State of North Dakota
Department of Health & Human Services
Behavioral Health Division

System of Care Needs Assessment

2023

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Executive Summary

Overview

In September 2022, North Dakota Department of Health & Human Services (DHHS) Behavioral Health Division (BHD) was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement, expand, and sustain a system of care (SOC) in the geographic service areas of Lake Region Human Service Center (LRHSC) and West Central Human Service Center (WCHSC). LRHSC and WCHSC represent two of the eight regional Human Service Centers that provide a wide range of behavioral health services for children, youth, and families in their respective geographic catchment areas. These two regions differ in their current service array, populations served, and level of accessibility for rural populations. Although both identified regions are vastly rural, WCHSC, located in the state's capital city, allows for the implementation of an SOC approach in a more populated and service rich area than the region served by LRHSC. LRHSC and the greater Devils Lake region has been identified as a high need area due to lack of services and supports. BHD plans to initially implement in the two identified regions and to expand SOC efforts in future years.

System of care refers to a framework for reforming child and youth mental health services. The framework comprises three elements: (1) a philosophy, including values and principals, intended to guide service delivery for children, youth, and their families; (2) an infrastructure of structures, processes, and partnerships that promote use of data, quality improvement strategies, and financing mechanisms; and (3) a broad array of culturally responsive services and supports with a focus on home and community-based treatments.[1]

The purpose of SAMHSA's SOC Expansion and Sustainability grant program is to develop a comprehensive set of services and supports and to strengthen the existing service array to better respond to the behavioral health needs of children and youth. This federal funding aids the implementation, expansion, and integration of the SOC approach by developing sustainable infrastructure and services for children and youth ages 0 –21 with serious emotional disturbance (SED) and their families.

SAMHSA requires SOC awardees to conduct a needs assessment to identify gaps in services for children and youth with SED, racial and ethnic disparities, and cultural and linguistic needs within the service area. To complete a needs assessment for the service areas of LRHSC and WCHSC, BHD contracted with TriWest Group (TriWest). From January to March 2023, TriWest interviewed key stakeholders; reviewed documents (including other local health assessments);

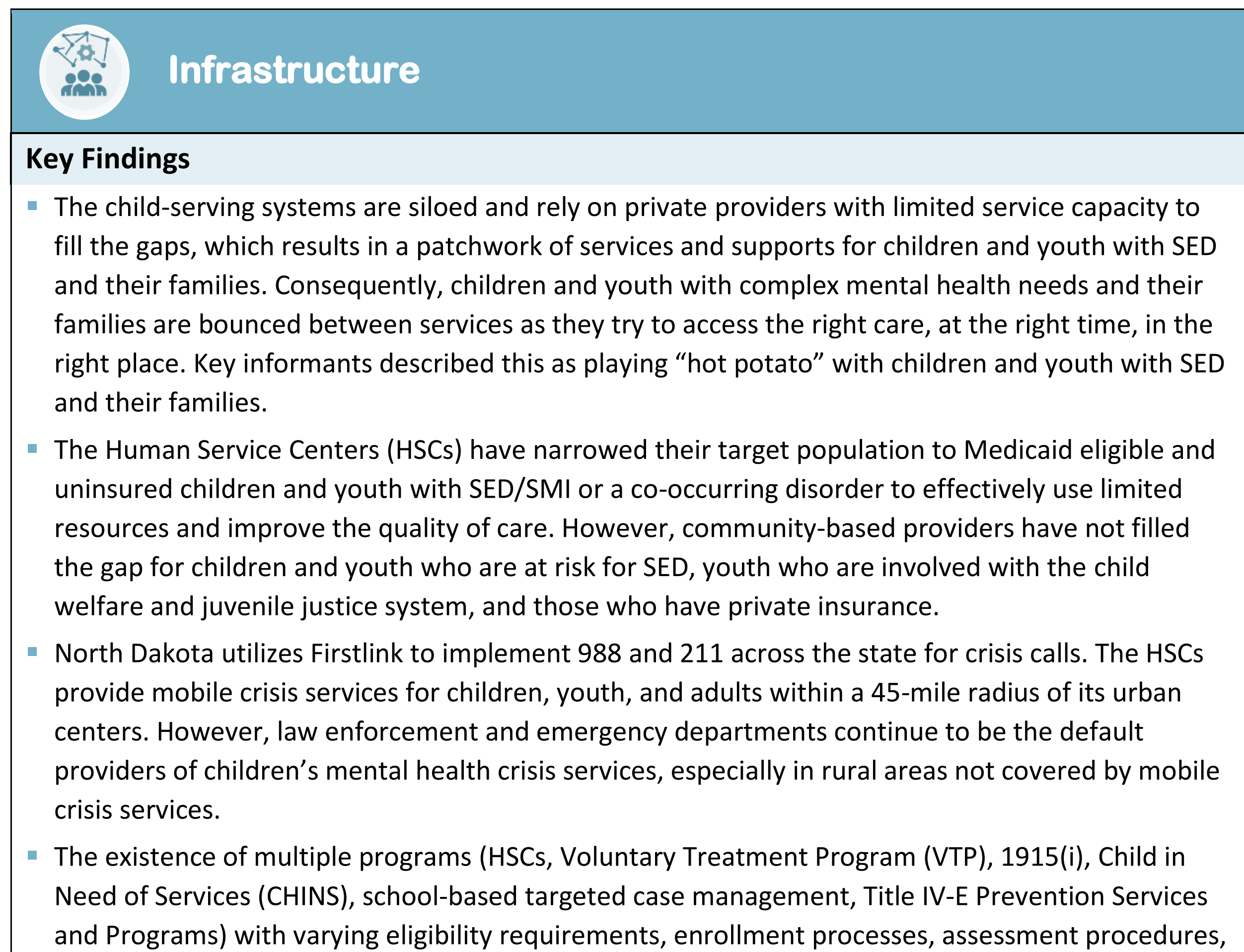
[1] Stroul, B. A., Blau, G. M., & Larsen, J. (2021). The evolution of the system of care approach. University of Maryland, School of Social Work. https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

and analyzed epidemiologic data to determine prevalence estimates in order to assess the behavioral health needs in the regions, strengths of the current system, and opportunities to better achieve the goals of the SOC approach. In this report, findings and considerations from the needs assessment are organized according to the three elements of the SOC approach: infrastructure, services and supports, and values.

Limitations of the Needs Assessment

The North Dakota System of Care Needs Assessment is not designed to be an exhaustive analysis of all providers, services, and supports available to children, youth, and families in North Dakota. It is a time-limited review of strengths, gaps, and opportunities within the system of care for children and youth (ages 6-21) at risk for or experiencing a SED in Regions III and VII. The findings and considerations presented in the needs assessment are based on interviews with a sample of key informants, a review of publicly available documents, and an examination of mental health service utilization data and prevalence estimates.

Summary of Key Findings and Considerations



Infrastructure

Key Findings

- The child-serving systems are siloed and rely on private providers with limited service capacity to fill the gaps, which results in a patchwork of services and supports for children and youth with SED and their families. Consequently, children and youth with complex mental health needs and their families are bounced between services as they try to access the right care, at the right time, in the right place. Key informants described this as playing “hot potato” with children and youth with SED and their families.
- The Human Service Centers (HSCs) have narrowed their target population to Medicaid eligible and uninsured children and youth with SED/SMI or a co-occurring disorder to effectively use limited resources and improve the quality of care. However, community-based providers have not filled the gap for children and youth who are at risk for SED, youth who are involved with the child welfare and juvenile justice system, and those who have private insurance.
- North Dakota utilizes Firstlink to implement 988 and 211 across the state for crisis calls. The HSCs provide mobile crisis services for children, youth, and adults within a 45-mile radius of its urban centers. However, law enforcement and emergency departments continue to be the default providers of children’s mental health crisis services, especially in rural areas not covered by mobile crisis services.
- The existence of multiple programs (HSCs, Voluntary Treatment Program (VTP), 1915(i), Child in Need of Services (CHINS), school-based targeted case management, Title IV-E Prevention Services and Programs) with varying eligibility requirements, enrollment processes, assessment procedures,

Infrastructure

and entry points into care makes accessing services and supports difficult for children, youth, and their families.

- The Voluntary Treatment Program (VTP) provides access to Qualified Residential Treatment Programs (QRTPs) and therapeutic foster home placement without requiring parents to relinquish custody. Due to limited funds, only eight youth have been placed through this program within the 2021-2023 biennium.
- The 1915(i) Medicaid State Plan Amendment includes the provision of care coordination, parent/caregiver skills training, family peer support, and respite care to Medicaid-enrolled children and youth with SED and their families. However, the full array of services is not available to children, youth, and their families, and few children and youth have been enrolled in these services.
- The federal Family First Prevention Services Act improved the quality of residential treatment facilities by increasing licensing standards for QRTPs, requiring residential providers to provide aftercare services for 6 months after discharge, and adopting a third party-administered uniform assessment process for more effectively identifying children and youth in need of this level of care. These changes, although positive, decreased the number of available QRTP beds before community providers had developed the capacity to provide intensive home and community-based services for those children and youth determined to be ineligible for this level of care.
- The North Dakota Title IV-E Prevention Services and Programs Plan allocated Title IV-E prevention funding to approved evidence-based prevention and early intervention services including family visitation programs (e.g., Healthy Families, Parents as Teachers, Nurse Family Partnership), therapy services targeted to young children (e.g., Parent-Child Interaction Therapy), and intensive home-based interventions (e.g., Brief Strategic Family Therapy, Homebuilders, Functional Family Therapy, Multisystemic Therapy). A limited number of community providers are approved to provide these services.
- The limited number of certified shelter beds has impacted respite support for youth and families in crisis, resulting in children and youth being placed in Human Service Zone (HSZ) offices and hotels and in emergency departments. North Dakota Health and Human Services has offered grant funds to establish certified shelter care programs. Grand Forks County Youth Services was certified in April 2023 and can serve children ages 10-17 in Region III and the surrounding area. There are currently no certified shelters in Region VII.
- Moving the CHINS program from the juvenile courts to the Human Service Zones (HSZs) was effective in decriminalizing status offenses. However, key informants report that many of the youth who are referred to the CHINS program require a higher level of care that the CHINS program does not currently have the capacity to provide.
- The Dual Status Youth Initiative is a good example of a cross-system partnership that addresses the needs of youth in the juvenile justice and child welfare systems. Its strengths include efficient data sharing, multidisciplinary team meetings, and effective system liaisons.

Infrastructure

- There is a strong collaboration between the BHD and school districts across the state. This collaboration has increased schools' and district's ability to build a multi-tiered system of support that addresses students' social, emotional, and mental health needs. In addition, North Dakota's Multi-Tier System of Supports helps integrate school behavioral supports with community-based mental health services.
- The Treatment Collaborative for Traumatized Youth (TCTY) has effectively trained communities and mental health providers across North Dakota in trauma-focused cognitive behavioral therapy and other trauma-informed practices.
- Standing Rock Tribe was awarded a SAMHSA SOC grant (2021-2025) which provides an opportunity to collaborate on SOC implementation on and off tribal lands.

Considerations

- Establish a North Dakota SOC governance structure and engage its advisory committee(s) to develop and adopt a mission and vision for the SOC that addresses siloed services.
  - Use this governing body and advisory committees to develop a strategic plan that identifies and prioritizes system-level challenges and barriers to accessing care.
  - Develop and adopt cross-system goals and measures for success that align with SOC core values, address system infrastructure challenges, and improve the continuum of care for children and youth who have or are at risk for SED. The Dual Status Youth Initiative is a strong example of cross-system collaboration.
- Build community capacity to provide evidence-based intensive home and community-based services and supports by aligning SOC capacity-building efforts with the North Dakota Title IV-E Prevention Services and Programs Plan.
- Partner with Children and Family Services to identify and support local providers in prioritizing implementation of Brief Strategic Family Therapy (BSFT), Homebuilders, Functional Family Therapy (FTT), and Multisystemic Therapy (MST). The Title IV-E Prevention Services and Programs Plan provides the infrastructure to build and sustain these programs. Implementation of these core services will begin to address the statewide gap in intensive home and community-based services and provide a solid foundation for adding additional practices to this component of the service continuum.
- Collaborate with Children and Family Services, Division of Juvenile Services, Department of Public Instruction, and tribal nations to identify additional evidence-based practices that address the mental health needs of children and youth at risk of out-of-home placement and add those to the North Dakota Title IV-E Prevention Services and Programs Plan.
- Use the TCTY (or establish a similar infrastructure) to increase the community's capacity to provide additional evidence-based practices that meet the needs of children and youth who have or are at risk for SED and youth at risk of out of home placement.

Infrastructure

- Expand the TCTY's capacity to train providers on evidence-based practices for skills training (e.g., Skillstreaming), co-occurring disorders (e.g., Seeking Safety), or care coordination (e.g., FOCUS, High Fidelity Wraparound).
- Continue efforts to partner with Standing Rock Tribe's SOC implementation.

Services and Supports

Key Findings

- Workforce issues continue to affect service capacity across all child-serving systems in Regions III and VII.
- The HSCs in both regions use an open access assessment process to increase service accessibility of team-based care to children and youth with SED and their families. Key informants reported significant wait times between when a child or youth is assessed and when services are initiated. They also noted that the frequency and intensity of these services are insufficient.
- The HSCs in Regions III and VII are implementing trauma-focused cognitive behavioral therapy and Structured Psychotherapy for Adolescents Responding to Chronic Stress. They have not adopted an evidence-based practice for intensive case management as a component of team-based care.
- Mobile crisis is limited to the urban areas and variable in response. Law enforcement and emergency rooms continue to be the default crisis care provider in all rural areas and some urban areas of the region. The HSCs in Regions III and VII are not implementing Mobile Response and Stabilization Services, a best practice for child and youth crisis response. The rural nature of North Dakota and limited staff capacity make this model challenging to implement.
- Regions III and VII lack substance use disorder treatment and recovery services. They also lack child and youth psychiatrists, therapists with extended working hours, skills trainers and integrators, parent support aides, and respite care providers.
- There are a limited number of providers that provide intensive home and community-based services in either region. This is especially true for individuals who have private insurance or need immediate access to care to remain in the community.
- There are a limited number of community-based mental health providers offering evidence-based services, and none provide intensive in-home interventions as approved in the North Dakota Title IV-E Prevention Services and Program Plan.
- Service contracts for in-home family therapy for families involved with the HSZs expired before community providers had developed the capacity to deliver approved services as outlined in the North Dakota Title IV-E Prevention Services and Program Plan.
- The lack of intensive community-based services puts increased demand on Psychiatric Residential Treatment Facilities (PRTFs) and QRTPs. Key informants reported a significant wait list for QRTP

Services and Supports

beds and that PRTF beds were also filled. There is a perception among key informants that the high demand for beds allows facilities to reject children and youth with the most complex needs in favor of those who could be served in the community.

- HSZ child welfare staff are certified in wraparound, as outlined in North Dakota Medicaid Policy, to implement targeted case management services. It should be noted ~~that~~ there are different and sometimes overlapping definitions of wraparound. State child-serving agencies may have differing definitions and regulations that refer to and drive implementation of “wraparound services.”
- All treatment foster care providers in North Dakota are trained in Together Facing the Challenge, an evidence-based model.
- There is a lack of trained foster parents who are willing, due to lack of home and community-based services, to take children and youth with complex needs and/or transitioning from a higher level of care.
- Schools and districts in Regions III and VII have partnered with the BHD and regional and local behavioral health providers to increase student access to services and supports that cultivate skills designed to advance students’ learning, relationships, and development.

Considerations

- Use the governance structure and steering committees to develop and support cross system adoption of shared definitions of service coordination, care coordination, case management, intensive case management, and wraparound services.
- Build the HSC’s capacity to deliver and sustain High Fidelity Wraparound services in Regions III and VII.
  - Identify additional partners (e.g., private mental health providers, HSZs, QRTPs, tribal nations) to expand implementation efforts.
- Develop and implement a plan to regularly assess quality, outcomes, and fidelity to the High Fidelity Wraparound model once it has been implemented in Regions III and VII.
- Work with Regions III and VII to build community capacity to deliver all services included in the 1915(i) Medicaid State Plan Amendment.
- Partner with the core child-serving systems to continue working toward recommendations from the 2018 North Dakota Behavioral Health System Study.
  - Include service capacity and workforce development as key areas of focus in the SOC strategic plan.
- Identify exemplars for implementing Mobile Response and Stabilization Services in rural communities and develop a plan to strengthen crisis interventions for children, youth, and families and decrease law enforcement response and emergency room encounters.

System of Care Values

Key Findings

- Agencies in both regions provide cultural competency training, and some have adopted Native American practices (talking circles, drumming, and dancing). However, regions III and VII struggle to meet the cultural needs of the Native American children, youth, and families they serve.
- Staff in Regions III and VII are not representative of the population they serve (i.e., Native Americans, Spanish language speakers, the deaf and hard of hearing community).
- Only one key informant indicated that they were trained in and implementing a culturally relevant evidence-based practice.
- The TCTY recommends Honoring Children and Mending Circles, which is a cultural adaptation of trauma-focused cognitive behavioral therapy for Native American youth and families.
- Residents of Regions III and VII do not have access to family support provider or youth support provider services.
- Only one organization indicated they had a youth advisory team as well as a youth with lived experience serving on their board.

Considerations

- Review the SOC governance structure to ensure it includes representation of tribal nations in North Dakota such as including a Native American family member and a youth on the SOC advisory team or governing body.
- Identify strategies within the SOC framework to build cultural awareness and strengthen relationships with community providers that support the Native American communities in North Dakota.
- Identify and include culturally responsive evidence-based practices in the SOC training plan. Disseminate these practices through the current training infrastructure.
- Partner with state-wide and local youth and family advocacy groups to increase family and youth participation at all levels of service delivery.
- Build on state efforts to train and certify peer support providers in order to build the system's capacity to provide family support services.

1 Introduction

In September 2022, North Dakota Department of Health & Human Services (DHHS) Behavioral Health Division (BHD) was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement, expand, and sustain a system of care (SOC) in the geographic service areas of Lake Region Human Service Center (LRHSC) and West Central Human Service Center (WCHSC). The purpose of SAMHSA's SOC Expansion and Sustainability grant program is to develop a comprehensive set of services and supports and to strengthen the existing service array to better respond to the behavioral health needs of children and youth. This federal funding aids the implementation, expansion, and integration of the SOC approach by developing sustainable infrastructure and services for children and youth ages 0–21 with serious emotional disturbance (SED) and their families.

