needs of the populations to be served and bring training opportunities to those who live and will likely stay in rural areas. This is often referred to as a "grow your own" approach, which is an adjunct to incentive-based programs, such as student loan repayment for working in rural areas. Loan repayment programs do provide a reason for many young professionals to live and practice in rural areas, but the period of repayment tends to be limited and it is unclear to what extent those participating in the program are trained in rural behavioral health. In addition, North Dakota has lost its National Health Service Corps designation for loan repayment, due to stricter parameters by NHSC. This might have a significant impact on recruitment of psychologists, nurse practitioners, physician's assistants and physicians.

Another step in developing a behavioral health workforce strategy in North Dakota was to undertake a process, called a Search Conference, facilitated by WICHE, which brings together key stakeholders in the areas of state mental health, higher education, and provider agencies. The purpose of the Search Conference was to create "A list of preliminary recommendations for recruitment and retention of North Dakota's Department of Human Services' behavioral health care work force." As it turned out, the conference participants were able to go beyond just a list of recommendations and also began developing some initial strategies for achieving the recommendations.

There were six recommendations/outcomes developed by Search Conference participants, each with related strategies for achieving them. These are briefly summarized here (for more detail, see the previous section of this report). The recommendations will be discussed with other stakeholders and likely be included in a larger, general workforce development plan being developed in North Dakota.

Recommendation/Outcome 1: Employers provide flexible work schedules.

Strategies

1. Survey employee needs for the benefit of the organization and clients.
2. Survey other organizations which currently offer flexible schedules to determine best practices.
3. Provide training to supervisors/decision makers on the benefits to provide a flexible work schedule.
4. Develop policies which will accommodate employers' and employees' needs.

Recommendation/Outcome 2: Retiree expertise is maximized in the workforce.

Strategies

1. Research existing laws (employment and tax) and policies/practices to identify barriers and recommendations for change.
2. Conduct post-retirement planning for employees within 10 years of retirement.
3. Cost/benefit analysis.
4. Develop training courses for supervisors and staff on multi-generational workforce issues
5. Design an ongoing succession plan to fully utilize part-time retirees while developing younger workforce.
6. Consult with AARP and other groups throughout process.

Recommendation/Outcome 3: Employees anywhere serve clients everywhere in N.D. through technology.

Strategies

1. Inventory internal and external public hardware/software technology for applicability to telemedicine.
2. Research and determine technology methods to connect clients and employees (needs, costs, resources considered).
3. Research and develop confidentiality and data security needs, policies and procedures.

4. Develop stakeholder and partner relationships and form work team (primary care, insurers, reservations community leaders, etc.).
5. Determine pilot location.
6. Develop and implement pilot project (admission details; pursue use of community human resources to manage technology, hardware, client training, etc; remediating staff skills, HR issues).
7. Develop and implement ongoing, dynamic communication plan to address practice change and increase readiness of partners – change initiative.
8. Develop plan for pilot analysis and statewide applicability (include capacity analysis: increase client access and staff capacity).

Recommendation/Outcome 4: Public/private partnerships maximize workforce availability.

Strategies

1. DHS will assess workforce needs in underserved areas.
2. DHS will discuss potential partnership opportunities in defined shortage areas.
3. DHS will study insurance coverage issues and identify solutions to barriers.
4. DHS will enter into two public/private partnerships, and study outcomes.
5. DHS will develop a model framework for increasing availability of workforce in underserved areas.
6. DHS will develop methods to expand partnerships.

Recommendation/Outcome 5: DHS has competitive recruitment and retention incentives

Strategies

1. Increase career awareness.
2. Legislative issues.
3. Identify 'hard to fill' positions through data analysis.
4. Evaluate competitiveness of wages, benefits, and incentives.
5. Communicate consequences of key workforce shortages.
6. Find a champion.
7. Tell the story.
8. Funding.
9. Incentives

Recommendation/Outcome 6: Minimum qualifications to provide behavioral health services are redefined.

Strategies

1. Identify critical areas of service needs and workforce shortages.
2. Define range of specialties & scopes of practices to meet the need (job analysis).
3. Identify areas of licensure and/or certification that need to be redefined.
4. Investigate peer support & BA level best practice models.
5. Work with DHS cabinet & state practice boards to make and promote changes.

