



North Dakota Behavioral Health System Study

Final Report
April 2018



This document was prepared for the North Dakota Department of Human Services as part of the North Dakota Comprehensive Behavioral Health Systems Analysis contract.

About the Human Services Research Institute

The Human Services Research Institute (www.hsri.org) is an independent, nonprofit research institute that helps public agencies develop effective, sustainable systems to deliver high-quality health and human services and supports in local communities. In the behavioral health space, our goal is to deliver actionable, viable, and culturally relevant strategies that empower service users and promote wellness and recovery.

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Executive Summary



Key Findings

This report presents the findings from the North Dakota Comprehensive Behavioral Health Systems Analysis, conducted by the Human Services Research Institute for the North Dakota Department of Human Services Behavioral Health Division. The main aims of the project were:

1. Conduct an in-depth review of North Dakota's behavioral health system
2. Analyze current utilization and expenditure patterns by payer source
3. Provide actionable recommendations for enhancing the comprehensiveness, integration, cost-effectiveness and recovery orientation of the behavioral health system to effectively meet the needs of the community
4. Establish strategies for implementing the recommendations produced in Aim 3.

Our work is rooted in a vision of a good and modern behavioral health system [1] that focuses on the health and wellbeing of the whole population to prevent mental health and substance use problems before they occur, identify and intervene early when behavioral health issues are present, and provide person-centered, trauma-informed, culturally responsive, and recovery-oriented services and supports to those with behavioral health–related needs. A well-functioning behavioral health system attends not only to the intensive needs of children, youth, and adults with serious mental

health conditions and substance use disorders but also to the outpatient and community-based service and support needs of individuals, and, critically, to 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.

This work is also informed by the social determinants of health, which are “the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age” [2]. Roughly 10% to 20% of health determinants—including behavioral health determinants—derive from medical care, while social, behavioral, and environmental factors account for the remaining 80% to 90% of health outcomes [3, 4, 5]. Therefore, a good and modern behavioral health system incorporates a continuum of social support services that includes employment, housing, and self-help alongside clinical treatment [6].

Prevalence of Need

Compared to national averages, North Dakota fares well on most indicators of physical and behavioral health. One exception to this is alcohol use; North Dakota ranks much higher than the national average in excessive drinking and alcohol-related motor vehicle crash deaths. Consistent with national trends, rates of illicit drug use, particularly heroin and methamphetamine, are on the rise.

At the county level, the state shows significant variability in indicators of behavioral health. These regional differences are important to keep in mind when considering the results presented throughout this report; the divergences reflect disparities in access to care, and access to culturally appropriate care, and countless individuals struggling with undiagnosed, preventable conditions who won't appear in provider or medical claims data. These obstacles are compounded by the typical barriers to accessing care for behavioral health issues, including misperceptions and stigma, retraumatization, and fears of criminal justice and child welfare system involvement.

Services Reach and Gaps

Using various quantitative and qualitative data sources, we examined the service provision across the categories that constitute an optimal behavioral health service 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. An overarching theme that emerged in our analysis is that North Dakota's behavioral health system—like many others throughout the country—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. While some residential and inpatient services are needed to meet the needs of the community, over-relying on these services is problematic for many reasons, which are discussed throughout the report. Chiefly, these arrangements are inefficient from a cost perspective and undesirable from a population health perspective. Our recommendations focus on ways the state might strategically examine utilization

patterns and need for services to ensure people receive the right level of care at the right time. Such strategies will allow the state to 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.

Community Awareness and Education

Stakeholders identified a need for public education to combat misperceptions and stereotypes regarding mental health and substance use disorders so that members of the public understand that these disorders impact many Americans, and that those with behavioral health conditions can participate meaningfully in society. Several state and local initiatives to raise awareness of substance use issues are currently underway. Notably, these initiatives have focused more on substance use awareness than on mental health promotion. Stakeholders expressed a need for helping communities, service users, and families to understand mental health and trauma in addition to substance use issues.