SAMHSA requires SOC awardees to conduct a needs assessment to identify gaps in services for children and youth with SED, racial and ethnic disparities, and cultural and linguistic needs within the service area. This section provides an overview of BHD and the division's behavioral health services in the geographic service areas of LRHSC and WCHSC. It summarizes the purpose and goals of North Dakota's SOC grant and describes the methodology for the needs assessment.

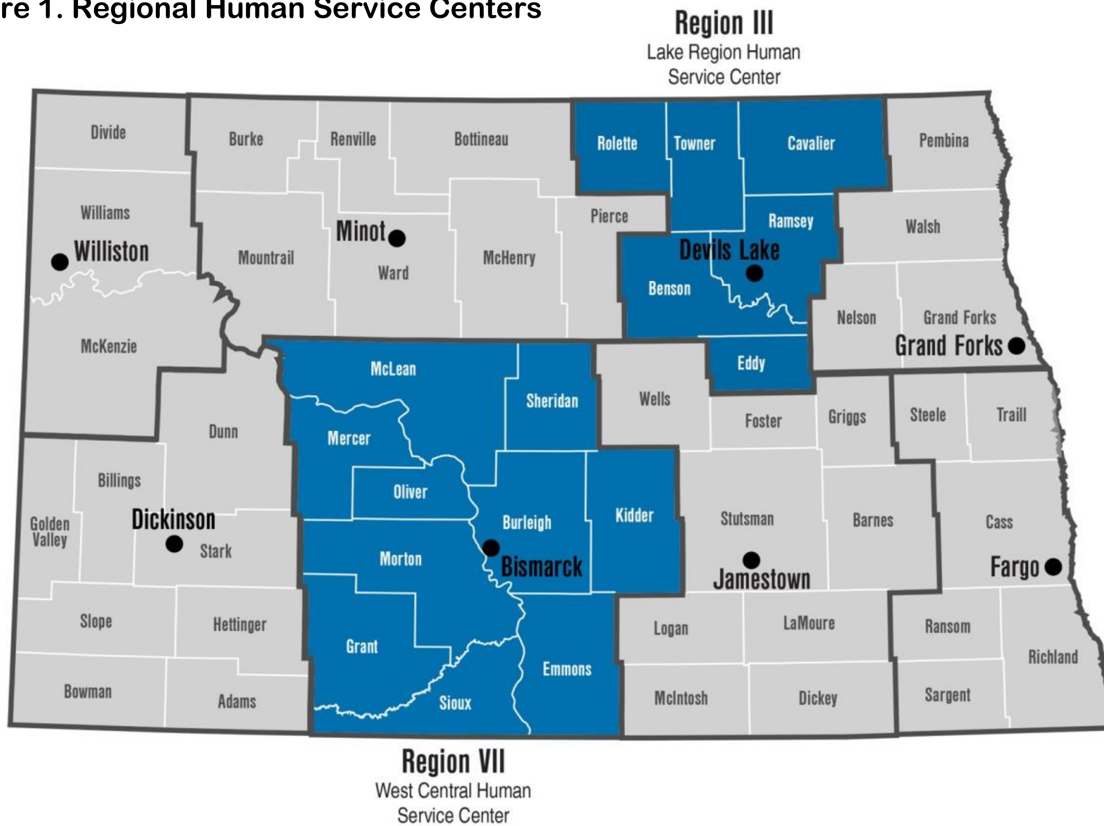
Background

The population of focus for North Dakota's SOC grant is children and youth with serious emotional disturbance (SED) and their families in Regions III and VII, two of the eight regional Human Service Centers (HSC) operated by the North Dakota Department of Health and Human Services (See Figure 1). HSCs provide crisis services, outpatient, and intensive team-based behavioral health services to residents in their greater region.

LRHSC, located in Devils Lake serves the 38,000 people who reside in Region III. Region III covers 6,756 square miles and includes Benson, Cavalier, Eddy, Ramsey, Rolette, and Towner counties as well as the Turtle Mountain Reservation and Spirit Lake Reservation, where the Turtle Mountain Band of Chippewa and Spirit Lake Nation reside (See Figure 2).

WCHSC, located in Bismarck, serves the population of Region VII. This 14,452-square-mile area is home to approximately 166,000 people. WCHSC serves the 10-county area of Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux, and includes the Standing Rock Indian Reservation and part of the Fort Berthold Indian Reservation. The Standing Rock Sioux Tribe and the Mandan, Hidatsa, and Arikara Nation, also known as the Three Affiliated Tribes, reside in parts of Region VII (See Figure 2).

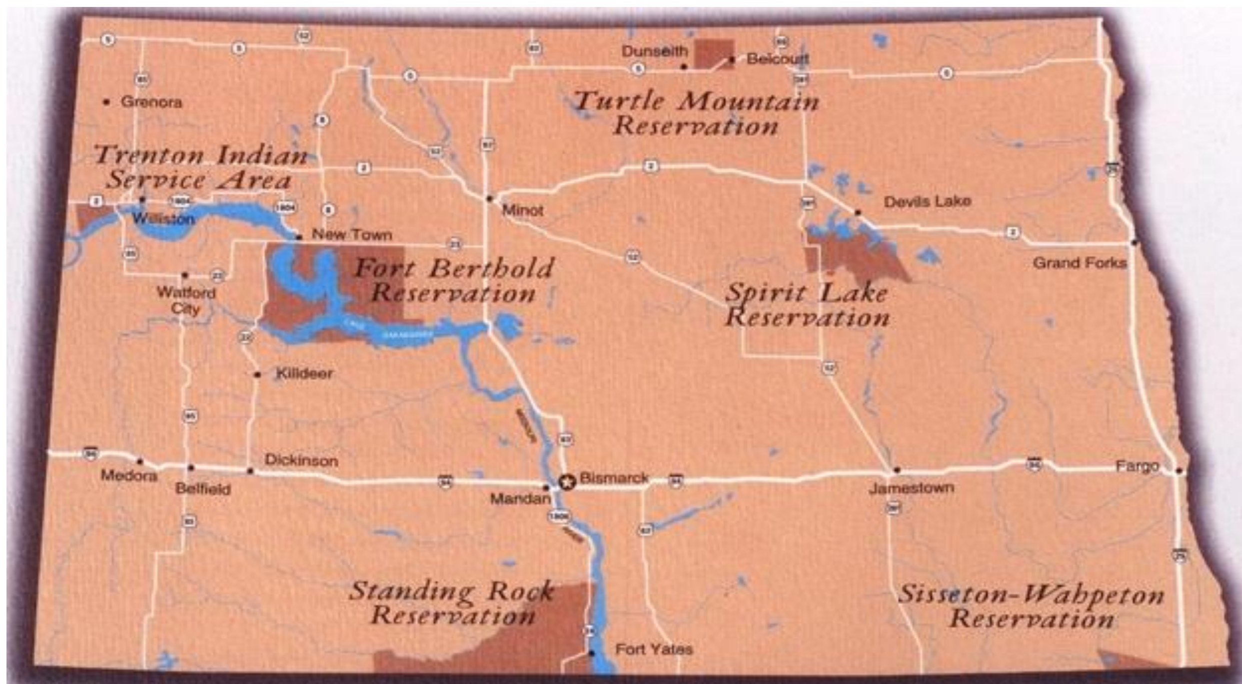
Figure 1. Regional Human Service Centers



LRHSC and WCHSC represent two of the eight regional HSCs that provide a wide range of behavioral health services for children, youth, and families in their respective geographic catchment areas. The goal of BHD was to initially implement and develop infrastructure in two regions that are unique as it relates to current service array, diversity of populations served, and challenges in accessibility for rural populations. Although both identified regions are vastly rural, WCHSC located in the state's capital city allows for the implementation of SOC approach in a more populated and service rich area than the region served by LRHSC. LRHSC and the greater Devils Lake region has been identified as a high need area due to lack of services and supports. BHD plans to initially implement in the two identified regions to expand SOC efforts in future years.

As part of the SOC grant funding, BHD will provide training to service providers in SOC development and implementation, including evidence-based, practice-based, or community-defined interventions. The trainings will expand the availability of culturally responsive services; expand the availability of supports for the behavioral health workforce; increase Native American representation (including children, families, and tribal leadership) on state workgroups; and support the dissemination of culturally relevant evidence-based practices to providers working directly with children and families.

Figure 2. North Dakota Tribal Nations



BHD plans to involve families and youth in the development, implementation, and evaluation of the SOC at the state and local levels. A clinical administrator was hired to manage the funding and oversee the development of the framework. A lead family administrator was hired to collaborate with existing family organizations to enhance the integration of child and family input in both policy and service development.

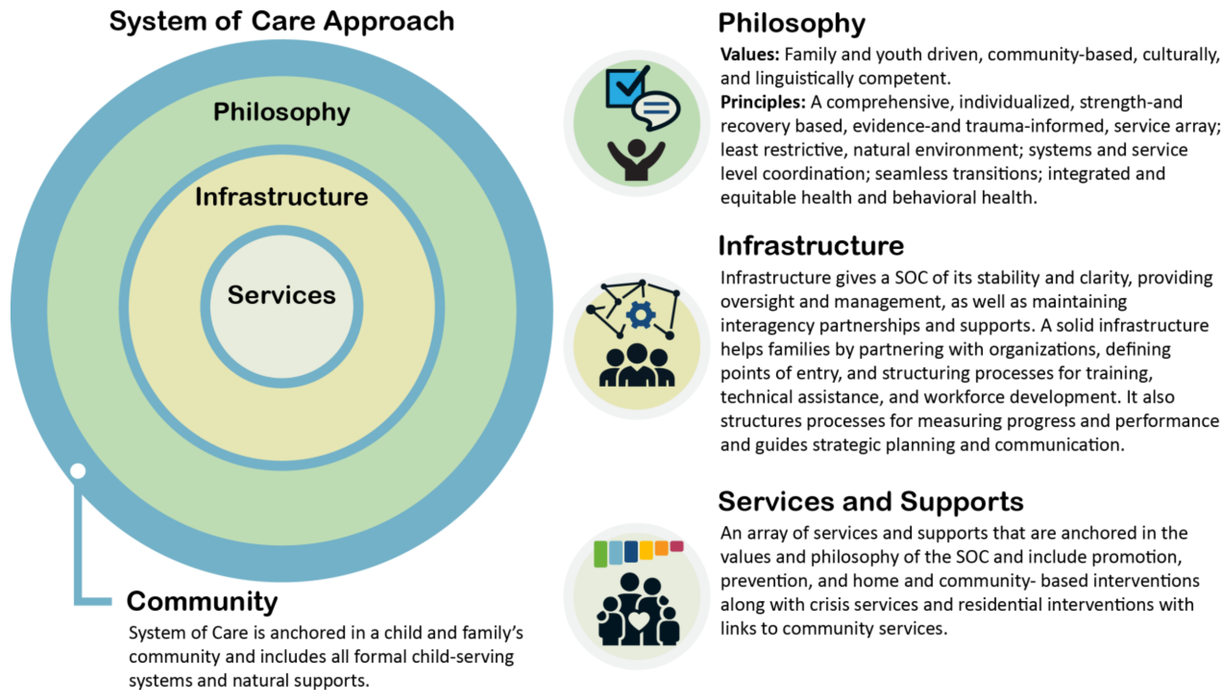
Finally, the grant will support the state's efforts to increase capacity to provide behavioral health services to children and youth with SED. This includes enhancing specialization in early childhood diagnostic and evaluation services; developing school-based mental health services to develop a statewide infrastructure for school-based service delivery; training and hiring additional staff to increase access to crisis services; improving access to intensive in-home supports, including contracting with private providers to develop these services; exploring the use of foster care parents as extended respite support for and mentors to children with SED and their families; and contracting with private providers to increase the availability of intensive day treatment and respite care services.

What Is a System of Care?

A system of care (SOC) is a coordinated and organized network of flexible and effective **services and supports** for an identified population, often children and youth who have SED and their families. A SOC incorporates care planning and management across multiple levels and is driven by a clear **philosophy** that incorporates youth and family input, provides care in the

community, and ensures that systems and services are culturally and linguistically competent. A SOC is data driven and includes a supportive policy and management **infrastructure**.[2] Figure 3 below illustrates the SOC approach. The specific SAMHSA requirements for the SOC grant are outlined in Appendix A.

Figure 3. System of Care Approach



Purpose of the SOC Needs Assessment

SAMHSA requires SOC grant awardees to conduct a needs assessment to "address gaps in service delivery for the children/youth to be served by this project in the proposed geographic service area. The needs assessment must include the identification of racial and ethnic health disparities, and specialized cultural and linguistic needs."[3] The needs assessment is intended to help awardees understand the population of focus and prepare to meet the behavioral health needs of the service area(s).

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[2] Stroul, B. A., Blau, G. M., & Larsen, J. (2021). *The evolution of the system of care approach*. University of Maryland, School of Social Work. https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

[3] SAMHSA. (2022). *FY 2022 grants for expansion and sustainability of the comprehensive community mental health services for children with serious emotional disturbances* (Notice of Funding Opportunity No. SM-22-007). Department of Health and Human Services. https://www.samhsa.gov/grants/grant-announcements/sm-22-007

Methodology

TriWest Group (TriWest) serves as the program evaluator for the North Dakota SOC grant and worked collaboratively with BHD to conduct the needs assessment from January to March 2023. To complete the assessment, TriWest conducted 39 virtual key informant interviews with BHD staff, state officials, service providers, and other community stakeholders between February 17, 2023 and March 10, 2023 (listed in Table 4, Appendix B). We asked key informants and stakeholders to describe what services and supports were available in each region, discuss what was lacking, identify barriers to accessing care, and describe community strengths. We also asked questions on culture and language and racial and ethnic disparities. We combined the information gathered during these interviews and compared it to an ideal continuum of care to assess the current array of services and supports available to children and youth who have or are at risk for SED/SMI in Regions III and VII. We also completed a review of organizational documents (including the strategic plan and quality improvement reports) and other local health assessments (e.g., *2018 North Dakota Behavioral Health System Study*).

We examined demographic characteristics across the two regions in North Dakota using the most recent data published by the U.S. Census Bureau's Population Estimates Program and American Community Survey. We also estimated county-level behavioral health needs by applying the most local and recent epidemiological data, including sub-state, state-level, and national data from SAMHSA's National Survey on Drug Use and Health.

2 Summary of Behavioral Health Needs

This section provides an overview of the demographic characteristics of Region III and VII. It presents health insurance coverage estimates by age and service area. Finally, it summarizes the prevalence of behavioral health-related conditions and behaviors for the service area.

Demographic Characteristics

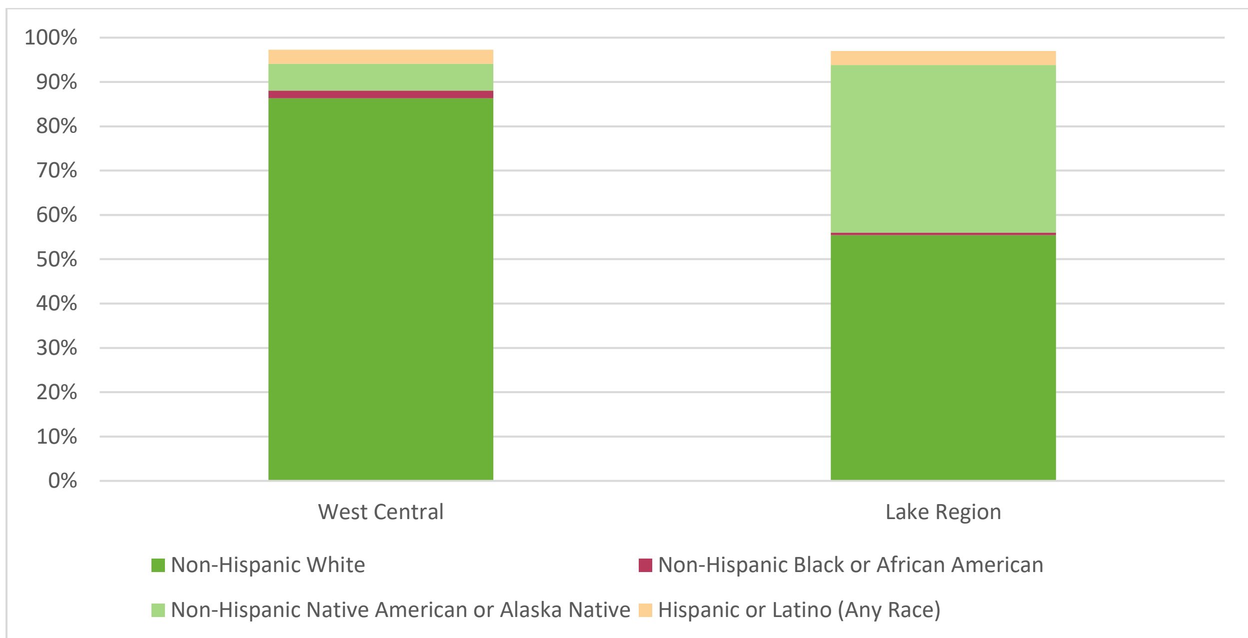
Table 1 presents select demographic characteristics for both regions. Among the 166,000 residents of Region VII, most are White (86%); among the 38,000 residents of Region III, a little over half are White (55%). Region III has a much higher population of Native Americans or Alaska Natives (38%) compared to Region VII (6%) (Figure 4).[4]

Table 1. Demographic Characteristics

Demographic Characteristics	Region VII: WCHSC		Region III: LRHSC		Total	
	n	%	n	%	n	%
Total Population	165,505	82%	37,568	18%	203,073	100%
Age						
0 to 5	12,486	8%	3,523	9%	16,009	8%
6 to 11	13,530	8%	3,742	10%	17,272	9%
12 to 17	13,075	8%	3,517	9%	16,592	8%
18+	126,415	76%	26,786	71%	153,201	75%
Race						
White	142,919	86%	20,840	55%	163,759	81%
Black or African American	2,806	2%	217	1%	3,023	1%
Native American or Alaska Native	9,992	6%	14,191	38%	24,183	12%
Asian or Asian American	1,190	1%	201	1%	1,391	1%
Native Hawaiian or Other Pacific Islander	179	0%	6	0%	185	0%
Two or More Races	3,128	2%	924	2%	4,052	2%
Ethnicity						
Hispanic or Latino	5,291	3%	1,189	3%	6,480	3%
Gender						
Male	83,728	51%	19,155	51%	102,883	51%
Female	81,777	49%	18,413	49%	100,190	49%

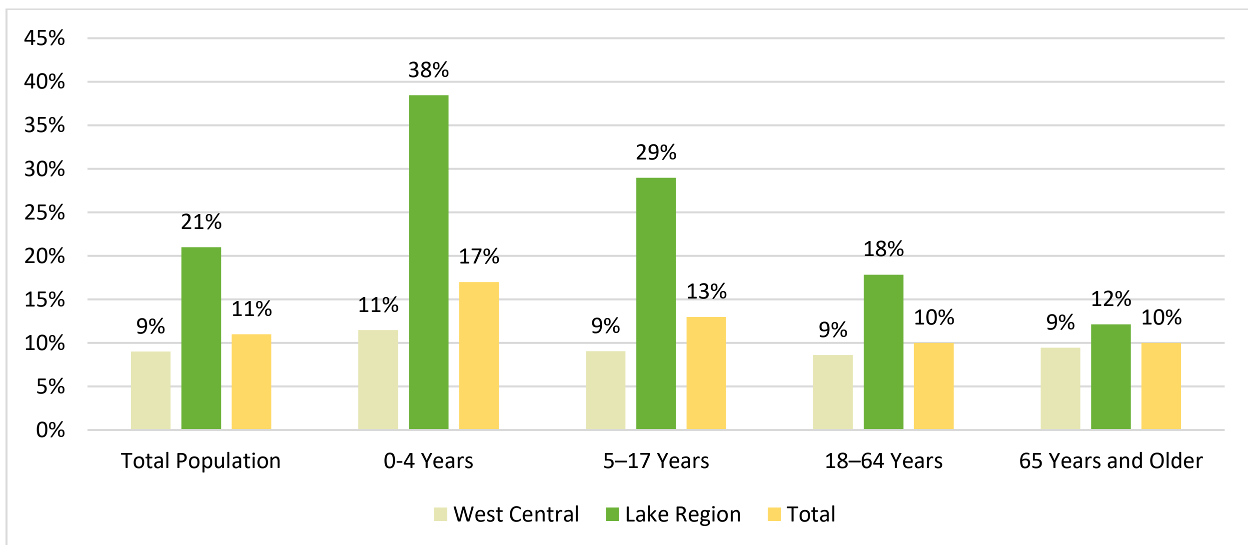
[4] U.S. Census Bureau. (2022). *Population estimates program, vintage 2021*.

