

Over the last several years, the North Dakota Federation of Families for Children's Mental Health has been alarmed about the status of children, youth, and young adults with mental health disorders and their families. Over the last decade the depths of the mental health systems crisis have become clear to North Dakotans. In hindsight, it's striking to notice that warning signs were present, and that long-standing problems affecting this population of youth would soon become exacerbated with the drastic decline in quality and quantity of mental health services and supports in the state. Some problems affecting this population were long obscured by existing data collection methods.

In 2005, the North Dakota Department of Public Instruction (DPI) felt that its drop-out rate for students with disabilities had shrunk to less than 4%. This was an astonishing accomplishment, given that a decade prior, states across the country could expect a quarter or more of their special education population to drop out of school. But in 2006 the drop-out rate increased by double digits. At first, the Department of Public Instruction believed that this was as a result of students "choosing" alternative education placements or those who aged out. Advocates were not convinced of that rationale, and in time DPI agreed. After DPI adjusted its formula to more accurately account for graduation and drop-out rates in 2010, drop-out rates rose to over 21%. Reacting to the alarming data, DPI gathered stakeholders to disaggregate the data in 2012. The stakeholders determined that "Native Americans are more likely to drop out and students with emotional disabilities are more likely to drop out than other students." It was also discovered that this population of students had some of the lowest academic outcomes in the state. These findings later propelled DPI to address this problem in the State Systemic Improvement Plan (SSIP).

In the last decade, we learned a great deal more. The North Dakota Behavioral Health Stakeholders group issued a report that discussed North Dakota's inability to recruit and retain a healthy behavioral health workforce, much of which was influenced by counterproductive administrative policies or licensing standards. In 2014 the Schulte Report concluded that the state's mental health and substance use system "is in crisis"—a self-imposed crisis caused by a lack of funding, a lack of diversified funding, as well as ineffective administrative policies. The exploding criminal justice populations were largely rooted in behavioral health service gaps. It was discovered that 2/3rds of North Dakota judges had sentenced an adult to prison to in order to

obtain behavioral health services. From 2011 to 2017, the juvenile justice population went through a dramatic demographic change. Between 13-20% of North Dakota's child population has a serious emotional disorder. In 2011, 49% of the juvenile justice population had a serious emotional disorder. Right then and there that should have rose the alarm bells. But in 2015, that figure rose to 75%. Two years later that rose once more to 79%. The Dual Status Youth Initiative Report said that the schools were the most likely referral to the juvenile justice system (at 38%). The North Dakota Youth Risk Assessment had seen a steady increase in the amount of youth who felt isolated and hopeless, and most alarmingly, the number of youth who had contemplated or planned to commit suicide. Suicide was the 2nd leading cause of death in adolescents and young adults, and the CDC found that from 1999 to 2016, North Dakota had, by far, the highest increase of suicide rates in the country. Over the last few years, "school safety" or "teacher safety" became negative code words associated with this population of youth. Seclusion and restraint use in the schools was both widespread and underreported. School districts also started to feel justified in segregating these students from their peers, pushing them into separate facilities where there were few, if any, attempts to deliver a proper education for such children.

The Mental Health Advocacy Network's "Let's Hear it from the People" survey found that professionals and families alike knew the system was in tatters. There was overwhelming agreement that consumers and families with children needing mental health services had insufficient access to or options in securing mental health services. Most consumers and families had to wait well over a month to secure any services, with over 40% waiting at least 2 to 6 plus months for services. These wait times were often occurring when consumers and families were in crisis. 49% of professionals reported that families had to relinquish custody of their children so that child could receive mental health services. 89% of families and 70% of professionals reported that children with mental health needs either had not received EPSDT or the professional or family had never heard of it.

Separated from their families, performing poorly academically, dropping out of school, placed in the juvenile justice system, it was tempting and remains tempting for some to believe that either their parents failed them or that they failed themselves. But that's not true. You are learning that just as your predecessors did in 1982 and in 1986 that it is the system that has failed these kids. In moments of economic decline and constitutional imperatives to balance the budget it is

tempting to say, as unfortunate as it is, cuts needed to be made. But as the Schulte Report warned, the state of North Dakota had legal responsibilities—responsibilities it is failing to uphold. It is likewise tempting to say that because legislative change is a hard sell, there is not much that can be done. But that’s not true either. The Schulte Report and the recently released HSRI report made that abundantly clear.

The HSRI report had 65 recommendations to provide, the Schulte Report, and the Behavioral Stakeholders Report had additional recommendations. We also have some recommendations.

- Fund peer support for children and youth with mental health needs.
- Reinstate the Children’s Coordinating Committee and the Regional Wraparound teams—with 51% parent membership in the governing structure so that we can ensure services are family-driven.
- Implement a zero-reject model for the Department of Human Services. Children and families are currently being denied services on the basis of “not being compliant.” We believe, partly, this stems from treatment plans that are not created with the family’s needs and vision at the center.
- Create an independent grievance and appeals process. The Schulte Report noted that DHS “in this role, there is no independent appeal mechanism for families or consumers. DHS is the provider, regulator, and oversight to itself. The lack of checks and balances makes a very poor business model in any field.”
- Fully implement Early Periodic Screening Diagnostic and Treatment (EPSDT) in Medicaid to comply with federal mandates providing medically necessary treatment for children with mental health needs. (Examples are PATH family support, intensive in-home, and case aides.)
- Restore the Partnership Program: Currently the Partnership program is not implemented with fidelity. We need to ensure that the children in North Dakota with a serious emotional disorder are getting into the wraparound process to prevent out of home placements.
- Seclusion and Restraint regulations: Prone restraints are deadly. Current adherence to best practices with seclusion and restraint are done on a completely voluntary basis and schools with seclusion and restraint policies are not even following through on their own

policies. Time and time again, voluntary policies have been shown to be ineffective and lack the safety of actual regulations.

- Each school district shall adopt a seclusion and restraint policy containing certain minimum standards or policy components set forth in the statute.
- The policy should include clear definitions of what is meant by seclusion and restraint, and should describe what uses of seclusion and restraint are permitted and what uses are prohibited.
- The policy should be in writing and shall ensure that any use of physical restraint or seclusion in schools does not occur, except when there is a threat of imminent danger of serious physical harm to the student or others, and occurs in a manner that protects the safety of all children and adults at school.
- No restraint or seclusion should be used in a manner that restricts a child's breathing or harms the child.
- Prone or supine restraints should be prohibited.
- Mechanical restraints should be prohibited.
- Chemical restraints should be prohibited.
- Restraint or seclusion should never be used as a punishment or discipline.
- Teachers and other school staff should be trained regularly in the use of effective alternatives to physical restraint and seclusion, such as comprehensive positive behavioral interventions and supports, to prevent and reduce instances of dangerous behaviors that may lead to the use of restraint or seclusion. They should also be trained and certified on the safe use of physical restraint and seclusion.
- Parents should be notified as soon as possible following each instance of restraint or seclusion with their child.
- Each incident of physical restraint or seclusion must be documented in writing and provide for the collection of data for the main purposes of: (1) preventing future need for the use of restraint or seclusion and, (2) creating a record for consideration when developing plans to address the student's needs and staff training needs.

- The data should be reported to the superintendent and to the Department of Public Instruction.