Appendices

Appendix A

Health Professional Shortage Area Criteria for Mental Health

General Criteria: *Health professional(s) shortage area* means any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility. (http://bhpr.hrsa.gov/shortage/hpsacrit.htm)

Mental Health (http://bhpr.hrsa.gov/shortage/hpsacritmental.htm)

Part I -- Geographic Areas
A. Criteria: A geographic area will be designated as having a shortage of mental health professionals if the following four criteria are met:

1. The area is a rational area for the delivery of mental health services.

2. One of the following conditions prevails within the area:

(a) The area has --
(i) A population-to-core-mental-health-professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1, or
(ii) A population-to-core-professional ratio greater than or equal to 9,000:1, or
(iii) A population-to-psychiatrist ratio greater than or equal to 30,000:1;

(b) The area has unusually high needs for mental health services, and has --
(i) A population-to-core-mental-health-professional ratio greater than or equal to 4,500:1 and a population-to-psychiatrist ratio greater than or equal to 15,000:1, or
(ii) A population-to-core-professional ratio greater than or equal to 6,000:1, or
(iii) A population-to-psychiatrist ratio greater than or equal to 20,000:1;

3. Mental health professionals in contiguous areas are over-utilized, excessively distant, or inaccessible to residents of the area under consideration.

Part II -- Population Groups
A. Criteria: Population groups within particular rational mental health service areas will be designated as having a mental health professional shortage if the following criteria are met:

1. Access barriers prevent the population group from using those core mental health professionals which are present in the area; and

2. One of the following conditions prevails:

(a) The ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group is greater than or equal to 4,500:1 and

the ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group is greater than or equal to 15,000:1; or,

(b) The ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group is greater than or equal to 6,000:1; or,

(c) The ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group is greater than or equal to 20,000:1.

Part III -- Facilities

A. Federal and State Correctional Institutions
1. Criteria: Medium to maximum security Federal and State correctional institutions for adults or youth, and youth detention facilities will be designated as having a shortage of psychiatric professional(s) if both of the following criteria are met:

(a) The institution has more than 250 inmates, and
(b) The ratio of the number of internees per year to the number of FTE psychiatrists serving the institution is at least 2,000:1.

Here the number of internees is defined as follows:

(i) If the number of new inmates per year and the average length-of-stay (ALOS) are not specified, or if the information provided does not indicate that intake psychiatric examinations are routinely performed upon entry, then -- Number of internees = average number of inmates.
(ii) If the ALOS is specified as one year or more, and intake psychiatric examinations are routinely performed upon entry, then -- Number of internees = average number of inmates + number of new inmates per year.
(iii) If the ALOS is specified as less than one year, and intake psychiatric examinations are routinely performed upon entry, then -- Number of internees = average number of inmates + 1/3 x (1 + (2 x ALOS)) x number of new inmates per year where ALOS = average length-of-stay (in fraction of year). (The number of FTE psychiatrists is computed as in Part I, Section B, paragraph 3 above.)

B. State and County Mental Hospitals.

1. Criteria: A State or county hospital will be designated as having a shortage of psychiatric professional(s) if both of the following criteria are met:

(a) The mental hospital has an average daily inpatient census of at least 100; and
(b) The number of workload units per FTE psychiatrists available at the hospital exceeds 300, where workload units are calculated using the following formula:

Total workload units = average daily inpatient census + 2 x (number of inpatient admissions per year) + 0.5 x (number of admissions to day care and outpatient services per year).

C. Community Mental Health Centers and Other Public or Nonprofit Private Facilities.
1. Criteria: A community mental health center (CMHC), authorized by Pub. L. 94 - 63, or other public or nonprofit private facility providing mental health services to an area or population group, may be designated as having a shortage of psychiatric professional(s) if the facility is providing (or is responsible for providing) mental health services to an area or population group designated as having a mental health professional(s), and the facility has insufficient capacity to meet the psychiatric needs of the area or population group.

Appendix B

Human Service Center Initiatives

- Evidence-based practices are being implemented/piloted in all of the centers, including Matrix Model for individuals with methamphetamine abuse problems, Recovery Model for individuals with serious mental illness, and Integrated Dual Disorders Treatment for individuals with co-occurring substance abuse and mental illness.
- Expanded residential bed capacity in the Jamestown region will allow for transition of 21 additional State Hospital patients to the community by summer 2007.
- The Department is regularly meeting with DOCR staff to assess service needs of common clients and determine priorities. This closer collaboration will result in better joint strategic planning, reduced program duplication, and improved treatment services.
- Likewise, DHS is working more closely with the ND Long Term Care Association to determine possible partnerships that would utilize available basic care beds to meet residential needs of some of our clients, with ongoing psychiatric consultation and support from the HSCs. This, too, would be a mutually beneficial arrangement for both systems.
- New models of service delivery such as telemedicine are being piloted and explored for potential expansion. This can have very positive outcomes for our rural state and for individuals who have difficulty accessing needed treatment.
- Electronic data systems are producing service reports with increasing accuracy and usefulness for managerial planning/decision-making. For example, all centers are using common measures to insure maximum use of resources; this data can be used to identify resource needs and determine potential shifts/savings.