Figure 4. Population by Race and Hispanic or Latino Ethnicity



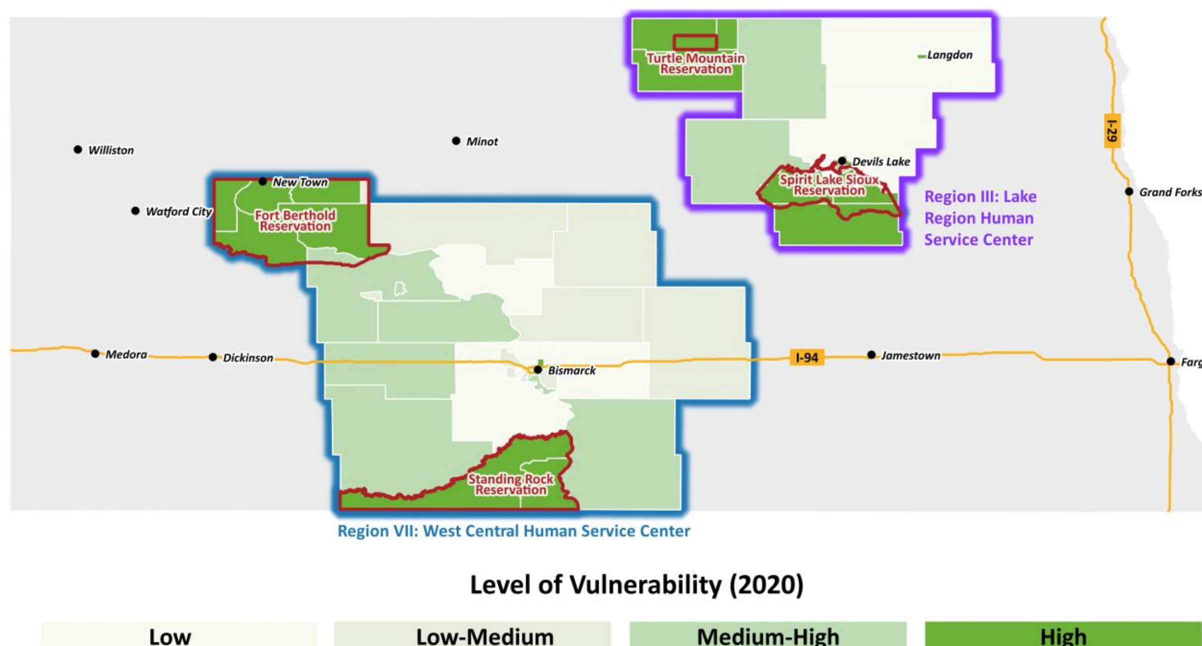
Poverty is closely associated with the behavioral health needs of a community. Eleven percent of the total population within the two service areas live below the federal poverty level (FPL) (Figure 5). However, Region III's poverty rate is over twice that of Region VII's. This disparity is most pronounced for children and youth between the ages of 0 and 4 years. The FPL for a family of four is $26,500 in annual income.[5]

Figure 5. Federal Poverty Level by Age Group



[5] American Community Survey. (2020). *5-year estimates, table s1701, poverty status in the past 12 months.*

Figure 6. Social Vulnerability



The Centers for Disease Control and Prevention's Social Vulnerability Index uses 16 variables from the U.S. census to determine the degree to which communities experience greater or lesser negative effects caused by "external stresses on human health." [6] Figure 6 shows there are census tracts within both regions that have the highest levels of overall social vulnerability relative to other census tracts in North Dakota. Native American reservations are denoted by a red outline. The areas with the highest levels of social vulnerability in North Dakota include the four reservations and one small area around Langdon in Region III.

Among residents in these two service areas, more than 8,596 (4.6%) speak a language other than English, and 1.4% (more than 2,689 residents) speak English less than "very well" and are considered to have limited English proficiency (LEP). The three most common languages other than English are other Indo-European languages (2%), Spanish (1%), and other (1%).[7] Although other Indo-European languages are the most common languages spoken other than English in the two regions combined, this varies by county within each region. For instance, in Benson, Rolette, and Sioux counties where 6–10% of residents speak a language other than English, the primary language spoken is listed as "Other." More discrete data are not available, but languages spoken by members of the Spirit Lake Nation, Turtle Mountain Band of Chippewa, Standing Rock Sioux Tribe, and the Three Affiliated Tribes are likely to constitute a significant

[6] Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry. (n.d.) *CDC/ATSDR Social Vulnerability Index.* https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

[7] American Community Survey. (2021). *5-year estimates, table S1601, language spoken at home*.

proportion of the "Other" languages spoken in these areas, given the prevalence of those groups in the population. In other counties such as Towner and Kidder, however, where 3–4% of the population speak a language other than English, Spanish is the most common language spoken other than English.

Health Insurance Coverage

Table 2 presents health insurance estimates by age group across the United States (US), North Dakota, and within Region III and VIII. A total of 92% of North Dakotans have health insurance, compared to 91% of the population in the US. For children and youth between the ages of 0 and 18, North Dakota has a lower percentage of the population with health insurance relative to the US overall. Among those with health insurance, North Dakota has a higher percentage with private health insurance relative to the US overall (for all age groups).

Table 2. Percentage of the Population with Health Insurance by Age Group

Age	With Insurance[8]				With Private Health Insurance[9]			
	US	North Dakota	Region VII	Region III	US	North Dakota	Region VII	Region III
All Ages	91%	92%	94%	85%	68%	79%	80%	57%
0 to 5	96%	93%	94%	88%	58%	75%	78%	44%
6 to 18	94%	93%	94%	85%	62%	77%	78%	48%
19 to 25	86%	89%	90%	78%	71%	82%	81%	52%
26 to 34	85%	87%	88%	75%	69%	78%	82%	54%
35 to 44	87%	92%	92%	81%	74%	83%	83%	60%
45 to 54	89%	91%	92%	83%	76%	84%	84%	68%
55 to 64	92%	93%	96%	83%	75%	84%	86%	66%
65 to 74	99%	99%	100%	98%	57%	68%	66%	62%
75+	99%	100%	100%	99%	60%	73%	74%	62%

A smaller percentage of people in Region III (85%) have health insurance than in Region VII (94%). This difference nearly disappears for adults 65 years of age and older, the age when individuals typically become eligible for Medicare coverage. Among those with health insurance, a smaller percentage of the population in Region III have private insurance. This

[8] American Community Survey. (2021). *5-year estimates, table B27001, health insurance coverage status by sex by age*.

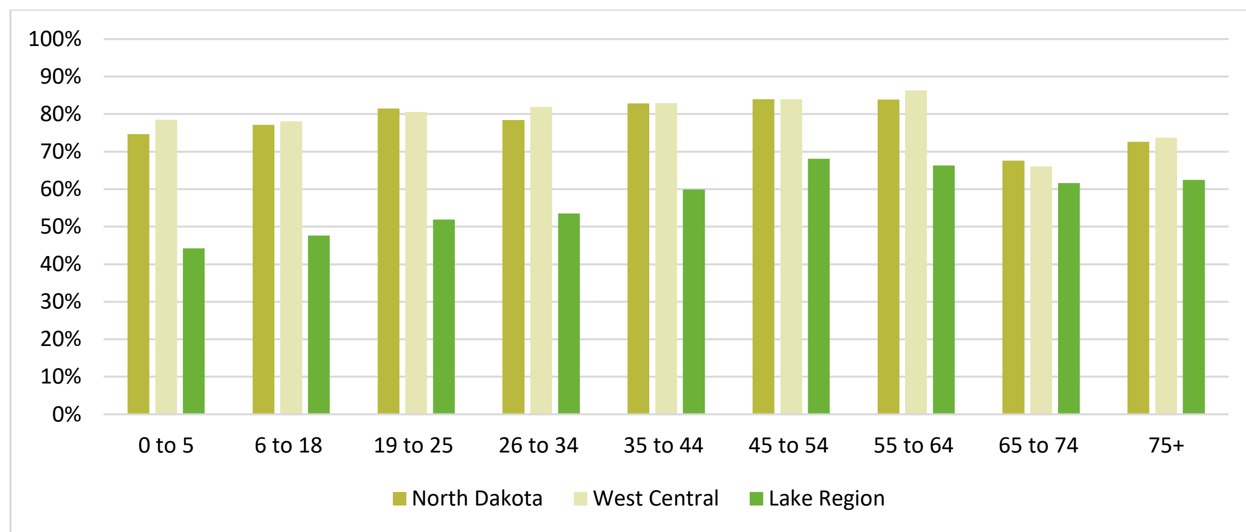
[9] American Community Survey. (2021). *5-year estimates, table B27002, private health insurance status by sex by age*.

difference is most pronounced for children between the ages of 0 and 5: Only 44% of children in this age group have private insurance in the Region III compared to 78% of those in Region VII. There is also a large difference for those 6 to 18 years old: Only 48% of children and youth in this age group in Region III have private health insurance compared to 78% of those in Region VII.

Native Americans and Alaska Natives have access to health care through Indian Health Services, regardless of health insurance status. Lower health insurance rates in Region III, which has a larger population of Native Americans and Alaska Natives, might be offset in part by access to and use of Indian Health Services.

Poverty and unmet social need can increase barriers to obtaining health insurance and paying for procedures and medications.[10] The fact that the Region III has over twice the poverty rate of Region VII is likely associated with lower rates of health insurance coverage. In 2021, 19% of children and youth between 0 and 18 years of age in North Dakota living below 100% FPL were uninsured, compared to 7.1% of all children and youth 0 to 18 years of age (Figure 7).[11] Further, among children and youth with health insurance, more than twice as many in Region III have public health insurance than in Region VII, where there are higher rates of private health insurance coverage.

Figure 7. Percentage of the Population with Private Health Insurance



[10] Healthy People 2030. (n.d.). *Poverty.* https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty#:~:text=Unmet%20social%20needs%2C%20environmental%20factors,for%20people%20with%20lower%20incomes.&text=For%20example%2C%20people%20with%20limited,for%20expensive%20procedures%20and%20medications.

[11] Kaiser Family Foundation. (n.d.). *Health insurance status by FPL*. https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status-by-fpl/

TriWest

Prevalence of Behavioral Health Conditions and Needs

According to behavioral health prevalence estimates[15] for the Regions III and VII, in any given year over 2,000 children and youth between the ages of 6 and 17 experience one or more major depressive episodes, over 1,400 attempt suicide, and an estimated 3,400 have SED. More than 700 have SUD, more than 400 have an alcohol use disorder, and more than 450 have an illicit drug use disorder. Based on multiple national-level data sources, we estimate that approximately 700 youth in these service areas need, but do not receive substance use treatment.[16] Table 3 shows the estimated prevalence of mental health conditions and SUD for the two service areas.

Native American and Alaska Native children, youth, and families experience disproportionately higher rates of behavioral health concerns, including suicidal thoughts and behaviors, psychological distress, and Substance Use Disorder (SUD) compared to other demographic groups.[12,13] These disparities are attributed to limited access to behavioral health services, poverty, historical trauma, social injustices, among other risk factors.[14]

Table 3. Twelve-Month Behavioral Health Prevalence Estimates

Children and Youth (6–17)[17]	Region VII		Region III		Total	
	n	%	n	%	n	%
Mental Health Conditions						
Serious Emotional Disturbance (Ages 6–17)	2,687	10%	733	10%	3,420	10%
Major Depressive Episode (MDE) (Ages 12–17)	1,582	12%	448	13%	2,030	12%
Attempted Suicide	**1,118**	**4%**	**296**	**4%**	**1,414**	**4%**

[12] Mental Health America. (n.d.). *Native and indigenous communities and mental health.* https://www.mhanational.org/issues/native-and-indigenous-communities-and-mental-health

[13] Office of Minority Health. (2021). *Mental and behavioral health - American Indians/Alaska Natives*. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39

[14] SAMHSA. (2016). *The national tribal behavioral health agenda.* https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep16-ntbh-agenda.pdf

[15] Unless otherwise specified, prevalence estimates are based on national, state, and substate rates reported from: SAMHSA. (2020). *National estimates of serious mental illness from the 2018 National Surveys on Drug Use and Health.*
SAMHSA. (2019). *State estimates of serious mental illness from the 2018 National Surveys on Drug Use and Health.*

[16] U.S. Census Bureau. (2021). *Population Estimates Program, vintage 2020*.

[17] These data capture behavioral health estimates for children and youth living in the following counties: Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, Sioux, Benson, Cavalier, Eddy, Ramsey, Rolette, and Towner. The data also include portions of the following reservations within those counties: Standing Rock Indian Reservation, Fort Berthold Indian Reservation, Spirit Lake Reservation, and Turtle Mountain Reservation.

Children and Youth (6–17)[17]	Region VII		Region III		Total	
	n	%	n	%	n	%
Substance Use Disorder (SUD)[18]	**587**	**2%**	**185**	**3%**	**771**	**2%**
Alcohol Use Disorder	329	1%	81	1%	409	1%
Illicit Drug Use Disorder	361	1%	96	1%	457	1%
Co-Occurring MDE and SUD	437	2%	124	2%	560	2%
Needing but not receiving any or sufficient SUD Treatment	**561**	**2%**	**163**	**2%**	**725**	**2%**
Needing but not Receiving Any or Sufficient Alcohol Treatment	310	1%	75	1%	385	1%
Needing but not Receiving Any or Sufficient Illicit Drug Use Treatment	321	1%	84	1%	405	1%
Experiencing Two or More Adverse Childhood Experiences (ACEs)	**4,257**	**16%**	**1,161**	**16%**	**5,418**	**16%**

According to 12-month prevalence estimates, more than 1,500 (6%) children and youth between the ages of 6 and 17 experience one or more major depressive episodes, over 1,100 (4%) attempt suicide, and 2,600 (10%) have SED in Region VII. More than 580 children and youth have SUD, more than 320 have alcohol use disorder, and more than 360 have illicit drug use disorder. Based on data from the National Survey on Drug Use and Health (NSDUH), we estimate approximately 560 youth need but do not receive substance use treatment.

In Region III, more than 400 (6%) children and youth between the ages of 6 and 17 experience one or more major depressive episodes, over 290 (4%) attempt suicide, and over 730 (10%) have SED. More than 180 children and youth have SUD, more than 80 have alcohol use disorder, and more than 90 have illicit drug use disorder. Based on NSDUH data, we estimate approximately 160 youth need substance use treatment but do not receive it.

[18] Alcohol Use Disorder and Illicit Drug Use Disorder do not sum to SUD total, because there may be individuals with one or both disorder, and the SUD row is unduplicated.

3 Findings and Considerations

This section discusses **findings from the needs assessment and considerations** for strengthening North Dakota's SOC for children and youth. The section is organized according to the three elements of the SOC framework: (1) North Dakota's current **infrastructure** for delivering children's behavioral health services, (2) the **array of services** available to children and youth who have or are at risk for serious emotional disturbance (SED) or serious mental illness (SMI) in Regions III and VII, and (3) the **values** that guide service delivery.

Infrastructure

Four core child-serving systems serve as the main infrastructure for North Dakota's current SOC for children and youth at risk for SED and their families: Department of Health and Human Services – Behavioral Health Division (BHD), Children and Family Services and Human Service Zones (HSZ), the Juvenile Courts/Division of Juvenile Services, and the Department of Public Instruction. Other key child-serving systems such as physical health (including Medicaid and Children's Health Insurance Program), early childhood, and social welfare provide additional and necessary services and supports. The four core systems, combined with various nonprofit and for-profit community behavioral health providers provide an array of services and supports across the state that range from prevention to residential treatment.

State, regional, and local infrastructure support access to services and supports across the continuum of care. However, our review of the array of behavioral health services and supports available in **Regions III and VII** suggests that a siloed approach to delivery of care, varying eligibility criteria, limited or no service capacity, workforce issues, and social determinants of health all affect families' ability to access behavioral health services when they need it, where they need it, and at the level they need it. These factors can also make cross-system coordination and collaboration difficult.