Prevention and Early Intervention

Compared to funding for treatment services, there's a relative scarcity of funds for early intervention and prevention work—which many stakeholders viewed as a missed opportunity. A lack of payment options makes it difficult for providers to plan and deliver prevention services. Most of the current prevention activities in North Dakota are focused on substance use prevention, with fewer initiatives promoting social and emotional wellness and mental health-specific prevention strategies. While stakeholders saw current suicide prevention efforts as important, they also identified areas that could expand these activities. In general, stakeholders saw a need for increasing prevention activities across the board and for educating legislators and the public about the return on investment for these strategies.

In terms of early intervention, there have been significant gains in improving the capacity for the system to meet the needs of individuals experiencing a first episode of psychosis. Prairie St. John's operates a first-episode psychosis program based on an early intervention model that has been shown to enable more effective functioning and reduce the severity of disability across the lifespan in individuals experiencing early psychosis. However, stakeholders noted some impediments to expanding the program to other areas of the state; these included a lack of a sustainable funding outside of SAMHSA's mental health block grant and workforce shortages of providers trained to provide wraparound services to individuals experiencing early psychosis. There have also been gains in improving access to services for pregnant women with substance use disorders and substance-exposed newborns.

Outpatient Treatment

Initiatives. The DHS Division of Field Services is leading a range of initiatives to expand outpatient treatment. These include a transition to an Open Access model and an effort to expand the array of evidence-based outpatient and community-based service offerings, including Assertive Community Treatment (ACT), Wraparound Case Management, and other psychosocial rehabilitation practices. Approximately three of

four (73.4%) individuals who received information and referral services at HSCs during the study period received some type of HSC service, suggesting that information and referral events usually result in some kind of connection to services. However, we noted significant regional variation in the proportions of individuals receiving outpatient services—ranging from 70 people per 1,000 in one region to 28 per 1,000 in another.

Screening. Nationwide, screening for mental health and substance use issues have been proven to be a critical step toward population health and toward identifying and eliminating disparities in access to treatment. Although there are multiple promising screening initiatives taking place across the state, there is currently no screening process focusing specifically on behavioral health or trauma that is widely used throughout the health and social service sectors. Generally, stakeholders noted that the state should continue to improve its capacity to conduct screenings and provide appropriate referrals to services.

Integrated care. The benefits of integrated physical and behavioral health care are well-established. Based on our analysis of the data, integrated physical and behavioral health services in North Dakota are still in the early stages of development. Stakeholders with expertise in integration with whom we spoke noted that, at present, there are limited incentives to deliver behavioral health services in primary care settings, and minimal collaboration between behavioral and physical health stakeholders to move toward systems integration. Stakeholders also identified unique benefits and challenges for rural clinics.

Services for children and youth. A common theme in stakeholder interviews was a need for a more comprehensive continuum of outpatient services for children and youth. Stakeholders noted that child and youth services are often “swallowed up” by a systems emphasis on adult services. Stakeholders discussed a lack of infrastructure and coordination to support early childhood mental health for very young children. They also noted the importance of the availability of mental health services in schools and saw school-based services as a system gap. Based on available claims data, only 5% of all services of any type for persons under age 18 were delivered in a school-based setting, and 0.1% of youth substance use disorder treatment services were delivered in school settings during FY 2017. Notably though, penetration rates for mental health outpatient treatment services for children and youth increased across the study period. In another positive development, a greater proportion of children and youth outpatient services are financed through Medicaid relative to HSC-funded services.

Stakeholders noted that because of significant shortages of licensed addiction counselors—there are only two licensed addiction counselors who treat children in the Southwest region of the state, for example—individuals’ and families’ only option to access substance use disorder treatment is through a residential facility. In general, stakeholders expressed concern that the state has an overreliance on residential substance use treatment services for children and youth, missing opportunities to

intervene early in the community and address substance use problems before they rise to a level of severity that warrants life-disrupting residential treatment.

Substance use disorder treatment for adults. In North Dakota and around the United States, the numbers of individuals accessing treatment for a substance use disorder is far lower than those who have a diagnosed (or diagnosable) substance use problem. A common theme in stakeholder interviews was related to a lack of substance use disorder treatment across the state, and particularly in rural areas. The expansion of medication-assisted treatment (MAT) in North Dakota is very promising, though stakeholders indicated that more access to these services is needed and that low-income individuals face significant barriers to affording MAT services, many of which are self-pay.