Appendix C

Region I: Northwest Human Service Center
Regional Director: Marilyn Rudolph
P.O. Box 1266
316 2nd Avenue West
Williston, ND 58802
Phone: (701) 774-4600
Toll Free: (800) 231-7724
Crisis Line: (701) 572-9111TTY: (701) 774-4692
Fax: (701) 774-4620
Outreach Offices: Crosby, Tioga and Watford City.

Region II: North Central Human Service Center
Regional Director: Marilyn Rudolph
1015 South Broadway Suite 18
Minot, ND 58701
Phone: (701) 857-8500
Toll Free Crisis Line: (701) 857-8500 or (888) 470-6968
TTY: (701) 857-8666
Fax: (701) 857-8555
Outreach Offices: Bottineau, New Town Rugby Stanley

Region III: Lake Region Human Service Center
Regional Director: Kate Kenna
Box 650
200 Hwy 2 South West
Devils Lake, N.D.
Phone: (701) 665-2200
24 Hour Crisis: (701) 662-5050 [collect calls accepted]
Toll Free: (888) 607-8610
TTY: (701) 665-2211
Fax: (701) 665-2300
Outreach Office: Rolla

Region IV: Northeast Human Service Center
Regional Services Director: Kate Kenna
151 South 4th Street, Suite 401
Grand Forks, ND 58201-4735
Phone: (701) 795-3000
Toll Free: (888) 256-6742
TTY: (701) 795-3060
Fax: (701) 795-3050
Outreach Office: Grafton

Region V: Southeast Human Service Center
Regional Services Director: Candace Fuglesten
2624 9th Avenue Southwest
Fargo, N.D. 58103-2350
Phone: (701) 298-4500
Toll Free: (888) 342-4900
TTY: (701) 298-4450
Fax: (701) 298-4400

Region VI: South Central Human Service Center
Regional Director: Candace Fuglesten
520 3rd Street, NW, PO Box 2055
Jamestown, N.D. 58402-2055
Phone: (701) 253-6300
TTY: (701) 253-6414
Crisis: (701) 253-6304
Fax: (701) 253-6400
Outreach Offices: Carrington, Oakes, Valley City, and Wishek

Region VII: West Central Human Service Center
Regional Director: Tim Sauter
1237 West Divide Avenue, Suite 5
Bismarck, ND 58501
Phone: (701) 328-8888
Toll Free: (888) 328-2662
TTY: (800) 366-6888
Fax: (701) 328-8900
Outreach Offices: Mercer, McLean, and Oliver Counties

Region VIII: Badlands Human Service Center
Regional Director: Tim Sauter
200 Pulver Hall
Dickinson, ND 58601-4857
Phone: (701) 227-7500
Toll Free: (888) 227-7525
Crisis Line: (701) 225-5009
TTY: (701) 227-7574
Fax: (701) 227-7575

Appendix D

SUMMARY OF CORE SERVICES:
DEPARTMENT OF HUMAN SERVICES REGIONAL HUMAN SERVICE CENTERS[34]

Aging Services:
· Aging Services Administration
· Vulnerable Adult Protective Services
· Long-Term Care Ombudsman Program
· Adult Family Foster Care Licensure

Developmental Disabilities
· Case Management
· Day Supports (Southeast)
· Extended Services (Northwest and Badlands)
· Infant Development (Northwest, Northeast, Southeast, South Central)

Vocational Rehabilitation
· Assessment for eligibility and rehabilitation needs
· Counseling and Guidance
· Information and Referral
· Job related services
· Vision Services
· Supported Employment Services (Badlands and Northwest)
· Rehabilitation Technology Services (Badlands and West Central)
· Business Services including ADA Consultation and Assessment

Child Welfare Services
· Program Supervision – Regional Reps and Child Care Licensing Specialists
· Parental Capacity Evaluation
· Foster Parent Support Services
· Acute/Clinical Services as deemed clinically appropriate

Children's Mental Health
· Level I Criteria
- Care Coordination
- Acute/Clinical Services as deemed appropriate
· Level II Criteria
- Care Coordination
- Case Aide Services
- Crisis Residential/Safe beds
- Flexible funding
- Acute Clinical Services as deemed appropriate