Overview of North Dakota's Child-Serving Infrastructure

The **North Dakota Department of Health & Human Services (DHHS)** houses the **Behavioral Health Division (BHD) which includes a policy team, eight Human Service Centers (HSC), State Hospital and Life Skills Transition Center**. BHD's policy team is responsible for reviewing and identifying service needs and activities in the state's behavioral health system in an effort to ensure health and safety; access to services; and quality services. BHD works to establish quality assurance standards for the licensure of substance use disorder program services and facilities and provide policy leadership in partnership with public and private entities. Within BHD, the **children's behavioral health** team supports school-based behavioral health services, builds community capacity to deliver evidence-based and trauma-informed interventions, and licenses Psychiatric Residential Treatment Facilities (PRTFs). The division's eight regional **HSCs** provide behavioral health mobile crisis response, team-based behavioral health services to

children and youth with SED/SMI, first episode psychosis (FEP) care, and school-based behavioral health interventions.

The **Human Services Division** encompasses the Children and Family Services Division and the **Human Service Zones (HSZs)**, as well as other related services and supports. The **Children and Family Services Division (CFS)** oversees the implementation of the Family First Prevention Services Act and provides support and technical assistance to the Children in Need of Services (CHINS) program, child protection, family preservation, foster care and adoption, as well as other child and family related services. CFS licenses foster homes, child-placing agencies, supervised independent living programs, shelter care programs, and Qualified Residential Treatment Programs (QRTPs) and provides supervision and technical assistance to county-run HSZs. HSZs are responsible for determining eligibility and enrolling families into services and supports that address social determinants of health such as Medicaid, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families. They are also responsible for investigating child abuse and neglect, providing family preservation services, overseeing/monitoring the care of children and youth in public custody, determining 1915(i) eligibility, and providing CHINS services.

The **juvenile courts** under the **State of North Dakota Courts** and **Division of Juvenile Services (DJS),** both of which are under the **North Dakota Department of Corrections and Rehabilitation,** are responsible for delivering juvenile justice services. Juvenile court officers work for regional juvenile courts to screen and assess youth who have been referred for delinquent or unruly behavior. Juvenile courts can refer youth to community programming as part of diversion, informal adjustment, or court order. DJS youth community services are delivered regionally by juvenile correction specialists, and the youth correction center provides detention and correction services for youth across the state.

All education services fall under the **North Dakota Department of Public Instruction**. School districts and schools adopt and deliver mental health services to meet the unique needs of their students. These include school-based counseling, community-based mental health counseling, and targeted case management. BHD provides school districts and schools in the state with behavioral health supports, crisis and suicide prevention supports, and behavioral health staff. **North Dakota's Multi-Tier System of Support** provides Positive Behavioral Intervention and Supports training and technical assistance on how to address the social, emotional, and behavioral needs of students.

Behavioral Health Division

The Division oversees and supports the provision of an array of school and community-based behavioral health prevention, early intervention, intensive home and community-based, and

residential services and supports initiatives that strengthens the children's SOC. A brief overview of each is provided below.

Regional Human Service Centers. HSCs provide mental health and substance use disorder services and supports to Medicaid-eligible or uninsured children and youth ages 0–21 with SED/SMI and their families. Some HSCs also provide services to youth who are experiencing a FEP. (See Appendix C, Tables 5 and 6, for utilization data from 2022 for each region.)

- **Open access.** HSCs offer open access assessments during regular working hours. The HSC screening determines eligibility.
- **Integrated assessment.** HSC's integrated assessment is a comprehensive mental health and substance use assessment that incorporates the World Health Organization's Disability Assessment Schedule 2.0 (WHODAS 2.0), the Daily Living Activities Functional Assessment and the Global Assessment of Functioning to determine the child or youth's current level of functioning and mental health and substance use treatment needs.
- **Team-based care.** Enrolled children and youth and their families are provided team-based mental health and recovery services. Team-based care includes individual, group, and family psychoeducation; skills training; skills integration; and therapy. It can also include care coordination, psychiatric evaluation and medication management, and tele-behavioral health.
- **Systems for individuals with First Episode Psychosis (FEP).**[19] WCHSC and Southeast Human Service Center (SEHSC) provides North Dakota HELP (Helping, Empowering, and Learning about Psychosis) program, which uses an evidence-based program (Coordinated Specialty Care) to treat youth and young adults who are experiencing a FEP.

HSCs also provide mobile crisis services within a 45-mile radius of Bismarck and Devils Lake and school-based mental health services to partnering schools.

Community Behavioral Health Promotion.[20] BHD plans and leads prevention and promotion efforts and activities throughout the state focusing on maintaining the health and safety of children, youth, and adults.

- **Suicide Prevention.**
  - **988 Suicide and Crisis Line.** North Dakota launched 988, the new national three-digit emergency number for behavioral health crisis, in July 2022. FirstLink, North

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[19] North Dakota Department of Health & Human Services. (n.d.). *First episode psychosis.* https://www.hhs.nd.gov/behavioral-health/mental-health/first-episode-psychosis

[20] North Dakota Department of Health & Human Services. (2023). *North Dakota behavioral health division: Department of health & human services.* https://www.hhs.nd.gov/sites/www/files/documents/BH/BHDPortfolio_web.pdf

Dakota's contracted Lifeline crisis center provider, employs trained crisis staff to provide call line support to any resident of North Dakota that calls 988 or 211. If additional crisis support is needed FirstLink staff complete a warm handoff to the HSC mobile crisis team closest to the caller.
  - **Resources and Technical Assistance.** BHD provides training, technical assistance and resources to communities, schools, and parents in North Dakota. Free Through Recovery and Community Connect administrators and providers connect regionally to collaborate and share resources. BHD also provided suicide prevention and grant funds to six communities. Grant funds support suicide prevention efforts through June 2023.
- **Parents Lead.** Parents Lead is an evidence-based program that is being offered in 51 out of 53 counties and four federally recognized tribes. Parents Lead provides parents and caregivers with a wide variety of tools and resources to support them in creating a safe environment for their children that promote behavioral health. The program also provides training to communities and professionals who interact with children and parents.

Children's Behavioral Health.[21]

- **Behavioral Health in Schools.** BHD's school-based prevention and early intervention programming includes the following:
  - **Prevention and early intervention pilot grant.** Three schools have received grant funding to strengthen behavioral health prevention and early intervention by promoting strategies such as school-wide positive behavioral supports, behavioral health lessons, and counseling and social skills training for students at risk. Two of the three awarded schools are currently receiving funding under the pilot grant.
  - **Behavioral Health in Education Resources and Opportunities Technical Assistance Center (B-HERO).** BHD contracts with the Central Regional Education Association to provide resources, information, and support to school behavioral health resource coordinators. Training tools and opportunities provided by B-HERO include Classroom WISE, a training to assist educators in supporting students' mental health needs; Question, Persuade, Refer, a suicide prevention gatekeeper training; Trauma Sensitive Schools training; and Cognitive Behavioral Intervention for Trauma in Schools training.[22]

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[21] North Dakota Department of Health & Human Services. (2023). *North Dakota behavioral health division: Department of health & human services.* https://www.hhs.nd.gov/sites/www/files/documents/BH/BHDPortfolio_web.pdf

[22] B-HERO Technical Assistance Center. (2023). *Resource hub.* https://b-hero.org/resource-hub/

- **School-based intervention programs.**[23] School behavioral health grants allocate state general fund dollars to schools that billed Medicaid the previous school year to identify prevention and early intervention services with no other funding source, use funds to reimburse clinical or treatment services that are effective but not currently covered services, and fill gaps in service coverage for populations that do not qualify for other forms of reimbursement.
- **Virtual Behavioral Health Training (Kognito).**[24] Kognito delivers a practice based digital learning that helps educators and students build critical life skills to navigate difficult real-life situations, leading to more positive outcomes both in and out of the classroom. Kognito provides students and the school community with the opportunity to build skills focused on mental health and well-being through a virtual learning environment. BHD offers these modules at no cost to North Dakota districts. At-Risk staff modules are available at the elementary, middle, and high school level and are available to all school personnel. The At-Risk modules allow staff to interact with several virtual students who are experiencing mental health concerns and learn to recognize warning signs, initiate conversations, and connect to appropriate resources when needed. Friend2Friend peer modules are available to all 6th-12th grade students in North Dakota and allow students to practice conversations and learn skills with virtual peers. The following modules are available: Substance Use, Bullying Prevention, Safe and Caring Schools, Resiliency and Growth, and Emotional/Mental Wellness.[25]

- **Treatment Collaborative for Traumatized Youth (TCTY).**[26] BHD funds Sanford Research North to run TCTY. According to TCTY's list of trained providers, no Region III or VII providers have been trained in Parent Child Interaction Therapy, an approved approach in the North Dakota Title IV-E Prevention Services and Programs Plan, and no providers have been trained in Honoring Children and Mending Circles.[27]
- **Voluntary Treatment Program (VTP).** This program provides out of home treatment services (Qualified Residential Treatment Providers and Nexus-PATH foster homes) for Medicaid-eligible children with an SED without requiring parents to relinquish custody. Qualified children must show that their functional

A total of 11 children and youth were approved for QRTP placement through VTP; of those, seven were admitted to a QRTP.

[23] North Dakota Department of Health & Human Services. (2023). *North Dakota behavioral health division: Department of health & human services.* https://www.hhs.nd.gov/sites/www/files/documents/BH/BHDPortfolio_web.pdf

[24] North Dakota Department of Health & Human Services. (2023).

[25] Information provided by North Dakota Behavioral Health staff (April 2023).

[26] Treatment Collaborative for Traumatized Youth. (2020). *What we do.* https://www.tcty-nd.org/what-we-do/

[27] Treatment Collaborative for Traumatized Youth. (2020). *Clinicians.* https://www.tcty-nd.org/clinicians/

impairment substantially interferes with or limits the child's role or functioning in family, school, and community activities. To be eligible for the program, parents/guardians and the child must exhaust community-based resources available to them and be actively involved in the child's treatment.

- **Psychiatric Residential Treatment Facility (PRTF).** BHD licenses PRTFs, which provide intensive psychotherapeutic interventions in a residential setting. This level of care is appropriate for children and youth whose severe behavioral health needs cannot be treated in a less restrictive environment.
- **Parent to Parent.** Parent to Parent educates, trains, supports, and builds the capacity of parents who have children or youth with mental health disorders. BHD contracts with the ND Federation of Families for Children's Mental Health to administer Parent to Parent support services.

Adult Addiction and Mental Health.[28]

- **Substance Use Prevention, Treatment, and Recovery Services.** Substance Use Prevention, Treatment and Recovery Service Block grant funds are authorized by section 1921 of the Title XIX, Part B, Subpart II and III of the Public Health Services Act and are administered through SAMHSA. SAMHSA requires that no less than 20% of the block grant funds are spent on primary prevention strategies.
  - **Prevention Activities.** Activities include training and technical assistance, tribal and community drug prevention programs, underage drinking prevention efforts including Parents Lead, adult binge drinking prevention efforts, Opioids Fill with Care, driving under the influence education licensing and provider certification, minor in possession education provider certification, and Synar program (youth tobacco enforcement).
  - **Treatment and Recovery Activities.** Activities include public program funding, youth residential services, pregnant and parenting woman services, tribal programs, Recovery Talk program, mobile outreach program, peer support development, withdrawal management, workforce development, and Call Kay.
- **Mental Health Block Grant Services.** Mental Health Block Grant (MHBG) funds are authorized by section 1911 of the Title XIX, Part B, Subpart I and II of the Public Health Services Act and are administered through SAMHSA. The target population for mental health block grant services are children with SED and adults with SMI. MHBG programs and services include the Consumer Family Network, Peer Support, Workforce Training and Development, Statewide Family Network, Trauma Training and Consultation for PRTFs, Children's Services, FEP, and Crisis Services.

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[28] North Dakota Department of Health & Human Services. (2023). *North Dakota behavioral health division: Department of health & human services.* https://www.hhs.nd.gov/sites/www/files/documents/BH/BHDPortfolio_web.pdf

Community Supports.[29]

- **Peer Supports.** BHD trains and certifies peer support specialists in North Dakota. To date, the division has hosted 28 trainings and trained over 790 individuals. A total of 195 individuals have been certified as a Peer Support Specialist I or II. Peer Support Specialists I and II provide support and encouragement, help with accessing clinical care and community resources, and skills training on stress management, conflict resolution, and parenting.
- **Free Through Recovery.** Free Through Recovery is a partnership between the Department of Health and Human Services and the Department of Corrections and Rehabilitation to provide community-based recovery services to individuals involved in the criminal justice system with behavioral health and/or SUD needs. Free Through Recovery services include care coordination, recovery services, and peer support services. As of October 2022, 295 individuals were being served in Region VII and 99 individuals were being served in Region III.
- **Community Connect.** Community Connect provides recovery services to individuals with behavioral health and/or SUD who are not involved in the criminal justice system. Like Free Through Recovery, Community Connect services include care coordination, recovery services, and peer support services. As of January 2023, there were 110 participants in Region III and 380 active participants in Region VII.
- **1915(i) Medicaid State Plan Amendment.** North Dakota's 1915(i) state plan amendment increases access to home and community-based supports for children, youth, and adults enrolled in Medicaid or Medicaid Expansion. Services under 1915(i) include care coordination, caregiver training and support, transitional services, benefits planning, non-medical transportation, respite care, prevocational training, supported education and employment, housing support, and family peer/peer support.[30] These services are available in Bismarck and Devils Lake.[31]
- **Mental Health Directory.** Senate Bill 2161, passed during the 67th Legislative Assembly, directed the BHD to develop and maintain a directory of mental health programs to help citizens of North Dakota locate and access mental health services. As of January 30, 2023, the directory contains 226 mental health programs.

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[29] North Dakota Department of Health & Human Services. (2022). *Program guidance: Title IV-E prevention services plan.* https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/iv-e-program-guidance.pdf

[30] North Dakota Department of Health & Human Services. (2023). *1915i web system cheat sheet.* https://www.hhs.nd.gov/sites/www/files/documents/1915i/Web%20System%20Cheat%20Sheet.pdf

[31] North Dakota Health & Human Services. (n.d.). *Medicaid 1915i state plan amendment: Find an enrolled provider*. https://www.hhs.nd.gov/sites/www/files/documents/1915i/Providers%20by%20Service%20and%20Region.pdf

Human Services Division

Children and Family Services Division

North Dakota's Title IV-E evidence-based prevention service array.[32] The Title IV-E Prevention Services and Programs Plan approves a comprehensive array of evidence-based home and community-based parent skill-based programs; mental health programs; and substance use prevention and treatment programs for children, youth, and their families.[33]

According to the current list of enrolled providers, the full array of Title IV-E approved evidence-based practices is not available.[34] The majority of approved providers are in the Bismarck area, and the approved services are only appropriate for young children ages 0–8 and their parents. There are no community-based providers approved to provide Title IV-E approved interventions that are effective for older children and youth. There are seven enrolled Title IV-E providers in **Region VII**. There are no enrolled providers in **Region III**.

Qualified Residential Treatment Providers (QRTP). In addition to enhancing family support to decrease the number of children and youth placed in foster care, the Title IV-E Prevention Services and Programs Plan seeks to decrease the use of congregate, residential, and group home care and increase the number of children and youth in foster care who are placed in a family setting.[35] As part of its efforts to implement the Title IV-E Prevention Services and Programs Plan, North Dakota revised its administrative code to bring QRTP licensing standards in line with federal standards. QRTP admission is restricted to children and youth in the public custody of a HSZ, tribal nations, or DJS, and children and youth who are not in public custody but have been approved for placement and reimbursement by DHHS' Voluntary Treatment Program (VTP).

Foster homes, child-placing agencies, emergency shelters, and transitional living center licensing. CFS is responsible for licensing foster homes, child-placing agencies, certified shelter care programs, as well as transitional living centers and other childcare facilities, except for PRTFs. Current changes to licensing standards have decreased the number of emergency shelter beds in North Dakota. Key informants indicated a request for proposals for an

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[32] North Dakota Human Services, Children and Family Services Division. (2020). *2020-2024 Title IV-E prevention services and program plan.* https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/ approved-nd-title-iv-e-prevention-services-programs-plan.pdf

[33] North Dakota Department of Health & Human Services. (2022). *Program guidance: Title IV-E prevention services plan.* https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/iv-e-program-guidance.pdf

[34] North Dakota Department of Health & Human Services. (n.d.). *North Dakota Title IV-E providers.* https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/find-iv-e-provider-chart.pdf

[35] National Conference of State Legislatures. (2022). *Family first prevention services act*. https://www.ncsl.org/human-services/family-first-prevention-services-act

emergency shelter in the Bismarck area was released, but they were uncertain if any providers had responded.

Key informants indicated that HSZ used emergency shelter beds as temporary placements to place children and youth in foster care while appropriate placements were found. Similarly, law enforcement used emergency shelter beds to place youth in crisis or those not suitable for detention. Consequently, the decrease in beds has resulted in more children and youth being temporarily placed in HSZ offices and hotels and in more emergency room encounters.

Human Services Zones

Economic assistance to address social determinants of health.[36] For eligible families who need economic assistance to address social determinants of health, HSZs help them enroll in Medicaid and the Children's Health Insurance Program, the Supplemental Nutrition Assistance Program, the Temporary Assistance for Needy Families program, heating assistance, basic care assistance, and assistance with childcare.

Children in Need of Services (CHINS). The CHINS teams are staffed by HSZ professionals. The program serves youth whose behaviors include truancy from school, regularly disobeying their parents, using and possessing tobacco and tobacco related products, and running away. The CHINS program focuses on prevention, treatment, and support, and focuses on youth at risk for involvement in the juvenile justice system. Parents, schools, and law enforcement can refer youth to CHINS. The goal of the program is to connect youth and their families to appropriate community services.[37]

Child welfare services.[38] HSZs' child welfare services include child protective services, family preservation services, and foster care services. **Child protective services** (CPS) staff conduct a present danger assessment on any child or youth referred to HSZ by the statewide Child Abuse & Neglect Reporting Line. CPS staff are responsible for assessing the child or youth's immediate safety, determining if the allegation of abuse and neglect can be substantiated, developing a safety plan, and determining which families are appropriate for in-home prevention services. HSZ **child welfare workers** provide safety planning, assessment, parent aide services, in-home family preservation services, and care coordination for youth in the custody of HSZs who are placed in kinship care, foster care, or a residential placement (e.g., a QRTP).

