# North Dakota Behavioral Health System Study

## ABSTRACTED SUMMARY

Compiled by

**The Consensus Council, Inc.**

**North Dakota Behavioral Health System Study**
**Human Services Research Institute**
**Draft Release**

**Summary Compiled by**
**The Consensus Council, Inc.**

**April 2018**

## Vision

A good and modern behavioral health system focuses on

- the health and wellbeing of the whole population to prevent mental health and substance use problems before they occur,
- identifies and intervenes early when behavioral health issues are present, and
- provides person-centered, trauma-informed, culturally responsive, and recovery-oriented services and supports to those with behavioral health-related needs

## A Functional System

A well-functioning behavioral health system attends to

- the intensive needs of children, youth, and adults with serious mental health conditions and substance use disorders,
- the outpatient and community-based service and support needs of individuals,
- the social and emotional well-being of the majority of the population who have not been diagnosed with a behavioral health condition—especially children, youth, and young adults, and
- a continuum of social support services that includes employment, housing, and self-help alongside clinical treatment.

## Key Findings

### A. Prevalence of Need

- ALCOHOL ABUSE. ND fairs well on most physical and mental health indicators; however, ND ranks much higher on the national average in excessive drinking and alcohol-related motor vehicle crash deaths.
- ILLICIT DRUG USE. Rates of heroin and methamphetamine are on the rise.
- DISPARITY IN CARE ACCESS. ND shows disparities in access to care, access to culturally appropriate care, and numbers individuals with undocumented and undiagnosed, preventable conditions.

- ACCESS BARRIERS. Misperceptions and stigma, retraumatization, and fears of criminal justice and child welfare system involvement.

B. Services Reach and Gaps

- OPTIMAL SYSTEM. Wellness and community education, prevention and early intervention, outpatient and community-based mental health and substance use disorder treatment services, crisis and inpatient services, and behavioral health/criminal justice system initiatives.

- INEQUITABLE FUNDING FOCUS. ND pours a majority of its resources into residential, inpatient, and other institution-based services with relatively fewer dollars invested in prevention and community-based services.

- REFOCUS FUNDING. Disinvest from costly and undesirable institutional services and reinvest funding upstream to promote population health and prevent and reduce the need for intensive behavioral health services.

C. Community Awareness and Education

- STEREOTYPES. Provide public education to combat misperceptions and stereotypes regarding mental health and substance use disorders.

- BROADEN AWARENESS. Help communities, service users, and families to understand mental health and trauma in addition to substance use issues.

D. Prevention and Early Intervention

- DISPARITY OF ATTENTION. Early intervention and prevention work receives less funding than treatment services. Lack of payment options.

- ATTEND TO WELLNESS EFFORTS. Current prevention work focused on substance use prevention, less on social and emotional wellness and mental health-specific prevention.

- SUSTAINABLE FUNDING AND STAFFING. Lack of sustainable funding outside of mental health block grant, and workforce shortages of trained providers.

E. Outpatient Treatment

- INITIATIVES. DHS Field Services working to expand the array of evidence-based outpatient and community-based service offerings. Information and referral events connect people to services.

- SCREENING. Screenings help identify and eliminate disparities in treatment access. Unable to identify a universal screening process that focused specifically on behavioral health or trauma.

- INTEGRATED CARE. Integrated physical and behavioral health services in early development in ND. Limited incentives to deliver behavioral health services in primary care settings. Minimal collaboration between behavioral and physical health stakeholders, especially rural settings.

- CHILDREN SERVICES. Need to improve continuum of care for children, where resources to adults is emphasized. Lack of infrastructure and coordination, including school-based service system gaps. Shortage of licensed addiction counselors, where residential treatment is only option.

- ADULT SUBSTANCE USE DISORDER TREATMENT SERVICE GAP. Far fewer adults seek treatment than are diagnosed for substance use disorders. Lack of service options statewide, especially in rural settings. Access and affordability for medication-assisted treatment needed. Need for sober living environments to aid transitions from inpatient to community-based care.

F. Community-Based Services

- SERVICE GAPS. Gaps identified for housing, employment, and transportation for those seeking services. System is crisis-oriented and pays inadequate attention to rehabilitative and community-based services.