Serious Mental Illness (Extended Care Coordination)
· Care Coordination
· Case Aide Services
· Needs-based array of residential services
· Community Support Services
· Medical Management

[34] http://www.nd.gov/humanservices/locations/regionalhsc/docs/hsc-core-services.pdf

· Acute/Clinical Services as deemed clinically appropriate

Acute Clinical Services

· Core Populations:
- Self-Harm/Suicide
- Child Abuse and Neglect
- Foster Care/ Subsidized Adoption
- Acute Psychiatric

· Services
- Psychological evaluation and testing
- Psychiatric evaluation
- Clinical evaluation
- Individual Therapy
- Group Therapy
- Family Therapy
- Clinical Case Management
- Medication Management
- Crisis Residential
- Short Term Hospital
- Lab and Clinical Screening

Substance Abuse Services

· Care Coordination/Case Aide
· Evaluation
· Social and Medical Detoxification Services
· Needs based array of primary treatment services
- Low intensity outpatient
- Intensive outpatient
- Day treatment

· Needs validated residential services
· Medication/Medical monitoring/Management

Crisis/Emergency Response Services

· 24-hour a day/7-days a week crisis call response from a designated, trained Center employee
· Regional Intervention Services
- Screening
- Gatekeeping/referral

Note: Funding varies depending upon the service and the financial status of the client for a combination of federal funding sources, general funds, and third party collections including private pay and insurance.

Appendix E

Designated Mental Health Professional Shortage Areas in North Dakota[35]

NAME	TYPE
COAL COUNTY CHC	CHC
FAMILY HEALTHCARE CENTER	CHC
NORTHLAND HEALTH PARTNERS CHC	CHC
TRENTON INDIAN SERIVE AREA	CHC
VALLEY CHC	CHC
NORTH CENTRAL HSC	OF
NORTHEAST HSC	OF
NORTHWEST HSC	OF
SOUTHEAST HSC	OF
WEST CENTRAL HSC	OF
DEVILS LAKE CA	GA
DICKINSON CA	GA
JAMESTOWN CA	GA
DIVIDE	GA
ADAMS	SC
BARNES	SC
BENSON	SC
BILLINGS	SC
BOTTINEAU	SC
BOWMAN	SC
BURKE	SC
CAVALIER	SC
DICKEY	SC
DIVIDE	SC
DUNN	SC
EDDY	SC
EMMONS	SC
FOSTER	SC
GOLDEN VALLEY	SC
GRANT	SC
GRIGGS	SC
HETTINGER	SC
KIDDER	SC
LAMOURE	SC
LOGAN	SC
MCINTOSH	SC
MCKENZIE	SC

[35] www.hrsa.gov

MCLEAN	SC
MERCER	SC
MOUNTRAIL	SC
NELSON	SC
OLIVER	SC
PEMBINA	SC
PIERCE	SC
RAMSEY	SC
RANSOM	SC
RENVILLE	SC
RICHLAND	SC
ROLETTE	SC
SARGENT	SC
SHERIDAN	SC
SIOUX	SC
SLOPE	SC
STARK	SC
STEELE	SC
STUTSMAN	SC
TOWNER	SC
TRAILL	SC
WALSH	SC
WELLS	SC
BELCOURT PHS INDIAN HOSPITAL	IHS
FORT BERTHOLD PHS INDIAN HEALTH CENTER	IHS
FORT TOTTEN PHS INDIAN HEALTH CENTER	IHS
FORT YATES PHS INDIAN HOSPITAL	IHS
NORTH DAKOTA STATE HOSPITAL	SMH
JAMES RIVER CORRECTIONAL CENTER	CI

CHC = Community Health Center; CI = Correctional Institution; GA = Geographic Area;
HSC = Human Service Center; IHS = Indian Health Services; OF = Other Facility;
PHS = Public Health Service; SC = Single County; SMH = State Mental Hospital.