[36] North Dakota Department of Health & Human Services. (n.d.). *Human service zones.* https://www.hhs.nd.gov/human-service/zones

[37] North Dakota Department of Health & Human Services. (n.d.). *Children in need of services.* https://hhs.nd.gov/cfs/children-need-serviceshttp

[38] North Dakota Department of Health & Human Services. (2022). *Program guidance: Title IV-E prevention services plan.* https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/iv-e-program-guidance.pdf

Kinship-North Dakota (Kinship-ND). The Kinship-ND program provides kinship navigation services to adults who provide full time care to a child that is not their own. A kinship caregiver can be a relative, member of a tribe or clan, godparent, stepparent, or other adult that has a relationship with a child. Kinship navigation services include one-on-one support, assistance finding financial support, parenting skills and child development training, support navigating the educational system and understanding legal options, and connections to other kinship caregivers.[39]

Family preservation services. HSZ child welfare workers rely on community-based providers to provide intensive home-based services for children, youth, and their families enrolled in family preservation services. As noted above, the North Dakota Title IV-E Prevention Services and Programs Plan authorizes the use of Title IV-E funding for approved evidence-based intensive home and community-based services, home visiting programs, and therapeutic interventions. Prior to the implementation of the plan, The Village Family Service Center (The Village) was contracted to deliver in-home family services to children, youth, and families enrolled in family preservation services. The Village's in-home family service model is not an approved intervention in the North Dakota Title IV-E Prevention Services and Programs Plan, and their contract has expired.

As of this report, only one organization in North Dakota was authorized to provide a Title IV-E approved intensive home and community-based program that is evidence based (i.e., Brief Strategic Family Therapy) to a targeted population of youth in the juvenile justice system.
There were no providers approved to deliver Homebuilders, Multisystemic Therapy (MST), and Functional Family Therapy (FFT). This leaves HSZ child welfare workers and the families they support without access to intensive home-based services.

Foster care services. A child or youth is placed in foster care in North Dakota when the characteristics or circumstance of the family or family member affect the parent or caregiver's ability to safely care for the child or youth. HSZ child welfare workers provide licensing support for prospective foster homes, help foster families care for a child or youth placed in their care and oversee the care and safety of children and youth in HSZ's custody.

Nexus-PATH provides licensing and foster parent support to all treatment foster homes in North Dakota. Nexus-PATH implements the evidence-based foster care model, Together Facing

[39] North Dakota Human Services (June 2021). *Kinship-ND Navigation.* https://kinshipnd.com/wp-content/uploads/2021/09/Kinship-ND-Brochure.pdf

the Challenge. This model includes training for administrators and supervisors as well as training, enhanced consultation, and in-home coaching for treatment parents.[40] Eighty percent of Nexus-PATH's treatment foster parents and case workers are certified in Together Facing the Challenge.[41] In addition to treatment foster homes, Nexus-PATH provides family support homes as well as transition and assessment beds.

Medicaid 1915(i) eligibility determinations. HSZ staff conduct 1915(i) eligibility determinations. Eligible individuals are children with SED and adults with SMI who enrolled in Medicaid or Medicaid Expansion who live below 150% of the federal poverty level, have a qualifying mental health or substance use diagnosis or brain injury, do not reside in an institution, and have a complex score of 25 or higher on the WHODAS 2.0 assessment.

A total of 18 children and youth under the age of 18 were enrolled in 1915(i) services as of February 1, 2023. Similarly, there were no providers enrolled to provide caregiver training and support and family peer support for individuals under 18 years of age. Community Options is the only enrolled provider that provides care coordination services and non-medical transportation for children and youth.

North Dakota Courts

Juvenile Court

Children in need of protection. HSZs refer children in need of protection cases to the juvenile court as part of a child abuse and neglect investigation. In 2021, there were 904 confirmed cases of child abuse and neglect in North Dakota.

Juvenile court units.[42] Youth are referred to juvenile court for delinquent offenses that would be considered a crime if an adult committed the act. Upon referral, a juvenile court officer will administer the Youth Assessment Screening Instrument pre-screen to assess the likelihood the youth will be referred again to juvenile court. The pre-screen is administered at diversion meetings, informal adjustment conferences, and predisposition assessments during the formal court process. If the pre-screen determines the youth is at moderate to high risk of reoffending, a juvenile court officer will complete a Youth Assessment Screening Instrument full screen.

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[40]Murray, M. E., Khoury. D. Y., Farmer, E. M. Z., & Burns, B. J. (2018). *Is more better? Examining whether enhanced consultation/coaching improves implementation.* American Journal of Orthopsychiatry. https://sites.duke.edu/tftc/files/2019/05/Murray-et-al-2018-Is-more-better.pdf

[41] Reported during key informant interview on February 24, 2023

[42] North Dakota Juvenile Court. (2021). *2021 North Dakota juvenile court annual report.* https://www.ndcourts.gov/Media/Default/Trial%20Courts/Juvenile%20Court/juvenile-court-annual-report-2021.pdf

The most common referral type in 2021 for Juvenile Court Unit 1 Northeast Judicial District (Region III) was property offenses (91 referrals). The most common referral type for Juvenile Court Unit 3 South Central Judicial District (Region VII) was drug and alcohol offenses (229 referrals).

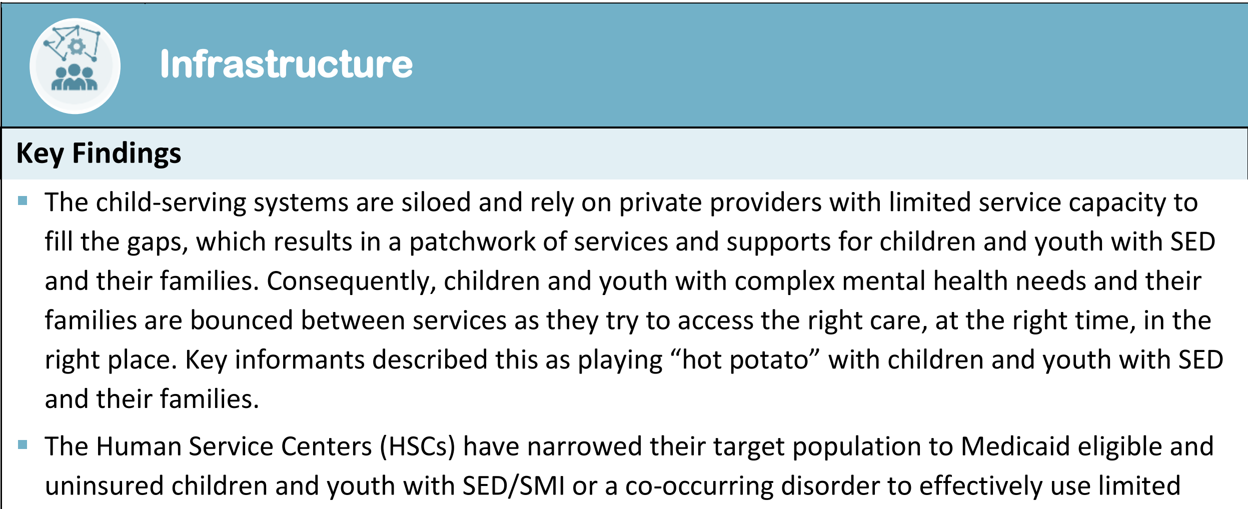
Dual Status Youth Initiative. Dual status youth are involved in the juvenile justice system and the child welfare system. The Dual Status Youth Initiative promotes interagency information sharing, policy and practice changes, and child- and family-centered multidisciplinary teams. HSZs and juvenile courts have designated dual status youth liaisons. There were 749 dual status youth in North Dakota in 2021.[43]

Statewide, of the 374 youth new to the Dual Status Youth Initiative in 2021, 56 were in Region III and 166 were in Region VII. The remaining 152 youth were in other regions.

Division of Juvenile Services[44] (DJS)

DJS operates the North Dakota Youth Correctional Center and eight regional offices. Both Region III and Region VII have a DJS office. All youth served by DJS have been deemed delinquent and placed in custody of DJS. DJS works with CFS and the North Dakota Association of Counties to provide an array of placements (residential and attendant care) and treatment services for youth in its care.

Infrastructure Key Findings and Considerations



Infrastructure

Key Findings

- The child-serving systems are siloed and rely on private providers with limited service capacity to fill the gaps, which results in a patchwork of services and supports for children and youth with SED and their families. Consequently, children and youth with complex mental health needs and their families are bounced between services as they try to access the right care, at the right time, in the right place. Key informants described this as playing “hot potato” with children and youth with SED and their families.
- The Human Service Centers (HSCs) have narrowed their target population to Medicaid eligible and uninsured children and youth with SED/SMI or a co-occurring disorder to effectively use limited

[43] North Dakota Juvenile Court. (2021). *2021 North Dakota juvenile court annual report.* https://www.ndcourts.gov/Media/Default/Trial%20Courts/Juvenile%20Court/juvenile-court-annual-report-2021.pdf

[44] North Dakota Corrections and Rehabilitation. (n.d.) *Division of juvenile services*. https://www.docr.nd.gov/division-juvenile-services

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resources and improve the quality of care. However, community-based providers have not filled the gap for children and youth who are at risk for SED, youth who are involved with the child welfare and juvenile justice system, and those who have private insurance.

- North Dakota utilizes Firstlink to implement 988 and 211 across the state for crisis calls. The HSCs provide mobile crisis services for children, youth, and adults within a 45-mile radius of its urban centers. However, law enforcement and emergency departments continue to be the default providers of children's mental health crisis services, especially in rural areas not covered by mobile crisis services.
- The existence of multiple programs (HSCs, Voluntary Treatment Program (VTP), 1915(i), Child in Need of Services (CHINS), school-based targeted case management, Title IV-E Prevention Services and Programs) with varying eligibility requirements, enrollment processes, assessment procedures, and entry points into care makes accessing services and supports difficult for children, youth, and their families.
- The Voluntary Treatment Program (VTP) provides access to Qualified Residential Treatment Programs (QRTPs) and therapeutic foster home placement without requiring parents to relinquish custody. Due to limited funds, only eight youth have been placed through this program within the 2021-2023 biennium.
- The 1915(i) Medicaid State Plan Amendment includes the provision of care coordination, parent/caregiver skills training, family peer support, and respite care to Medicaid-enrolled children and youth with SED and their families. However, the full array of services is not available to children, youth, and their families, and few children and youth have been enrolled in these services.
- The federal Family First Prevention Services Act improved the quality of residential treatment facilities by increasing licensing standards for QRTPs, requiring residential providers to provide aftercare services for 6 months after discharge, and adopting a third party-administered uniform assessment process for more effectively identifying children and youth in need of this level of care. These changes, although positive, decreased the number of available QRTP beds before community providers had developed the capacity to provide intensive home and community-based services for those children and youth determined to be ineligible for this level of care.
- The North Dakota Title IV-E Prevention Services and Programs Plan allocated Title IV-E prevention funding to approved evidence-based prevention and early intervention services including family visitation programs (e.g., Healthy Families, Parents as Teachers, Nurse Family Partnership), therapy services targeted to young children (e.g., Parent-Child Interaction Therapy), and intensive home-based interventions (e.g., Brief Strategic Family Therapy, Homebuilders, Functional Family Therapy, Multisystemic Therapy). A limited number of community providers are approved to provide these services.
- The limited number of certified shelter beds has impacted respite support for youth and families in crisis, resulting in children and youth being placed in Human Service Zone (HSZ) offices and hotels and in emergency departments. North Dakota Health and Human Services has offered grant funds

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to establish certified shelter care programs. Grand Forks County Youth Services was certified in April 2023 and can serve children ages 10-17 in Region III and the surrounding area. There are currently no certified shelters in Region VII.

- Moving the CHINS program from the juvenile courts to the Human Service Zones (HSZs) was effective in decriminalizing status offenses. However, key informants report that many of the youth who are referred to the CHINS program require a higher level of care that the CHINS program does not currently have the capacity to provide.
- The Dual Status Youth Initiative is a good example of a cross-system partnership that addresses the needs of youth in the juvenile justice and child welfare systems. Its strengths include efficient data sharing, multidisciplinary team meetings, and effective system liaisons.
- There is a strong collaboration between the BHD and school districts across the state. This collaboration has increased schools' and district's ability to build a multi-tiered system of support that addresses students' social, emotional, and mental health needs. In addition, North Dakota's Multi-Tier System of Supports helps integrate school behavioral supports with community-based mental health services.
- The Treatment Collaborative for Traumatized Youth (TCTY) has effectively trained communities and mental health providers across North Dakota in trauma-focused cognitive behavioral therapy and other trauma-informed practices.
- Standing Rock Tribe was awarded a SAMHSA SOC grant (2021-2025) which provides an opportunity to collaborate on SOC implementation on and off tribal lands.

Considerations

- Establish a North Dakota SOC governance structure and engage its advisory committee(s) to develop and adopt a mission and vision for the SOC that addresses siloed services.
  - Use this governing body and advisory committees to develop a strategic plan that identifies and prioritizes system-level challenges and barriers to accessing care.
  - Develop and adopt cross-system goals and measures for success that align with SOC core values, address system infrastructure challenges, and improve the continuum of care for children and youth who have or are at risk for SED. The Dual Status Youth Initiative is a strong example of cross-system collaboration.
- Build community capacity to provide evidence-based intensive home and community-based services and supports by aligning SOC capacity-building efforts with the North Dakota Title IV-E Prevention Services and Programs Plan.
- Partner with Children and Family Services to identify and support local providers in prioritizing implementation of Brief Strategic Family Therapy (BSFT), Homebuilders, Functional Family Therapy (FTT), and Multisystemic Therapy (MST). The Title IV-E Prevention Services and Programs Plan provides the infrastructure to build and sustain these programs. Implementation of these core services will begin to address the statewide gap in intensive home and community-based services

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and provide a solid foundation for adding additional practices to this component of the service continuum.

- Collaborate with Children and Family Services, Division of Juvenile Services, Department of Public Instruction, and tribal nations to identify additional evidence-based practices that address the mental health needs of children and youth at risk of out-of-home placement and add those to the North Dakota Title IV-E Prevention Services and Programs Plan.
- Use the TCTY (or establish a similar infrastructure) to increase the community's capacity to provide additional evidence-based practices that meet the needs of children and youth who have or are at risk for SED and youth at risk of out of home placement.
- Expand the TCTY's capacity to train providers on evidence-based practices for skills training (e.g., Skillstreaming), co-occurring disorders (e.g., Seeking Safety), or care coordination (e.g., FOCUS, High Fidelity Wraparound).
- Continue efforts to partner with Standing Rock Tribe's SOC implementation.

Service Array for Children's Behavioral Health

The ideal children's behavioral health continuum of care lays out a seamless, comprehensive array of services and supports that link promotion and prevention services with physical health, mental health, and substance use disorder treatment. This continuum of care takes a population-based perspective to support all children, including those with emerging, low to moderate, and complex behavioral health needs. The continuum includes six components that range from promotion and prevention services to the most intensive interventions. It provides an overview of recommended practices for each component.

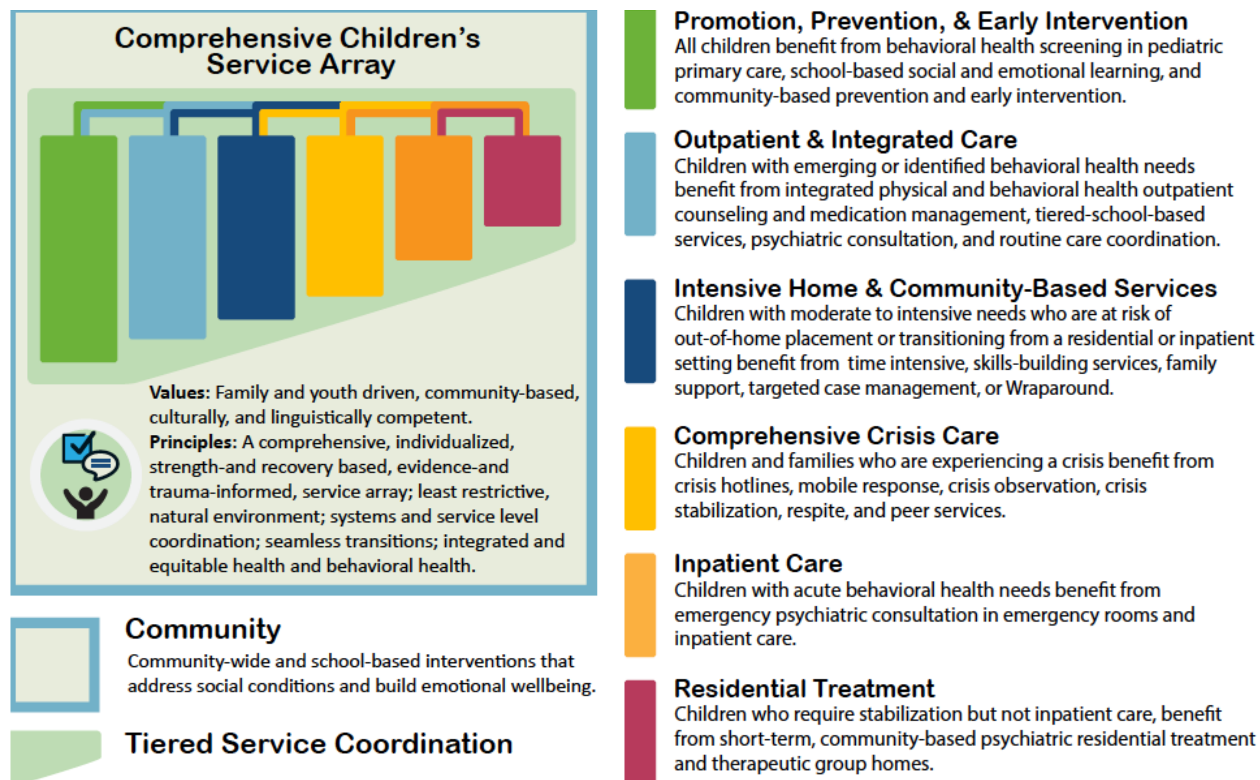
Overview of a Comprehensive Service Array

The **prevention and early intervention** component is key to a comprehensive service array. This component includes integrated pediatric primary care, behavioral health, and integrated mental health and substance use services. Also included are screening and assessment for mental health and substance use, school-based universal supports that cultivate skills, and community-based prevention and early intervention programs. The **specialty care** component of the continuum focuses on outpatient behavioral health care and recommends the use of evidence-based and trauma-focused treatment approaches for anxiety, depression, substance use, and trauma.