- CHILDREN, YOUTH, FAMILIES. Community demand exceeds current coordination of services for children and youth, especially support for children in foster care or at risk of placement. Lack of transparency around the process of service delivery and approval makes it difficult for families to understand and navigate the system.

- CASE MANAGEMENT. Significant regional variation exists in adult case management organization, delivery, and utilization. Complex needs make accessing case management challenging. Individuals perceive need to evidence motivation as precondition for receiving support. Comprehensive wraparound case management and independent living/skills required. The quality and fidelity of case management are unknown systemwide. Need to reevaluate and restructure case management services in ND and incorporate more rehabilitation-focused evidence-based and promising practices, including team-based approaches and alternative models of service navigation and self-management delivered by peer specialists and community health representatives.

- PEER SUPPORT. Peer support services develop self-advocacy skills and build confidence. Peer support demonstrates effectiveness in improving quality of life and outcomes with cost savings. Peer support must be provided according to national practice standards. Peer support requires education for providers to promote openness to this opportunity.

- EMPLOYMENT AND COMMUNITY SUPPORT. Need to increase community engagement and independence for service users to lessen isolation and increase connections. Employment and community support programs are underfunded. Peer-run organizations can serve as community resources for support, education, and advocacy.

- HOUSING. Unstable housing and homelessness negatively impact behavioral health outcomes and treatment access. Lack of affordable housing is a major contributor to homelessness. Wraparound services are required to maintain housing placements.

- HARM REDUCTION. Harm reduction efforts (e.g., naloxone and syringe services) needed to reduce problematic substance use and secure a modern health system.

- COMMUNITY HEALTH WORKERS. Community health representatives work effectively with individuals with behavioral health needs. These representatives have preexisting community

relationships and facilitate connections and engagement. Need to expand this service and seek sustainable funding, including Medicaid reimbursement.

### G. Residential Treatment and Foster Care

- PRIORITY TENSIONS. Residential treatment is among highest per capita costs of all service types. Tension exists between needing more residential services and the difficulty in assessing the need for other services when current community-based service array is insufficient: residential treatment responds to shortage in community-based system (i.e., prevention, outreach, and in-home and community-based treatment and support). Need to address community-based service continuum before the need arises for residential or inpatient treatment.

- CHILDREN AND YOUTH: DOUBLE BOTTLENECK. Some children and youth are underserved while others receive a higher level than needed. Concerns that residential facilities might 'cherry pick' individuals with lower level needs than those with challenging behavior. It is difficult to find an appropriate placement for children, particularly those with complex needs, resulting in poorer outcomes and difficulty in reuniting families.

- TREATMENT FOSTER CARE. High prevalence of behavioral health treatment needs among children and youth in the child welfare systems. Many parents of these children are themselves struggling with behavioral health issues, with cyclical, cascading effects upon reunification, including further residential treatment and child welfare involvement.

### H. Crisis, Inpatient, and Long-Term Care Services

- INITIAL CARE RESPONSE. Expressed need for support services, such as peer-run warmlines, to avert life-disrupting and costly emergency and crisis services. First responders (i.e., police, fire, and medical staff) should divert individuals with behavioral health needs to treatment rather than jail. Crisis response services are lacking in ND, especially outside metro areas and regarding children and youth needs. Rates of inpatient services have remained stable, with bed capacity approximately twice the national average. Inadequate outpatient and community-based supports follow inpatient treatment. Many individuals with behavioral health needs are receiving care in long-term care facilities, specifically designed to meet older adult needs.

### I. Services for Justice-Involved Populations

- HIGH PREVALENCE NEED. Criminal justice system evidences high need for behavioral health services for both adults and youth. State entities collaborating to improve policies and practices for youth (e.g., Dual Status Youth Initiative). Courts will sentence individuals with lo-level crimes to provide them with access to treatment they would not otherwise receive in the community. Community-based treatment providers generally are resistant to serving individuals with criminal justice histories. Need for community-based services is high among re-entry population.

### J. Additional System Challenges and Strengths

- COORDINATION AND COLLABORATION. Good-quality relationships exists among government entities; however, system siloing is a challenge to coordinating behavioral health services and moving forward with action.