Appendix F

Areas of Unmet need and Corresponding Action Plans from ND Block Grant 2006

- There are limited resources for completion of assessments. Because of the challenges recruiting and retaining clinical staff, workloads at the regional human service centers have increased at times resulting in delays in receiving an assessment.
    - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition, this program will help provide clinicians to those rural areas where often it is difficult to recruit. In addition, the Division is working with WICHE to draft a workforce development plan.
- There are limited employment opportunities for consumers.
    - The regional human service center staff assigned to the Extended Services and Supported Employment programs work extensively with employers to cultivate new job opportunities for consumers. In some areas of the state, employment opportunities are limited due to geographic location or job market. In Williston – currently experiencing a boom due to oil drilling – the job market is open and good paying positions are fairly easy to come by. Starting salaries are in excess of $9.00 per hour. However, opportunities in rural communities can be at times non-existent. The Division is exploring with Southeast Human Service Center the feasibility of implementing SAMHSA's model of Supported Employment. The Division will continue to work with the regional human service centers and Vocational Rehabilitation to enhance when possible employment services for consumers statewide.
- Access to psychological and psychiatric services in a timely manner can be challenging in some areas of the state. Again, the challenges of recruiting and retaining clinical staff has resulted, at times, in longer waits to receive some clinical services.
    - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition, this program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.
- There is a need for increased training opportunities for families.
    - A number of training opportunities are offered to families of consumers throughout the state. Often, stipends are made available allowing for free or reduced cost attendance. Some of these opportunities include the annual conference of the Family Connections Conference, the Children and Family Services Conference, the Indian Child Welfare Act conference, the North Dakota

Family Based Services Conference, and the Clinical Forum on Mental Health Conference.

- Advocacy and support to families.
    - A number of advocacy and support groups exist throughout the state. These include Protection and Advocacy Project, Parent-to-Parent Support Program, the Mental Health Association in North Dakota, Family Voices of North Dakota and the North Dakota Consumer and Family Network. The Division will continue to assist these organizations whenever possible.
- Access to information and dissemination of information from Federal Entities
    - The Division of Mental Health and Substance Abuse Services developed Prairie Notes (fact sheets on numerous topics in mental health). These are available through the Department's website. In addition, the Research Team has developed Research Notes, compiling statistical data on mental health and substance abuse trends in North Dakota.
- Access to community based treatment and psychiatric/psychological services.
    - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition this program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.
- Community-based mental health and substance abuse services for adults and children are full.
    - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition, this program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.
- Lack of increased funding for human services is a local concern.
    - Mental health services in North Dakota are provided by State funds, Federal funds, third party payer, and other specialty funds. The Division of Mental Health and Substance Abuse Services prepares a budget one year ahead of the legislative session. North Dakota's legislature meets every other year; therefore, the budgets are developed for a biennium. The Division develops a budget for its operation, which includes contracting with private providers for training, consultation, education, extended services, and homeless programs. Each human service center as well as the North Dakota State Hospital prepares its own budget. All budgets are then presented to the Executive and Fiscal division of the Department of Human Services for approval. Once approved, the budgets are reviewed by the Office of Management and Budget as well as the Governor's Office. When final approval has been granted by the Governor's Office, the budgets are presented to

the Legislature for approval. During the legislative session, consumers, families, and other advocates appear before the legislative committees to testify on behalf of all mental health programs in the state.

- North Dakota's guardianship system (court system) needs more resources; access is an issue for vulnerable adults and children.
    - The Division of Mental Health and Substance Abuse Services is working with the Division of Aging Services, the Division of Medical Services, and numerous other stakeholders to address the need of guardianship resources for vulnerable adults. The legislature mandated the creation of a guardianship program for vulnerable adults outside of the developmental disabilities system. However, only $40,000 was appropriated for this program. A Request For Proposal will be released soon for this program, which will serve approximately 12 adults with serious mental illness. Training was recently conducted for attorneys, judges, and human service center case managers concerning guardianships for vulnerable adults. One staff member from each human service center will be designated as the point person for all adults with a serious mental illness that require guardianship services. This will help to ensure continuity of care. The Division will continue to be an active player in this important issue.
- North Dakota's guardianship system (court system) needs more resources; access is an issue for vulnerable adults and children.
    - During the 2005 Legislative Session, SB 2028 provided for a guardianship services system for vulnerable adults who are ineligible for developmental disabilities case management services. Forty thousand dollars was appropriated for this system. The Division of Aging Services within the Department of Human Services was tasked with overseeing the implementation of the guardianship services system. Because of the limited funding ($40,000) and the need for such services from this target population, it was planned that twelve adults diagnosed with a serious mental illness would receive guardianship services through this program. A Request For Proposal was drafted for this program and training was conducted for attorneys, judges, and human service center case managers concerning guardianships for vulnerable adults. Unfortunately, there were no responses to the Request For Proposal. To meet the legislative mandate, it was decided that the North Dakota Department of Human Services would pay for adult emergency or full guardianship establishment fees. This includes the attorney's fee, filing fee, and other fees connected with establishing the guardianships. There is no ongoing daily rate of pay. The target population for the program was individuals diagnosed with a serious mental illness, persons with Traumatic Brain Injury or persons over the age of 60. The work with the attorney, families, and proposed guardian is the responsibility of the regional human service centers. The cost for establishing the guardianship cannot exceed $2,500.
- Youth transitioning to adult system do not have as many services or contact with the SMI case manager, time is limited with caseload.
    - MHSA Services Division will compile data from the on-site HSC visits to distribute for further discussion and implement strategic planning efforts to address need.