Children and youth with more complex needs benefit from **intensive home and community-based services**. Services in this system component are provided to youth at risk for out-of-home placement or returning from placement. This aspect of the ideal continuum includes intensive evidence-based services—such as FFT, MST, and High Fidelity Wraparound—that focus on the family and interventions to help youth learn skills that allow them to achieve success at home, at school, and in the community. Also included in the **rehabilitation and intensive services** component is coordinated specialty care for first episode psychosis.

The crisis care component of the ideal SOC includes a continuum of services that range in intensity from **crisis services** to **residential treatment services** and **inpatient care** (Figure 8). The crisis care component includes mobile crisis response teams to address urgent needs outside of care delivery. It also includes an array of crisis placements (such as in-home crisis respite, crisis stabilization, and acute inpatient care) tailored to the needs of the community. More importantly, the crisis continuum is an adjunct, not a substitute, to a robust array of outpatient and intensive community-based services. It also includes time-limited follow-up care, coordination with emergency medical services, and short-term residential treatment care as the last option.

Figure 8. Model of an Ideal System of Care



Overview of North Dakota's Service Array

In general, the state and regional key informants and stakeholders we interviewed described North Dakota's child-serving system as staffed and run by caring individuals who are delivering quality services and want to do the best for the children, youth, and families they serve. However, they also described characteristics of the system that hamper its ability to provide the best care. First, the current system is overburdened by the growing behavioral health needs of children, youth, and families; by recent system reorganizations and changes; and by workforce shortages. This situation has left providers unsure of how to meet the needs of children and youth, resulting in a breakdown in collaboration and shared responsibility.

Second, key informants and stakeholders agreed the separate core child-serving systems are "siloed"—isolated from each other and relying on private providers to bridge gaps in care. This patchwork system of service delivery can result in children, youth, and families with complex needs not always being connected with the care they need. One stakeholder stated that the child-serving systems need to identify "the pain points [in the system] in terms of community connections" and determine how to fill these gaps without involving children, youth, and families. This requires state, regional, and community investment.

Third, both regions include tribal nations. Key informants and stakeholders at state and regional levels agreed that more work needs to be done to make sure system providers are engaging Native American children, youth, and families in a culturally appropriate manner.

Promotion, Prevention, and Early Intervention Programs

The promotion, prevention, and early intervention programs in **Regions III and VII** include economic stability supports (Medicaid, TANF, SNAP) and Child in Need of Services (CHINS) interventions through HSZs. The juvenile courts contract with community providers to deliver diversion services such as Alternatives for Family Cognitive Behavioral Therapy. Youthworks implements a cultural achievement program for youth at risk of further involvement in the juvenile justice system.

Key informants in both regions from juvenile justice, child welfare, and education shared concerns related to the changes in the CHINS program. They agreed with the need to decriminalize status crimes such as truancy, disobedience, running away, and underage tobacco use. However, they expressed concerns that the program is slow to respond and that the need for services is greater than the program's capacity, which means that youth are not always connected to services. Key informants also noted that they were uncertain what to do with youth who present with ongoing truancy, disobedience, or runaway behaviors.

The Behavioral Health Division provides all school personnel with access to Kognito, an online evidence-based learning tool that increases teachers' knowledge and understanding of youth mental health, suicide, psychological distress, and how to use referral processes. The Central Regional Education Association and BHD implement B-HERO.[45] BHD supported a behavioral health integration pilot in a Bismarck middle school in Region VII and the program is now self-sustained and considered a strong model for state-wide implementation. Dunseith Elementary School, located in Region III, currently has a contract with BHD for early intervention and prevention. BHD provides grant funds that schools can use to establish or strengthen school-based universal prevention programs as well as provide therapeutic supports.

Key informants in **Region III** and **Region VII** expressed concerns that the CHINS program did not have the capacity or the resources to meet the needs of the youth referred. One key informant noted that only 14 workers provide CHINS services to all eligible youth in North Dakota. Other key informants stressed the number of CHINS workers is not sufficient to meet the current need for CHINS services and indicated there were long wait times between when a youth was referred and when services were initiated. They also stressed many of the youth referred for CHINS services need more than prevention, education, and early intervention services, which

[45] B-HERO Technical Assistance Center. (2023). *About B-HERO*. https://b-hero.org/about/

results in referrals to community-based providers and HSCs. Many of these youth have not reached the level of mental health need served by the HSCs and are unable to access private community-based providers due to waitlist or insurance status.

In **Region III**, Devils Lake Public School launched a new curriculum and uses restorative justice in the middle schools. In **Region VII**, Bismarck Public Schools is using the interconnected systems framework to ensure that students' academic, social, emotional, and behavioral health needs are supported holistically. Bismarck Public Schools uses Second Step® as their universal curriculum for students in grades kindergarten through 8th and restorative justice for middle and high school students. The Native American Development Center in **Region VII** provides after-school programs that promote Native American cultural practices including drum groups, Native American dancing class, drum making class, and life skills development.

UspireND, identified as an approved Title IV-E Prevention Services and Programs plan provider, provides Healthy Families, an evidence-based home visiting prevention and early intervention program for young children and families, in four counties in **Region VII**.

Stakeholders stressed the need for more early intervention services targeting infants and young children. They also identified a need for out-of-school programming and opportunities to engage all students in after-school activities such as band and sports.

Outpatient Behavioral Health Specialty Services

Key informants indicated there are office-based, in-person, or virtual behavioral health outpatient specialty services available in both regions including diagnosis and evaluation, medication monitoring, and therapy. The need for these services in both regions has significantly outpaced capacity. Key informants from both regions indicated that because of the high demand for therapy, therapists can limit their offerings to office-based interventions delivered during regular working hours and to those whose needs are less acute. Reported estimated wait times for outpatient specialty services ranged from 2 weeks to more than 6 months.

The need for outpatient specialty providers in **Region III and Region VII** has outpaced the capacity.

Diagnostic and evaluation services. HSCs in both regions have shifted to an open access enrollment process. Children and youth are triaged to determine service eligibility and if eligible they receive an integrated assessment. Community-based private providers also deliver limited diagnostic and evaluation services. Children, youth, and families with private insurance rely heavily on these private providers. However, even for these individuals and families, the wait can be extremely long and act as a barrier to accessing care. Psychiatric services in **Region III** are predominantly delivered via telehealth. CHI St. Alexius's outpatient mental health services provide these services in addition to other private providers in **Region VII.**

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> One key informant described the Devils Lake Region as having *"limited but some psychiatric and medication monitoring services and limited but some mental health services."*

Outpatient specialty behavioral health services are available through HSCs, in the community, and in schools, though not at a level that meets the demand, especially for needs that are immediate or complex. The number and capacity of specialty mental health providers also varies by region, with fewer providers in **Region III** because of the rural nature of the area. One key informant stated psychiatric providers in the region were willing to serve those with mild to moderate mental health needs but were very reluctant to take more complicated cases.

In **Region III**, Native American children, youth, and families have access to mental health outpatient services through Indian Health Services located on Spirit Lake and Turtle Mountain tribal lands. However, available mental health services and supports vary by tribe.

- **Turtle Mountain** has strong therapists and a tribal school that understands trauma.
- **Spirit Lake** provides mental health services, recovery and wellness programs, and medication-assisted treatment to all ages. It provides telehealth services to the tribal school and is trying to hire a therapist to provide school-based counseling. Spirit Lake behavioral health staff occasionally make referrals off tribal land, but families are reluctant to send children or other family members to outside providers due to historical trauma and injustices.[46]

Key informants from **Region III** highlighted the following outpatient mental health providers.

- As part of its team-based care, LRHSC has seven clinicians trained in trauma-focused cognitive behavioral therapy (TF-CBT) and one trained in Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) through BHD's TCTY.[47,48,49]
- LifeWise Associates provides in-person, telehealth, and school-based mental health services to Devils Lake Public Schools and psychiatric medication monitoring via telehealth.
- Catholic Charities has a school-based provider in Cavalier County, a rural county on the Canadian border.

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[46] Remnick, C. (2018). *The nation's first family separation policy*. The Imprint Youth & Family News. https://imprintnews.org/child-welfare-2/nations-first-family-separation-policy-indian-child-welfare-act/32431

[47] North Dakota Department of Health & Human Services. (2023). *North Dakota behavioral health division: Department of health & human services.* https://www.hhs.nd.gov/sites/www/files/documents/BH/BHDPortfolio_web.pdf

[48] North Dakota Health & Human Services. (n.d.). *North Dakota Title IV-E providers.* https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/find-iv-e-provider-chart.pdf

[49] Treatment Collaborative for Traumatized Youth. (2020). *Clinicians.* https://www.tcty-nd.org/clinicians/

- An individual therapist in Devils Lake provides therapy services via telehealth.
- The schools in the area provide school-based counseling services.

Region III's outpatient service capacity limitations are evidenced by the fact that the region has no Title IV-E Prevention Services and Programs Plan approved PCIT providers or BSFT providers, and the Village closed its Devils Lake Family Service Center office approximately 1.5 years ago because of a workforce shortage.

Key informants in **Region VII** described the region, especially the Bismarck area, as having a "decent" number of high-quality mental health outpatient specialty providers, though, like Region III, there are long waits to see the private providers. TriWest heard of the following outpatient specialty service providers during interviews or via the Title IV-E Prevention Services and Programs plan-approved provider list.

- WCHSC provides individual, group, and family counseling and psychotherapy as well as medication management as part of its team-based care. TCTY reports training 40 clinicians in Bismarck in TF-CBT and five in SPARCS. WCHSC employs 10 TF-CBT clinicians and one SPARCS-trained clinicians.[50]
- Catholic Charities, Dakota Children's Advocacy Center, Solutions Behavioral Healthcare Professionals, and Together Counseling all provide outpatient therapy services, and all are Title IV-E Prevention Services and Programs Plan approved providers of PCIT.[51]
- CHI St. Alexius Hospital's outpatient mental health clinic, Archway Mental Health Services, provides psychiatric, prescriber, medication management, psychological, and therapy services.
- Youthworks offers individual and group counseling and workshops to address anger management and parent-child conflict.[52]
- The Village offers outpatient counseling and school-based mental health services in the Bismarck area.[53]
- Bismarck Public Schools' interconnected systems framework includes school-based counselors and social workers and contracted community-based mental health therapists.
- Standing Rock's Indian Health Services provides mental health services and supports to the members of its tribe.

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[50] Treatment Collaborative for Traumatized Youth. (2020). *Clinicians.* https://www.tcty-nd.org/clinicians/

[51] North Dakota Health & Human Services. (n.d.). *North Dakota Title IV-E providers.* https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/find-iv-e-provider-chart.pdf

[52] Youthworks. (n.d.). *Bismarck programs: Youth and family services (youth under 18).* https://youthworksnd.org/bismarck/

[53] The Village Family Service Center. (n.d.) *Bismarck.* https://www.thevillagefamily.org/locations/bismarck

Key informants in **both regions** indicated they need more outpatient behavioral health specialty services, both public and private, including child and adolescent psychiatrists, counseling services, addiction and SUD services and recovery supports, family services, and school-based counselors. Services are needed outside of traditional working hours, especially for providers trained to work with more complex family issues, providers that understand trauma, addiction specialists, and providers who that willing to offer services in the home and community.

The lack of services is more apparent in **Region III** because of higher levels of poverty and its predominantly rural nature. Contrary to other key informants, HSZ staff from **Region VII** reported relying on private providers to deliver mental health services to families in family preservation services and children and youth in foster care and described mental health provider capacity as sufficient. They believed the “real gap” in the region is in juvenile justice services.

Intensive Home and Community-Based Services

Both regions’ HSCs provide team-based care to children and youth with SED/SMI and their families. These multidisciplinary teams are led by the youth services lead and include an addiction counselor, skills trainer, skills integrator, and case manager. Teams have access to a child and adolescent psychiatrist and a psychologist. Children, youth, and their families also have access to individual, group, and family therapy and medication management. Key informants reported open access has improved the ability of families to qualify for team-based care. However, limited capacity because of workforce shortages continues to result in waiting periods before services are initiated.

HSZs provide in-home services including parent aid services. Before March 2023, they contracted with the Village to provide in-home family therapy to families in family preservation. However, as noted above, the state’s contract with the Village has expired, and as of this report, there was only one provider approved to provide in-home family therapy to a limited target population.

Key informants noted that the funding available to stand up the evidence-based practices outlined in the Title IV-E Prevention Services and Programs Plan does not sufficiently cover startup costs or sustain the programs.

Key informants report that Medicaid eligible children and youth in **Region VII** can still access in-home family therapy through the Village. The Village no longer provides services in Region III because of workforce issues. LRHSC is preparing to apply to DHHS to deliver FFT services in Region III. Despite this, at the time of this report, intensive home and community-based

support capacity in Regions III and VII was extremely limited, and there were no providers approved to provide Title IV-E prevention services (BSFT, Homebuilders, MST, FFT).

Other intensive home and community-based programs include the 1915(i) and WCHSC's North Dakota HELP program in Region VII.

- There is only one provider currently approved to provide 1915(i) services in both regions, and it only provides care coordination services.
- WSHSC's ND HELP program provides intensive home and community-based services to individuals 15 years and older who are experiencing their first episode of psychosis. However, HSC service data from 2022 suggest this program did not launch until FY 2023.

HSCs have not adopted an evidence-based care coordination intervention such as FOCUS or High Fidelity Wraparound.

Key informants in both regions praised the work of HSCs but did not consider the services they provide intensive. They also noted HSCs struggled with service capacity and the "philosophy of delivering in-home care." They expressed frustration with the shift to a more "restrictive" target population, noting it negatively affects children and youth at risk for SED, those at risk of juvenile justice involvement, and those with private insurance.

Key informants in both regions stressed the need to increase the number of providers that deliver intensive home and community-based services. They noted that the regions lack home and community-based family therapists, recovery supports, skills trainers, skills integrators to help families access appointments, family support providers, peer mentors, and parent aides.

Case management services. HSCs in both regions have established youth and family teams and provide targeted case management services as part of their team-based care.

All HSZ child welfare staff are required to be wraparound certified and participate in wraparound strength-based case management service training during their Child Welfare Certification Training program. They must recertify every 2 years.[54] Wraparound-certified staff from HSZ, Tribal Social Services, DJS, and QRTPs can enroll to become targeted case management providers.[55] Community Options also provides care coordination for Region III and

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[54] North Dakota. (2021). *Official portal for North Dakota state government: Glossary 607-05-01-01.* https://www.nd.gov/dhs/policymanuals/60705/60705.htm#607_05_01_01.htm?TocPath=Child%2520Welfare%2520Practice%2520Model%257CIntroduction%2520and%2520Overview%2520607-05-01%257C_____2

[55] Children & Family Services Training Center. (2023). *ND targeted case management.* https://und.edu/cfstc/workforce-training/nd-child-welfare-targeted-case-management.html

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VII for the 1915(i) program. The boxes below provide definitions for wraparound and targeted case management.[56,57]

The National Wraparound Implementation Center describes wraparound as an *"ecologically based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professional, and cross-system support."* It mobilizes resources and talents from various sources to create an individualized plan of care to fit the family.

Targeted Case Management (TCM) is defined as case management services that assist individuals who are eligible under the North Dakota state Medicaid plan to gain access to needed medical, social, educational, and other services. TCM does include direct delivery of a service. Medicaid eligible children and youth with SED and adults with SMI are eligible for TCM in North Dakota.

Nexus-PATH provides targeted school case management to Medicaid-eligible students in participating schools. The school-based case management staff work with the student, their family, and their support team to develop and implement an individualized care plan. Schools participating in school-based case management fund 25% of the total program costs. The remaining costs are funded through Medicaid reimbursement.[58] Wilton Public Schools and Mandan Public Schools in **Region VII** and Devils Lake Public Schools in **Region III** are partnering with Nexus-PATH.

Key informants noted that, despite an array of case management and wraparound service providers, the current service capacity and the level of intensity and frequency of service delivery are insufficient to meet current needs.

Partial hospitalization/intensive day treatment. Almost every key informant indicated a need for partial hospitalization and intensive day treatment services. CHI Alexius Hospital in Region VII limits its program to adults because it does not have a child and adolescent provider. Informants stated that when the hospital was able to serve children and youth, it was always full. LRHSC used to provide day treatment services but discontinued them because of workforce issues. To address the absence of partial hospitalization/day treatment programs, school districts in both regions have started school-based day treatment programs.

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[56] National Wraparound Implementation Center. (n.d.) *What is wraparound?* https://www.nwic.org

[57] United States Department of Health and Human Services, Office of the Inspector General. (n.d.) *Medicaid targeted case management*. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000235.asp

[58] B-HERO Technical Assistance Center. (n.d.). *Tell us something good*: *Targeted case management*. https://b-hero.org/wp-content/uploads/2022/04/Targeted-Case-Management-Feat.-Wilton-Public-School.pdf

- **Mandan Public School** in **Region VII** provides day treatment services for up to 15 students through its alternative high school with the support of the DHHS.
- **Devils Lake Public Schools** in **Region III** started a day treatment program through a partnership with its special education unit. Feedback from key informants was mixed regarding the quantity and quality of mental health services provided by these programs.

In addition to district-led day treatment programming, Dakota Boys and Girls Ranch (DBGR) provides day school services to children and youth placed there and has a limited number of openings for children and youth who can remain in the community with the right level of support. DBGR operates Memorial School located in Bismarck.

Key informants reported that there are "theoretically" enough licensed foster homes in North Dakota, and the availability of treatment foster homes and transition homes suggests there are foster homes available that are equipped to care for children and youth with more complex needs. However, key informants noted that the system's capacity is significantly limited by foster parents' refusal to accept children and youth with challenging behaviors or those transitioning out of higher levels of care. As a result, children and youth are housed in child welfare offices, hotels, and the detention center.

Foster care and treatment foster care. As noted in the infrastructure section, CFS licenses foster homes, HSZs provide support for regular foster homes, and Nexus-PATH provides support for treatment foster homes.

Key informants stressed the need to invest in foster homes. They noted that foster parents and prospective foster parents need more in-home supports, parent aid services, crisis response services, access to respite care, training (including on trauma-informed approaches), and coaching to be successful with children and youth with more complex needs.