- DATA SYSTEMS. Expressed need to harmonize data across services and systems and to ensure that data are collected, analyzed, and used to inform system design and development.

- WORKFORCE ISSUES. Expressed need to find and retain a qualified behavioral health workforce. Certification, licensing, staffing and retention raise barriers to ensuring a well-qualified workforce.

- TELEBEHAVIORAL HEALTH SERVICES. Expressed interest in expanding telebehavioral health services statewide.

- POPULATION-SPECIFIC ISSUES. State entities express a strong commitment to values of person-centeredness, cultural competency, and trauma-informed approaches. Individuals who receive services are not yet necessarily experiencing the system as reflecting these values, including documented disparities among American Indian populations, LGBTQ individuals, and New Americans. Expressed need exists for more culturally appropriate services and including a greater proportion of American Indians within the behavioral health workforce and in behavioral health leadership positions. Expressed need to strengthen partnerships within and between the tribal nations, the Indian Health Service, and state and counties to identify shared goals, fill knowledge gaps, share information resources, and coordinate action. Other racial and ethnic minorities, particularly New Americans, require access to appropriate and culturally responsive behavioral health services. LGBTQ youth and adults face barriers to treatment, including provider stigma and discrimination and a lack of culturally sensitive services.

## Recommendations

The study's recommendations are based on a wide range of sources including data, reports and key informants in North Dakota, as well as best practices from other locales and the research literature. These recommendations generally reflect the principles identified in a widely disseminated 2011 brief produced by SAMHSA entitled *Descriptions of a Modern Addictions and Mental Health Service System.* The document presents a vision and describers the basic services required for a transformed and integrated system of care:

> *A modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective.*

## Study Recommendations

| RECOMMENDATION | STRATEGY TIMEFRAME |
|---|---|
| **1 – Develop a comprehensive implementation plan** | |
| 1.1 Reconvene system stakeholders, including service users and their families | Short Term |
| 1.2 Form an oversight steering committee to coordinate with key stakeholder groups | Short Term |
| 1.3 Establish work groups to address common themes identified in this report | Short Term |
| **2 – Invest in prevention and early intervention** | |
| 2.1 Prioritize and implement evidence-based social and emotional wellness initiatives | Short & Long Term |
| 2.2 Expand existing substance use prevention efforts, restore funding for the Parents Lead program | Short Term |
| 2.3 Build upon and expand current suicide prevention activities | Short & Long Term |
| 2.4 Continue to address the needs of substance exposed newborns and their parents | Short & Long Term |
| 2.5 Expand evidence-based services for first-episode psychosis | Long Term |
| **3 – Ensure all North Dakotans have timely access to behavioral health services** | |
| 3.1 Coordinate and streamline information on resources | Short Term |
| 3.2 Expand screening in social service systems and primary care | Short & Long Term |
| 3.3. Ensure a continuum of timely and accessible crisis response services | Short & Long Term |
| 3.4 Develop a strategy to remove barriers to services for persons with brain injury | Short Term |
| 3.5 Continue to invest in evidence-based harm-reduction approaches | Short & Long Term |
| **4 – Expand outpatient and community-based service array** | |
| 4.1 Ensure access to needed coordination services | Short & Long Term |
| 4.2 Continue to shift funding toward evidence-based and promising practices | Short & Long Term |
| 4.3 Expand the continuum of SUD treatment services for youth and adults | Short & Long Term |
| 4.4 Support and coordinate efforts to enhance the availability of outpatient services in primary care | Short & Long Term |
| 4.5 Address housing needs alongside behavioral health needs | Short & Long Term |
| 4.6 Promote employment among behavioral health service users | Short & Long Term |