- Training needs and opportunities (funding) for staff; specialized training in treatments, ROAP, TBI,
    - A survey has been sent out to HSCs for training needs; the Division is waiting for the surveys to be sent back.
    - Several statewide Conferences offer training opportunities on the topics, but will examine the need for more intensive training on needs identified thus far by the HSC staff and survey results
- Community Education on mental illness, Stigma in communities; provide education with law enforcement, churches, social services, etc.
    - Discussion will occur with NDMHP Council on how to address community education efforts.
- Ruralness and outreach services; need more community-based services, travel time for staff.
    - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition this program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.
- Workforce shortage- retirement, competition with private providers (salary)
    - The Department is working with various entities to address workforce issues. For instance, North Dakota is working with WICHE, the University of North Dakota, and other western states to implement online social work – including graduate level – education. This will allow individuals located in rural areas to advance their education without needing to leave their home communities. In addition this program will help provide clinicians to those rural areas where often it is difficult to recruit for. In addition, the Division is working with WICHE to draft a workforce development plan.
- Dual diagnosed youth- CD and SED and SED and DD populations- specialized needs and treatment interventions.
    - Introduction of Statewide EBP's SPARCS, TF-CBT
    - Discussion with substance abuse personnel in the MHSA Division on interventions for these populations.
- Housing for young adults transitioning from children's services to adult services.
    - The Division will explore with Department administration the feasibility of establishing transitional housing for young adults.
- Distribution of information between State, local and Federal entities.
    - The Division of Mental Health and Substance Abuse Services developed Prairie Notes (fact sheets on numerous topics in mental health). These are available through the Department's website. In addition, the Research Team has developed Research Notes, compiling statistical data on mental health and substance abuse trends in North Dakota.
- Supportive employment for teens and young adults.

    - The Division will explore with Vocational Rehabilitation employment programs for transitioning youth.
- Staff development opportunities: revitalize staff, exposed to new ideas, ways of doing things, needed for morale and challenge to oneself.
    - The Division sponsors the annual Clinical Forum on Mental Health Conference. This conference – bringing together clinicians, researchers, consumers, and other stakeholders – focuses on the latest information in mental health recovery, transformation, and evidence-based practices. The 2007 conference included such topics as cognitive behavioral therapy, cultural competency, depression and suicide in the elderly, hoarding, individual justice planning, Integrated Dual Disorders Treatment, play therapy, sexual offender treatment and youth with mental health disorders. Stipends are provided to each regional human service center and the state hospital to help offset the costs of sending staff.
    - A survey has been sent out to the human service centers for training needs, the Division is waiting for the surveys to be sent back
    - Several statewide Conferences offer training opportunities on the topics, but will examine the need for more intensive training on needs identified thus far by the HSC staff and survey results.

Appendix G

North Dakota County populations, arranged in order of density

	Population, 2000 Census[36]	County land area in square miles	Persons per square mile	Percentage below poverty line	Estimated Population July 1, 2006[37]
North Dakota	642,200	70,762	9		635,867
COUNTY					
Cass County	123,138	1,765	70	10.1	132,525
Grand Forks County	66,109	1,440	46	12.3	65,435
Burleigh County	69,416	1,633	43	7.8	75,384
Ward County	58,795	2,056	29	10.8	55,270
Stark County	22,636	1,340	17	12.3	22,167
Rolette County	13,674	939	15	31	13,903
Morton County	25,303	1,945	13	9.6	25,754
Richland County	17,998	1,446	12	10.4	16,888
Stutsman County	21,908	2,298	10	10.4	20,761
Traill County	8,477	863	10	9.2	8,178
Walsh County	12,389	1,294	10	10.9	11,362
Ramsey County	12,066	1,301	9	12.6	11,267
Williams County	19,761	2,148	9	11.9	19,456
Barnes County	11,775	1,513	8	10.8	10,955
Mercer County	8,644	1,112	8	7.5	8,234
Pembina County	8,585	1,122	8	9.2	7,906
Ransom County	5,890	864	7	8.8	5,695
Foster County	3,759	647	6	9.3	3,583
Benson County	6,964	1,439	5	29.1	6,997
Dickey County	5,757	1,131	5	14.8	5,398
Sargent County	4,366	867	5	8.2	4,198
Bottineau County	7,149	1,698	4	10.7	6,650
Eddy County	2,757	644	4	9.7	2,502
Griggs County	2,754	716	4	10.10	2,456
LaMoure County	4,701	1,151	4	14.70	4,262
McLean County	9,311	2,328	4	13.5	8,543
Nelson County	3,715	1,009	4	10.3	3,289
Pierce County	4,675	1,082	4	12.5	4,221
Sioux County	4,044	1,128	4	39.2	4,282
Wells County	5,102	1,291	4	13.5	4,432