There is also a perception among some key informants that PRTFs and QRTPs are not accepting higher intensity children and youth, which then puts significant strain on the foster care system.

Crisis Continuum

24/7 mental health crisis emergency services. North Dakota's 24/7 mental health crisis call line (988) is administered through FirstLink. The crisis call line provides information, resources, and crisis support over the telephone. When additional mental health crisis support is needed, FirstLink staff forward the call to HSCs for mobile crisis response or to law enforcement.

WCHSC and LRHSC provide mobile crisis response services to children and adults within 45 miles of Bismarck and Devils Lake. HSC staff reportedly partner with law enforcement when a joint response is needed.

Mobile crisis cannot be dispatched to the rural areas. Key informants indicated that where mobile crisis is unavailable, parents are instructed to call law enforcement or take their child or youth to the nearest emergency room for mental health crisis care.

Key informants and stakeholders reported a child or youth who needs inpatient hospitalization can wait up to 36 hours in an emergency room before an inpatient bed is available. Sometimes these children and youth are sent out of state for care. Emergency room physicians and law enforcement can use the newly implemented 988 suicide and crisis line through FirstLink to engage mobile crisis services where available to help stabilize a child or youth and their family before they are discharged to a lower level of care.

There are no **mobile crisis response, crisis triage, crisis residential, or crisis stabilization** services for children and youth in North Dakota.

Youthwork's emergency shelter beds are used primarily by the juvenile justice system, but key informants noted Youthwork's emergency shelter beds, when available, were used as crisis respite beds with law enforcement referral. However, Youthwork's shelter contract for Bismarck expired, and it is uncertain if there has been a response to the current request for proposals for emergency shelter services in the area.

Nexus-PATH provides support homes for children and youth in family preservation services. Support homes provide planned and unplanned **crisis respite**. A family must meet specific criteria (service expenditures of more than $15,000) and be enrolled in family support services to access these supports, limiting access to these services to a small subset of the population. The North Dakota Association of Counties provides funding assistance for **attendant care**. Attendant care is a non-secure site for delinquent juveniles who have been picked up by law enforcement and need short term supervision. In the state, there are currently two attendant care sites operated by counties, four by private providers on behalf of a county, and one by a tribal agency.[59]

If a child or youth in the northern part of **Region III** needed to be hospitalized because of a mental health crisis, they would need to travel over 1 hour to receive crisis care. HSZ staff in

[59] North Dakota Association of Counties. (n.d.). *Attendant care program*. https://www.ndaco.org/programs_and_services/jj/statewide-detention-support-services-sdss/

Region VII reported that they call the sheriff's department when a child, youth, or family member under their care is in crisis. Key informants also noted there are no crisis services on the Standing Rock reservation. If a family is working with Tribal Social Services, they call their worker if they are in crisis. Mandan Public Schools noted that it makes a lot of referrals to area emergency departments and uses Youthworks.

Inpatient Care

Region VII is home to 5% (6) of the state's child and youth beds and 16% (29) of the adult beds. There are no child and youth or adult acute psychiatric beds in **Region III**. Key informants from **Region III** described families driving 1.5–2 hours to access acute psychiatric care. (The number and location of acute inpatient beds is in Table 7 in Appendix D.)

Key informants highlighted a lack of acute inpatient psychiatric beds for children and youth resulting in children and youth being boarded in emergency rooms or sent out of state for acute psychiatric care.

Residential Treatment

There are five agencies that oversee eight residential treatment facilities with a total of 138 licensed beds for children and youth in North Dakota.

Qualified Residential Treatment Programs. North Dakota has two QRTPs with a total of 56 licensed beds–DBGR in Minot, ND (20 beds) and Home on the Range in Sentinel Butte, ND (36 beds). Key informants noted, and state reports confirm, the state had six residential treatment programs with 122 licensed beds prior to the adoption of the Title IV-E Prevention Services and Programs plan standards for care.[60]

Title IV-E Prevention Services and Programs Plan standards of care require QRTPs to be nationally accredited, provide trauma-informed care, and provide aftercare services to children and youth for 6 months after discharge. Aftercare services include service coordination, supports to increase placement stability, monitoring of treatment outcomes, and other services identified by the QRTP.

One key informant mentioned the independent assessment process presents a barrier to accessing QRTP care and wait times for an open bed can be months. Another key informant mentioned the 90-day reassessment requirement can have a negative impact on the children and youth in QRTP placements. Improved Child and Adolescent Needs and Strengths (CANS)

[60] North Dakota Department of Human Services. (2019). *Family First Prevention Services Act PL 115-123: Stakeholder informational meeting highlights*. https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/family-first-meeting-resources-2019-7-17.pdf

scores can lead to discharge before it is clinically appropriate and before an appropriate community-based placement has been secured, resulting in children waiting in offices and hotels for placements and an increase in recidivism rates. Key informants also mentioned there are no residential treatment providers that accept children and youth with autism spectrum disorder or developmental disabilities.

Psychiatric residential treatment facilities. North Dakota has six PRTFs with a total of 82 beds (see Appendix D, Table 8). North Dakota's PRTF licensing standards do not require facilities to provide 6 months of aftercare, a best practice for residential care. According to interviewees, the goal is to demonstrate the positive impact of aftercare and use these outcomes to influence legislation and policy.

Key informants agreed that there are limited options for residential care. The community providers we spoke to reported trying to serve youth in the community who need to be in higher levels of care. They noted that PRTFs do not accept higher intensity youth and place youth in beds who could be served in the community. This leads to a mismatch in service delivery.

System Barriers and Strengths

In addition to asking about the services and supports available to children and youth who have or are at risk for SED and their families, we asked key informants to identify barriers to accessing care and to discuss what was working well in the system. Findings are summarized below.

Barriers to accessing care. Barriers in access to care exist in both **Region III and Region VII**. Key informants described the continuum in **Region III** as having a lot of good components but added the connections between the components need to be strengthened. The child-serving systems reportedly siloed in both regions and do not always work well together. Funding streams are siloed, and everyone thinks someone else should pay for child, youth, and family services. Key informants also discussed changes that have affected care. They discussed the HSC redesign and shift in the population of children HSCs serve, which has resulted in a disconnect between children, youth, and families, especially those served through juvenile justice, and needed services. They added that changes in QRTP regulations affect who can be served. Key informants indicated there is also a greater focus on adult services at the state level.

Workforce shortages are a barrier in both regions, including therapists and psychiatrists, especially those who serve youth with intensive needs or severe SUD. Key informants indicated that many providers have shifted to private practice or have "burned out" and stopped practicing. The shortage of providers has resulted in providers closing agencies or not being

able to offer new services. This also affects immediate access to services because when families are ready to seek services, they have to wait to see a provider and are often deterred from coming back as a result. Key informants indicated that families have to get to HSC open access early or they will not be seen; even then, there is a waitlist and shortage of services. Private providers do not accept new patients because their caseloads are full.

Region III experiences more barriers to services, in part because it is more rural and there are fewer services available. Transportation is a big issue because individuals must travel longer distances to access services in **Region III**. However, key informants indicated that even in **Region VII**, the HSC is a "long way from most families." Even if caregivers have a car, they often do not have money for gas, and many do not have a driver's license. The HSZ tries to provide gas vouchers to the families it serves, but there are not enough vouchers to meet the need. Lack of transportation not only keeps children and youth from accessing behavioral health services, but also keeps them from participating in after-school programming, tutoring, or other prosocial activities with peers and supportive adults. One key informant noted the number of Native American students involved in after-school programming, such as sports, teams were not representative of the schools' Native American population.

Families who face multiple challenges and complex needs require more caseworker support. Some families may need mentoring, peer-to-peer supports, natural supports, and other services, and they may need this level of support until their child is grown. Families and kinship providers caring for children of relatives need support, such as Temporary Assistance for Needy Families and childcare. Although Medicaid pays for many services, private insurance does not, and not all providers accept Medicaid. Private insurance does not always cover payment for placements. When individuals do not have Medicaid or private insurance, the cost of copayments or medications often makes care prohibitive. Families do not always have access to technology, phones, or phone data to take advantage of telehealth services.

Key informants indicated increased availability of home and community-based services, skills integrators who can help families access appointments, and mentoring as a preventive intervention might help address some of the barriers to access.

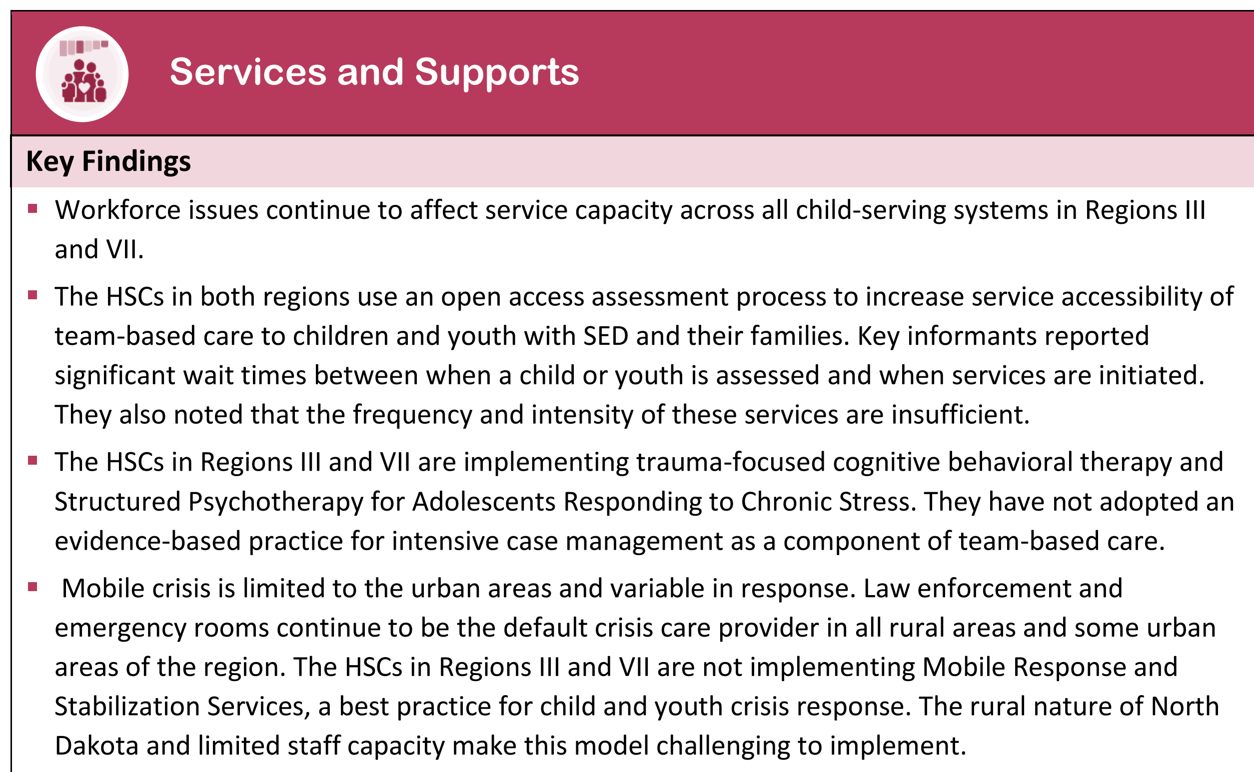
What is working in the current child-serving system. Both **Region III and Region VII** have strengths that can be used as opportunities for change. Key informants in both regions indicated agencies focus on children, youth, and families and everyone has good intentions and understands the importance of addressing the issues and needs children, youth, and families face. They expressed there is good support for children's issues from the governor on down. They indicated that people know each other and work together to the extent possible but are "bogged down" by red tape, statutes, and funding issues. Key informants indicated they are willing to have difficult conversations and work collaboratively and are "small enough to be

nimble." **Region VII** has community collaboration meetings where schools, courts, zones, and other providers come together. Other examples of collaboration in **Region III** include the Dual Status Youth Initiative and family-centered engagement meetings that bring everyone to the table.

According to key informants, both regions have good counselors and social workers who have been in the field for a long time and have much experience and motivation. Key informants described the staff that the HSZs have retained as strong. Interviewees highlighted **Region III's** team-based care, access to child psychiatric services (including telehealth and school-based mental health services), and the relationships they form with other providers as strengths.

Key informants indicated there are providers in **Region VII** providing therapy using different modalities and the availability of telehealth has increased since the COVID-19 pandemic. They also reported Healthy Families services for very young children are a strength. Schools in both regions are open to collaboration with providers, tiered systems, and early intervention. Key informants reported Turtle Mountain reservation schools in **Region III** has a good relationship with behavioral health providers. The Native American Development Center and NATIVE Inc in **Region VII** offers important cultural and linguistic resources. Further, another strength is inpatient therapists work with youth and families while youth are in inpatient care.

Service Array Key Findings and Considerations



Services and Supports

Key Findings

- Workforce issues continue to affect service capacity across all child-serving systems in Regions III and VII.
- The HSCs in both regions use an open access assessment process to increase service accessibility of team-based care to children and youth with SED and their families. Key informants reported significant wait times between when a child or youth is assessed and when services are initiated. They also noted that the frequency and intensity of these services are insufficient.
- The HSCs in Regions III and VII are implementing trauma-focused cognitive behavioral therapy and Structured Psychotherapy for Adolescents Responding to Chronic Stress. They have not adopted an evidence-based practice for intensive case management as a component of team-based care.
- Mobile crisis is limited to the urban areas and variable in response. Law enforcement and emergency rooms continue to be the default crisis care provider in all rural areas and some urban areas of the region. The HSCs in Regions III and VII are not implementing Mobile Response and Stabilization Services, a best practice for child and youth crisis response. The rural nature of North Dakota and limited staff capacity make this model challenging to implement.

Services and Supports

- Regions III and VII lack substance use disorder treatment and recovery services. They also lack child and youth psychiatrists, therapists with extended working hours, skills trainers and integrators, parent support aides, and respite care providers.
- There are a limited number of providers that provide intensive home and community-based services in either region. This is especially true for individuals who have private insurance or need immediate access to care to remain in the community.
- There are a limited number of community-based mental health providers offering evidence-based services, and none provide intensive in-home interventions as approved in the North Dakota Title IV-E Prevention Services and Program Plan.
- Service contracts for in-home family therapy for families involved with the HSZs expired before community providers had developed the capacity to deliver approved services as outlined in the North Dakota Title IV-E Prevention Services and Program Plan.
- The lack of intensive community-based services puts increased demand on Psychiatric Residential Treatment Facilities (PRTFs) and QRTPs. Key informants reported a significant wait list for QRTP beds and that PRTF beds were also filled. There is a perception among key informants that the high demand for beds allows facilities to reject children and youth with the most complex needs in favor of those who could be served in the community.
- HSZ child welfare staff are certified in wraparound, as outlined in North Dakota Medicaid Policy, to implement targeted case management services. It should be noted ~~that~~ there are different and sometimes overlapping definitions of wraparound. State child-serving agencies may have differing definitions and regulations that refer to and drive implementation of "wraparound services."
- All treatment foster care providers in North Dakota are trained in Together Facing the Challenge, an evidence-based model.
- There is a lack of trained foster parents who are willing, due to lack of home and community-based services, to take children and youth with complex needs and/or transitioning from a higher level of care.
- Schools and districts in Regions III and VII have partnered with the BHD and regional and local behavioral health providers to increase student access to services and supports that cultivate skills designed to advance students' learning, relationships, and development.

Considerations

- Use the governance structure and steering committees to develop and support cross system adoption of shared definitions of service coordination, care coordination, case management, intensive case management, and wraparound services.
- Build the HSC's capacity to deliver and sustain High Fidelity Wraparound services in Regions III and VII.
  - Identify additional partners (e.g., private mental health providers, HSZs, QRTPs, tribal nations) to expand implementation efforts.

Services and Supports

- Develop and implement a plan to regularly assess quality, outcomes, and fidelity to the High Fidelity Wraparound model once it has been implemented in Regions III and VII.
- Work with Regions III and VII to build community capacity to deliver all services included in the 1915(i) Medicaid State Plan Amendment.
- Partner with the core child-serving systems to continue working toward recommendations from the 2018 North Dakota Behavioral Health System Study.
  - Include service capacity and workforce development as key areas of focus in the SOC strategic plan.
- Identify exemplars for implementing Mobile Response and Stabilization Services in rural communities and develop a plan to strengthen crisis interventions for children, youth, and families and decrease law enforcement response and emergency room encounters.

System of Care Values

There are three core SOC values: **family and youth driven**, **culturally and linguistically competent systems and services**, and **community based**. As part of our needs assessment, we asked key informants and stakeholders about family and youth involvement, cultural and linguistic competency, and racial and ethnic disparities within North Dakota's SOC to determine the extent to which the practices of North Dakota's current child-serving system align with the first two SOC core values. Our analysis of North Dakota's infrastructure and continuum of services and supports suggests that the BHD, including Regions III and VII, understands the importance of being family and youth driven services and is striving to be culturally and linguistically competent but would benefit from focused efforts in both areas.

Cultural and linguistic needs. Cultural and linguistic needs vary within Regions III and VII. Some agencies have adopted traditional Native American practices, hired a representative workforce, delivered cultural competency trainings, and developed partnerships to help address the cultural and linguistic needs of their communities. Despite these efforts, interviews revealed the children's systems in Regions III and VII struggle to meet the cultural and linguistic needs of the area.

Racial and Ethnic disparities. Key informants stated Native Americans were 9-10% of the population of North Dakota and roughly 30% of the treatment population. When the key informants were asked, which factors might contribute to racial and ethnic disparities in behavioral health access and outcomes, they noted historical prejudice toward Native Americans, socio-economic status, inadequate or no health insurance, transportation issues, a small number of Native American providers, and few providers rooted in traditional Native American cultural practices. One key informant stated years of historical prejudice towards Native Americans and colonialism has resulted in distrust and a continued belief that non-native "providers are going to take their children away." They stressed this belief as well as continued prejudice and distrust keeps Native American families from accessing behavioral health care off the reservation. Access to behavioral health services and supports varies between reservations depending on the capacity of Indian Health Services and the support for behavioral health services by tribal governments.