| RECOMMENDATION | STRATEGY TIMEFRAME |
|---|---|
| 4.7 Restore/enhance funding for Recovery Centers | Short Term |
| 4.8 Promote timely linkage to community-based services following a crisis | Short & Long Term |
| 4.9 Examine community-based alternatives to behavioral health services currently provided in long-term care facilities | Short Term |
| **5 – Enhance and streamline system of care for children and youth** | |
| 5.1 Improve coordination between education, early childhood, and service systems | Short Term |
| 5.2 Expand targeted, proactive in-home supports for at-risk families | Short Term |
| 5.3 Develop coordinated system to enhance treatment foster care capacity and cultural responsiveness | Short & Long Term |
| 5.4 Prioritize residential treatment for those with significant/complex needs | Short & Long Term |
| **6 – Continue to implement/refine criminal justice strategy** | |
| 6.1 Ensure collaboration/communication between systems | Short Term |
| 6.2 Promote behavioral health training among first-responders and others | Short & Long Term |
| 6.3 Review behavioral health treatment capacity in jails | Short Term |
| 6.4 Ensure Medicaid enrollment for individuals returning to community | Short Term |
| **7 – Engage in targeted efforts to recruit/retain competent behavioral health workforce** | |
| 7.1 Establish single entity for supporting workforce implementation | Short Term |
| 7.2 Develop single database of statewide vacancies for behavioral health positions | Short Term |
| 7.3 Provide assistance for behavioral health students working in areas of need in the state | Short & Long Term |
| 7.4 Raise awareness of student internships/rotations | Short & Long Term |
| 7.5 Conduct comprehensive review of licensure requirements/reciprocity | Short Term |
| 7.6 Continue establishing training/credentialing program for peer services | Short Term |
| 7.7 Expand credentialing programs to prevention/rehabilitation practices | Short Term |
| 7.8 Support a robust peer workforce through training, professional development, competitive wage | Short & Long Term |

| RECOMMENDATION | STRATEGY TIMEFRAME |
|---|---|
| **8 – Expand the use of telebehavioral health** | |
| 8.1 Support providers to secure necessary equipment/staff | Short Term |
| 8.2 Expand the reach of services for substance use disorders, children and youth, American Indian populations | Short & Long Term |
| 8.3 Increase types of services available | Short & Long Term |
| 8.4 Develop clear, standardized regulatory guidelines | Short Term |
| **9 – Ensure the system reflects its values of person-centeredness, cultural competence, trauma-informed approaches** | |
| 9.1 Promote shared decision-making | Long Term |
| 9.2 Promote mental health advance directives | Short & Long Term |
| 9.3 Develop statewide plan to enhance commitment to cultural competence | Short Term |
| 9.4 Identify cultural/language/service needs | Short & Long Term |
| 9.5 Ensure effective communication with individuals with limited English proficiency | Short & Long Term |
| 9.6 Implement additional training | Short & Long Term |
| 9.7 Develop/promote safe spaces for LGBTQ individuals within the behavioral health system | Short & Long Term |
| 9.8 Ensure a trauma-informed system | Short & Long Term |
| 9.9 Promote organizational self-assessments | Short & Long Term |
| **10 – Encourage and support the efforts of communities to promote high-quality services** | |
| 10.1 Establish a state-level leadership position representing persons with lived experience | Short Term |
| 10.2 Strengthen advocacy | Short & Long Term |
| 10.3 Support the development of and partnerships with peer-run organizations | Short & Long Term |
| 10.4 Support community efforts to reduce stigma, discrimination, marginalization | Short & Long Term |
| 10.5 Provide and require coordinated behavioral health training among related service systems | Long Term |
| **11 – Partner with tribal nations to increase health equity** | |
| **12 – Diversify and enhance funding for behavioral health** | |
| 12.1 Develop an organized system for identifying/responding to funding opportunities | Short Term |

| RECOMMENDATION | STRATEGY TIMEFRAME |
|---|---|
| 12.2 Pursue 1915(i) Medicaid state plan amendments | Short Term |
| 12.3 Pursue options for financing peer support and community health workers | Short Term |
| 12.4 Sustain/expand voucher funding and other flexible funds for recovery supports | Short & Long Term |
| 12.5 Enroll eligible service users in Medicaid | Short & Long Term |
| 12.6 Join in federal efforts to ensure behavioral and physical health parity | Short & Long Term |
| **13 – Conduct ongoing, system-side data-driven monitoring of needs and access** | |
| **13.1 Enhance and integrate provider data systems** | **Short Term** |
| **13.2 Develop system metrics to track progress on key goals** | **Short & Long Term** |
| **13.3 Identify and target services to those with highest service costs** | **Long Term** |