[36] U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2.
[37] http://factfinder.census.gov/servlet/GCTTable?_bm=y&-context=gct&-ds_name=PEP_2006_EST&-mt_name=PEP_2006_EST_GCTT1_ST2&-CONTEXT=gct&-tree_id=806&-redoLog=true&-geo_id=04000US38&-format=ST-2|ST-2S&-_lang=en

Cavalier County	4,831	1,488	3	11.5	4,099
Adams County	2,593	989	3	10.4	2,332
Bowman County	3,242	1,167	3	8.2	2,991
Emmons County	4,331	1,555	3	20.1	3,645
McHenry County	5,987	1,912	3	15.8	5,429
McIntosh County	3,390	995	3	15.4	2,956
Mountrail County	6,631	1,941	3	19.3	6,442
Oliver County	2,065	731	3	14.9	1,808
Renville County	2,610	892	3	11	2,425
Steele County	2,258	715	3	7.1	1,943
Towner County	2,876	1,042	3	8.9	2,417
Dunn County	3,600	2,082	2	17.5	3,443
Divide County	2,283	1,294	2	14.6	2,092
Burke County	2,242	1,129	2	15.4	1,947
Golden Valley County	1,924	1,002	2	15.3	1,691
Grant County	2,841	1,666	2	20.3	2,588
Hettinger County	2,715	1,134	2	14.8	2,564
Kidder County	2,753	1,433	2	19.8	2,453
Logan County	2,308	1,011	2	15.1	1,999
McKenzie County	5,737	2,861	2	17.2	5,700
Sheridan County	1,710	1,006	2	21	1,408
Billings County	888	1,151	0.77	12.8	829
Slope County	767	1,219	0.63	16.9	713

Appendix H

Bismarck State College
1500 Edwards Avenue
Bismarck, ND 58506-5587

Dickinson State University
291 Campus Drive
Dickinson, ND 58601-4896

Lake Region State College
1801 College Drive North
Devils Lake, ND 58301-1598

Mayville State University
330 3rd St. NE
Mayville, ND 58257-1299

Minot State University
500 University Ave. W.
Minot, ND 58707-0001

Minot State University - Bottineau
105 Simrall Boulevard
Bottineau, ND 58318-1198

North Dakota State College of Science
800 N. 6th Street
Wahpeton, ND 58076-0002

North Dakota State University
PO Box 5167
Fargo, ND 58105-5167

University of North Dakota
PO Box 8193
Grand Forks, ND 58202-8193

Valley City State University
101 College Street SW
Valley City, ND 58072-4098

Williston State College
1410 University Avenue
Williston, ND 58802-1326

Appendix I

Tribal colleges:

Cankdeska Cikana Community College
P.O. Box 269
Fort Totten, ND 58335

Fort Berthold Community College
220 8th Ave N
New Town, ND 58763

Sitting Bull College
1341 92nd Street
Fort Yates, ND 58538

Turtle Mountain Community College
PO Box 340
Belcourt, ND 58316

United Tribes Technical College
3315 University Dr.
Bismarck, ND 58504

Private schools:

Aakers College
Bismarck Campus
1701 East Century Avenue
Bismarck, ND 58503

Fargo Campus
4012 19th Avenue SW
Fargo, ND 58103

Jamestown College
6000 College Lane
Jamestown, ND 58405

University of Mary
7500 University Drive
Bismarck, ND 58504

Trinity Bible College
50 6th Avenue South,
Ellendale, ND 58436

Appendix J

Human Service Center and North Dakota State Hospital Internships

Badlands Human Service Center – MSW interns; special education students; and application to the Board of Addiction Counseling Examiners pending to become a training site for addiction counselors.

West Central Human Service Center – Participate in the Missouri Valley Addiction Counseling Training Consortium (bachelor level addiction trainees); nursing; Masters and Bachelors levels in social work; and will consider psychology interns if it would be mutually beneficial.