> *"Native Americans make up 9% of the state's population and roughly 30% of the treatment center population, but providers have not been successful in building a representative workforce."*
> —Key Informant

Another key informant noted Bismarck has the largest urban Native American population in the state. However, the service providers in most behavioral health agencies are White and not representative of the city's population. This key informant believes North Dakota is not open to

diversifying its workforce or supporting Native American service providers. Other key informants linked the ethnic and racial disparities in North Dakota to poverty or socio-economic status, inadequate or no health insurance, lack of transportation, and the distance families are required to travel to access care. None of the key informants we spoke with had adopted evidence-based behavioral health interventions tailored for Native American children, youth, and families.

Key informants from both regions highlighted efforts to meet the cultural needs of the Native American populations they serve.

- In **Region III, Devils Lake Public Schools** holds cultural weeks throughout the school year, brings elders in to do storytelling, and hosts culturally recognized dance assemblies. Sixty percent of Amachi Mentoring and Recovery staff are Native Americans, and the agency encourages Native American cultural practices and recognizes and respects tribal elders.
- In **Region VII, Bismarck Public Schools** has a director of Native American education. The director and her staff promote awareness of the Native American cultural practices in the elementary schools and implement Prevention Racial and Ethnic Disparities (PRED). The Native American Development Center in Region VII provides culturally relevant after-school programming for youth, evening family engagement activities, and tribal wraparound for adults.

The assessment found additional efforts to meet the cultural and linguistic needs of the children, youth, and families they serve. Key informants in **Region VII** noted there is a large population of Spanish speakers in Mandan. HSCs contract with LanguageLink for phone/video interpreters but reported this service can be difficult to use when providing services in the home or the community. They also provide cultural sensitivity training including LGBTQ+ sensitivity training. One key informant stressed racism and transphobia have a significant negative impact on North Dakota's youth, resulting in a population of young people who feel marginalized. A key informant from **Region III** noted there was a higher population of individuals with hearing impairments in the area because it housed the state's school for the deaf.

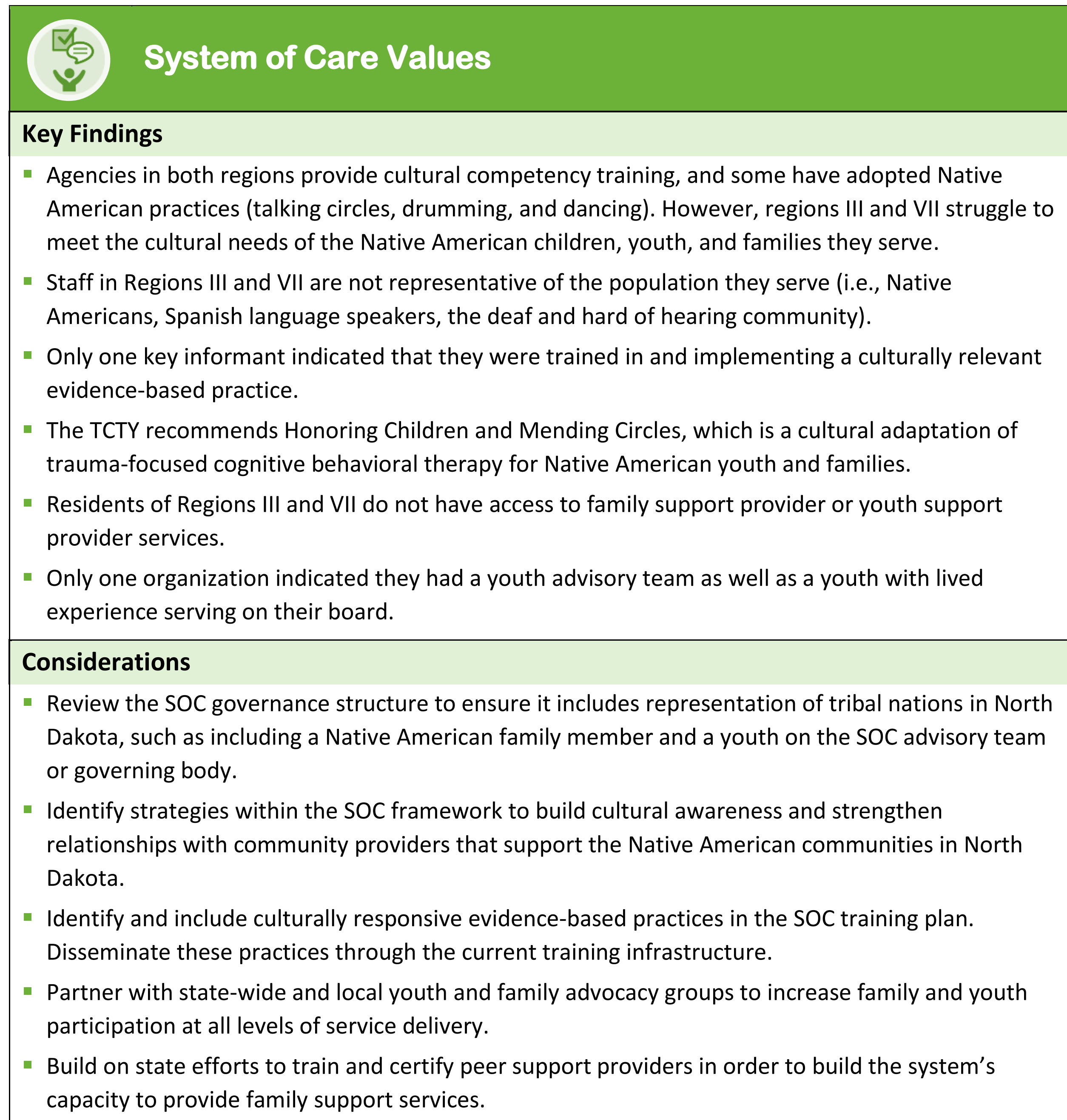
Family and youth driven. This finding aligns with the *North Dakota Behavioral Health System Study* recommendation that the State build on its efforts to train and certify peer support providers to build the system's capacity to provide family peer support services.[61] Key informants understood the importance of involving family and youth in all levels of service planning, implementation, and delivery. However, few agencies have family and youth peer

[61] HSRI (2018). *North Dakota behavioral health system study: Final report.*

support providers, and fewer have engaged family members and youth in all levels of decision-making.

> Nexus-PATH was the one agency we spoke with that had a former participant on its board of directors and a youth advisory committee.

System of Care Values Key Findings and Considerations



System of Care Values

Key Findings

- Agencies in both regions provide cultural competency training, and some have adopted Native American practices (talking circles, drumming, and dancing). However, regions III and VII struggle to meet the cultural needs of the Native American children, youth, and families they serve.
- Staff in Regions III and VII are not representative of the population they serve (i.e., Native Americans, Spanish language speakers, the deaf and hard of hearing community).
- Only one key informant indicated that they were trained in and implementing a culturally relevant evidence-based practice.
- The TCTY recommends Honoring Children and Mending Circles, which is a cultural adaptation of trauma-focused cognitive behavioral therapy for Native American youth and families.
- Residents of Regions III and VII do not have access to family support provider or youth support provider services.
- Only one organization indicated they had a youth advisory team as well as a youth with lived experience serving on their board.

Considerations

- Review the SOC governance structure to ensure it includes representation of tribal nations in North Dakota, such as including a Native American family member and a youth on the SOC advisory team or governing body.
- Identify strategies within the SOC framework to build cultural awareness and strengthen relationships with community providers that support the Native American communities in North Dakota.
- Identify and include culturally responsive evidence-based practices in the SOC training plan. Disseminate these practices through the current training infrastructure.
- Partner with state-wide and local youth and family advocacy groups to increase family and youth participation at all levels of service delivery.
- Build on state efforts to train and certify peer support providers in order to build the system's capacity to provide family support services.

Conclusion

North Dakota Department of Health & Human Services BHD's SAMHSA SOC expansion grant provides the division with the opportunity to strengthen cross-system infrastructure, enhance the continuum of services and support, and align SOC values and principles with core practices in the geographic service areas of LRHSC and WCHSC. Opportunities to strengthen state and regional SOC infrastructure include establishing and supporting cross-system governance and advisory teams, aligning intensive home and community-based capacity building initiatives across child-serving systems, and using existing infrastructure as a foundation to build and sustain the use of evidence-based behavioral health interventions. Opportunities to enhance the regions' current continuum of services and support include adopting a set of shared service definitions, developing and implementing a plan to access cross-system outcomes data and support fidelity of service implementation, and creating a plan to strengthen crisis response in the regions' rural areas. Finally, the grant presents the state and the regions with opportunities to increase the involvement of families, including Native American families, in all levels of service delivery; strengthen relationships with community providers that support Native American communities; and identify and adopt culturally and linguistically responsive evidence-based behavioral health practices.

The findings and considerations in this report offer both inspiration and direction as the BHD and regional partners seize these opportunities to expand the SOC approach in North Dakota.

Appendix A: SAMHSA SOC Required Activities

The SAMHSA SOC grant intends grantees to develop infrastructure and service delivery, according to the following guidance.[62]

- Provide evidence-based and culturally appropriate mental health services to children/youth with SED/SMI, including the following:
  - diagnostic and evaluation services, including an assessment of substance use history, trauma history, risk for suicide, and general health conditions
  - outpatient services provided in a clinic, office, school, or other appropriate location, including individual, group, and family counseling, professional consultation, and review and management of medications
  - 24-hour mental health crisis emergency services, 7 days per week
  - intensive home-based outreach and case management services for children and their families when the child is at imminent risk of out-of-home placement
  - intensive day treatment services
  - respite care services
  - therapeutic foster care services and services in therapeutic foster family homes, individual therapeutic residential homes, or group homes caring for no more than 10 children
  - transition from the child/youth system to the adult system
- Identify and provide referral pathways to recovery support services (e.g., assistance with obtaining education/job skills necessary for employment, assistance obtaining employment or supported employment, assistance with Supplemental Security Income enrollment).
- Incorporate trauma-informed care elements throughout all components of the SOC project, including screening for trauma, trauma-focused treatment, and a trauma-informed approach to care and services.
- Implement services and supports to promote and sustain family and youth engagement and involvement in the development, implementation, and evaluation of the SOC at the state and local levels (e.g., family and youth peer support, family and youth leadership development, mentoring, and youth-guided activities).
- Develop a sustainability plan that includes changes in policy and financing strategies to maintain and possibly expand behavioral health services and supports for youth when federal funding ends.

[62] SAMHSA. (2022). *FY 2022 grants for expansion and sustainability of the comprehensive community mental health services for children with serious emotional disturbances* (Notice of Funding Opportunity No. SM-22-007). Department of Health and Human Services. https://www.samhsa.gov/grants/grant-announcements/sm-22-007

- Provide training to service providers in all aspects of SOC development and implementation, including evidence-based, practice-based, or community-defined interventions.
- Develop new and/or maintain existing collaborative partnerships across child-serving agencies, providers, and programs (e.g., substance use, child welfare, juvenile justice, primary care, education, early childhood) to strengthen the delivery of services to children/youth with SED/SMI.
- Develop or enhance an existing governance structure/board that is responsible for decision-making at the client and policy levels.

Appendix B: Key Informants and Stakeholders

We conducted interviews on topics such as service availability, gaps and barriers to service, cultural and linguistic service needs, and racial and ethnic disparities across the service array. Table 4 lists the key informants who were interviewed for this needs assessment.

Table 4. Key Informant List

Key Informants		
Name	**Title**	**Agency**
Ariana Best	Clinical Director	WCHSC
Barb Ritter	Supervisor	South Country HSZ (Kidder/Emmons)
Brad Brown	Regional Director	WCHSC
Brenda Bergsrud	President	CFN (Consumer Family Network)
Carlotta McCleary	Executive Director	ND Federation of Families for Children's Mental Health & Mental Health America of ND
Carly Retterath	Former Director of Alternative Education, Current Assistant Superintendent of Mandan Public Schools	Mandan Public Schools
Carrie Hjellming	Juvenile Court Officer	Juvenile Court Region 7
Chelsea Flory	Director	Burleigh HSZ
Clete Winkelmann	Executive Director	Nexus-PATH
Cory Pedersen	Child and Family Services Director	DHHS CFS
Dan Cramer	Clinical Director	DHHS HSC
Deborah Hanson	Director of Behavioral Health	Spirit Lake Health Center
Dennis Meier	Director	Three Rivers HSZ
Heather Wilson	Clinical Director	LRHSC
Jackie Lelm	Youth Lead	WCHSC
Jeff Stenseth	Operations Director	DHHS HSC
Jenie Sveningson	Juvenile Court Supervisor	Juvenile Court Region 3
Jill Denault	Director	Northern Valley HSZ (Cavalier)
Jim Vetter	Vice President, Treatment Services/Gov Relations	Dakota Boys and Girls Ranch
Jolene Obrigewitch	Development Director	Home on the Range

Key Informants		
Name	**Title**	**Agency**
Julie Baumgarn	Regional Director	LRHSC
Kevin Dahmen	Pediatric Psychiatrist	CHI St. Alexius Hospital, Archway Mental Health Services, Manchester House, Home on the Range
Kim Ekart	Program Manager	Youthworks
Laura Feldmann	Executive Director	Home on the Range
Laura Kroetsch	Medical Director	DHHS HSC
Lisa Wilson	Director of Behavioral Health	CHI St. Alexius Hospital
Lorraine Davis	President	Native American Development Center, NATIVE Inc
Luke Klefstad	Division Director	The Village Family Service Center
Marisa Warren	Clinical Director	Youthworks
Matt Bakke	Superintendent	Devils Lake Public Schools
Matthew McCleary	Deputy Director	ND Federation of Families for Children's Mental Health
Maurice Hardy	Director	Dakota Central HSZ
Michelle Masset	Director	South Country HSZ (Kidder/Emmons)
Michelle Swanson	Admissions Director	Home on the Range
Mike Yantes	Student Support Services Interconnected Systems Frameworks	Bismarck Public Schools
Raquel Thompson	Director	Standing Rock Tribal Social Services
Rhonda R. Allery	Director	Mountain Lakes HSZ
Shawn Peterson	Director of Juvenile Court Unit 1	Juvenile Court Region 3
Tracy Famias	Student Support Services Interconnected Systems Frameworks	Bismarck Public Schools

Appendix C: Human Service Center Utilization Data

Table 5. Children and Youth Receiving Services at LRHSC in 2022

Services	Ages			Total Served
	6-11	12-17	18-21	
Total Served	44	163	105	**312**
Diagnostic and Evaluation Services				
Diagnostic Assessment	18	73	38	**129**
Diagnostic Assessment with Medical	7	19	9	**35**
Screening, Triage, & Assessment	23	72	49	**144**
Screening, Triage & Assessment (Emergency) - Crisis Service	5	57	31	**93**
Mental Health Outpatient Services				
Family Psychotherapy	1	1	0	**2**
Individual Counseling	23	64	30	**117**
Individual Psychotherapy	1	22	28	**51**
School-Based				
Mental Health Services	12	38	5	**55**
Substance Use Outpatient Services				
Group Therapy	0	0	1	**1**
Crisis Services				
Crisis Intervention	0	13	6	**19**
Crisis Line	1	13	4	**18**
Crisis Psychotherapy	0	4	9	**13**
Crisis Stabilization	0	0	5	**5**
Case Management Services				
Case Management & Targeted Case Management	24	74	42	**140**
Recovery Support Services				
Skills Integration - Individual	16	36	13	**65**
Skills Restoration - Individual	5	16	7	**28**
Medication Management	14	36	19	**69**

Table 6. Children and Youth Receiving Services at WCHSC in 2022

Services	Ages			Total Served
	6-11	12-17	18-21	
Total Served	105	210	120	**435**
Diagnostic and Evaluation Services				
Diagnostic Assessment	66	114	53	**233**
Diagnostic Assessment with Medical	15	16	8	**39**
Screening, Triage, & Assessment	41	123	77	**241**
Screening, Triage & Assessment (Emergency) - Crisis Service	2	10	20	**32**
Mental Health Outpatient Services				
Family Psychotherapy	3	11	2	**16**
Group Counseling	2	19	8	**29**
Group Psychotherapy	0	12	7	**19**
Individual Counseling	59	93	23	**175**
Individual Psychotherapy	13	50	37	**100**
School-Based				
Mental Health Services	43	48	2	**93**
Substance Use Outpatient Services				
Group Therapy	0	15	5	**20**
Crisis Services				
Crisis Intervention	3	11	6	**20**
Crisis Line	3	5	7	**15**
Crisis Psychotherapy	2	5	5	**12**
Crisis Stabilization	0	0	10	**10**
Case Management Services				
Case Management & Targeted Case Management	80	134	62	**276**
Recovery Support Services				
Skills Integration Group	0	6	1	**7**
Skills Integration - Individual	16	26	5	**47**
Skills Restoration Group	12	13	5	**30**
Skills Restoration - Individual	52	74	0	**126**
Medication Management	32	51	23	**106**

Appendix D: Acute Psychiatric Inpatient and Residential Beds

Table 7. Number and Location of Acute Psychiatric Beds in North Dakota for Children, Youth, and Adults

Acute Psychiatric Beds in North Dakota[63]			
Hospital	**Location**	**Adult**	**Child/Adolescent**
Altru Hospital	Grand Forks	15	8
CHI St. Alexius	Bismarck	11	6
Prairie St. Johns	Fargo	20	50
Sanford	Bismarck	18	0
Sanford	Fargo	20	0
Trinity Hospital St. Joseph's	Minot	18	8
Total Psychiatric Beds		**184**	**114**

Table 8. North Dakota Residential Treatment Facilities, Location, Type, Number of Beds, and Ages Served

North Dakota Residential Treatment Beds				
Name	**Location**	**Type**	**Number of Beds**	**Ages Served**
Dakota Boys and Girls Ranch	Bismarck	PRTF	16	10-18 years old
Dakota Boys and Girls Ranch	Fargo	PRTF	16	10-18 years old
Dakota Boys and Girls Ranch	Minot	PRTF	16	10-18 years old
Luther Hall (Nexus-PATH)	Fargo	PRTF	16	10-17 years old
Pride Manchester	Bismarck	PRTF	8	5-13 years old
Ruth Meiers Adolescent Center	Grand Forks	PRTF	10	12-18 years old
Home on the Range	Sentinel Butte	QRTP	36	12-19 years old
Dakota Boys and Girls Ranch	Minot	QRTP	20	10-19 years old
Total Beds			**138**	

[63] Human Services Research Institute. (n.d.). https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/nd-hospital-report-hrsi-2020-12-29.pdf