Northwest Human Service Center – Bachelors and Masters levels of internships in social work, clinical counseling, nursing, clinical nurse specialists, psychology, and addiction internships as long as supervisors are available to provide adequate oversight and supervision.

North Central Human Service Center - Bachelors and Masters levels of internships in social work, clinical counseling, nursing, clinical nurse specialists, psychology, and addiction internships as long as supervisors are available to provide adequate oversight and supervision.

South Central Human Service Center – participates in the local consortium for addiction training; Masters and Bachelors level for social work interns; and Masters level counseling internships. SCHSC used to provide nursing and Occupational Therapy internships.

Lake Region Human Service Center – Masters and Bachelors level internships in social work.

Northeast Human Service Center – Masters and Bachelors level internships in social work and nursing; Doctorate level psychology; 3rd year Med students; Med Residents; Masters level counseling; addictions counselors; Occupational and Physical Therapy; and rehab internships.

Southeast Human Service Center – Masters and Bachelors level personnel management; Masters and Doctorate level psychology; psychiatry residents; Masters level counseling; Masters and Bachelors level: social work, addiction studies, nursing; and Masters and Associate levels Occupational therapy.

North Dakota State Hospital – Under-graduate and graduate level nursing and social work; undergraduate level in occupational therapy and addiction studies; graduate level preferred in psychiatry and medicine and PA; undergraduate in human resources and recreation therapy; and seminary internships for individuals who have completed the coursework.

Appendix K

Northwest Human Service Center

Wait time is 3-5 days depending on when the client can come in. They can often accommodate a same day appointment for some services.

North Central Human Service Center

Service wait times are 10 days for all appointments except psychiatry (3 weeks).

Lake Region Human Service Center

Wait times are 2 days for substance abuse and 5 days for all other services.

Northeast Human Service Center

Wait times for services fall between 2-4 weeks, except for psychological intakes, which have a 7-week wait time.

Southeast Human Service Center

There is a 10-15 day wait time for all services except psychiatry. Wait time for routine psychiatry services is 20-31 days, however, psychiatry can schedule urgent cases in 4 days.

South Central Human Service Center

Psychiatry has a wait time of 7 days, Acute is 13 days, and Addiction/Medical is 19 days.

West Central Human Service Center

Most services have wait times between 2 and 9 days with the exception of psychiatry, which has a wait time of 25 days.

Badlands Human Service Center

Wait times vary across services with a low 1 day wait time for an Extended Care Intake and a high 26-day wait time for an Addiction intake.

Appendix L

Participant List

Dr. Vince Barnes
IHS, Standing Rock Tribe
Ft. Yates, ND

Maren Daley
Job Services
Bismarck, ND

Phil Davis
Job Services
Bismarck, ND

Dr. Tami DeCoteau
IHS, Standing Rock Tribe
Ft. Yates, ND

Shari Doe
Burleigh County Social Services
Bismarck, ND

Shelly Hegerle
Community Healthcare Association of the Dakotas
Bismarck, ND

Thomasine Heitkamp
UND School of Social Work
Grand Forks, ND

Susan Helgeland
Mental Health America
Fargo and Bismarck, ND

JoAnne Hoesel
DHS, DMHSAS and DD
Bismarck, ND

Cheryl Kalberer
University of Mary
Bismarck, ND

Marsha Krotseng
University System
Bismarck, ND

Karen Larson
Community Healthcare Association of the Dakotas
Bismarck, ND

Senator Judy Lee
West Fargo, ND

Jeanne MacDonald
DSU
Dickinson, ND

Lisa Fair McEvers
Labor Commission
Bismarck, ND

Nancy McKenzie
DHS
Bismarck and Fargo, ND

Carol Olson,
DHS
Bismarck, ND

David Peske
Psychiatric Society
Bismarck, ND

Shelly Peterson
Longterm Care Association

Stephanie Poitra
Turtle Mountain Community College
Belcourt, ND

Carley Randall
Counseling and Psychotherapy Centers Inc
Jamestown, ND

Dr. Paul Rokke
NDSU
Fargo, ND

Mr Lauren Sauer
DHS, DMHSAS
Bismarck, ND

Susan H. Wagner
DHS, DMHSAS
Bismarck, ND

Tami Wahl
Governor's Office
Bismarck, ND

Marlene Warnke
NAMI-ND Chapter
Bismarck, ND

Mr. Kerry Wicks
NDSH
Jamestown, ND

Linda Wright
Aging Services, DHS
Bismarck, ND

Marcie Wuitschick
DHS, HR
Bismarck, ND

Beth Zander
Job Services
Bismarck, ND