Stakeholders also described a need for services such as sober living environments that serve as a step-down to smooth the transition from inpatient and residential services to community living for people with substance use disorders. Currently, many individuals simply return to the environments they were in before treatment, which frequently results in relapse and a “revolving door” dynamic. The 2017 DHS budget included a significant increase in substance use disorder voucher funding, which will fill some—but not all—of the gaps we identified in this study. Further work is needed to remove barriers to access, particularly related to financing these services and enhancing the substance use disorder treatment workforce.

Community-Based Services

Previous needs assessments in the state have identified gaps in community-based services, particularly those that address the housing, employment, and transportation needs of people who use publicly funded behavioral health services [11, 12, 14]. Stakeholders similarly noted that the current behavioral health system is primarily crisis-oriented and pays inadequate attention to rehabilitative and community-based services. Notably, however, current leadership at DHS appears to be committed to reversing this dynamic and recognizes the critical importance of supporting the social determinants of health through rehabilitative, community-based services.

Children, Youth, and Families. North Dakota offers a range of services to support coordination of services for children and youth, with a particular emphasis on services that support children and youth in foster care or at risk of foster care placement. Although existing services appear to meet critical community needs, a common theme in stakeholder interviews was that current levels do not meet community demand. In addition, multiple stakeholders described a need for accessible family support and stabilization services in North Dakota. Stakeholders cited a lack of transparency around the process of service delivery and approval that made it difficult for families to understand and navigate the behavioral health system.

Case management. In our analysis, we found significant regional variation in adult case management utilization, which was supported by stakeholder observations about regional variation in how these services are organized and delivered in HSCs. Individuals with complex needs face additional challenges accessing case

management; this includes individuals with co-occurring mental health and substance use problems, and brain injury, as well as justice-involved individuals and those experiencing homelessness. Several were concerned about attitudinal barriers to working with people with complex needs, describing a culture in which individuals seeking services must prove they are “motivated” as a precondition for receiving support.

Individuals with brain injury—and particularly those with co-morbid mental health and substance use disorders—face barriers to accessing comprehensive services, particularly comprehensive wraparound case management and independent living/skills training. Behavioral health services designed to support individuals with a brain injury are few, disparate, and disjointed, and although some resources for persons with brain injury are available in the state, there is no single service system that focuses on the needs of people with brain injury.

Stakeholders said the quality of case management is unknown, that fidelity is not assessed, and that the extent to which case management services foster recovery and independence is unclear. Our findings indicate a need to reevaluate and restructure case management services in North Dakota and to incorporate additional rehabilitation-focused evidence-based and promising practices to behavioral health service coordination to meet the diverse needs of North Dakotans. These include more flexible team-based approaches for those with complex needs and alternative models of service navigation and self-management support delivered by peer specialist and community health representatives.

Peer support. Peer support services are delivered by individuals with personal experience as service users of behavioral health services. Peer support services are theorized to help service users to develop self-advocacy skills and build confidence to pursue their goals through establishing trust and rapport built on shared experiences. Several initiatives are underway to expand peer support services, particularly for adults with mental health and substance use issues. Given the growing evidence base for the effectiveness of peer support services—both in terms of quality of life and outcomes for individuals and in terms of cost savings to counties and states due to reductions in rates of hospitalization—these efforts have the potential to make significant improvements to the system. Critically, peer services must be delivered according to national practice standards in a manner that maintains the integrity of peer support [7]. This will require significant support for the peer workforce as well as education for providers to promote culture change and challenge misperceptions about the role of peers in clinical treatment settings.

Employment support and community engagement. In addition to expanding peer support, we documented a need for increased attention to supporting community engagement and independence for behavioral health services users. Although over 40% of working-age adults who receive publicly funded outpatient mental health services are unemployed, evidence-based employment support programs are limited. Similarly, Recovery Centers, which meet a key community need to decrease social isolation and connect individuals to community resources, are

inadequately funded. Although there are some mutual support and self-help groups throughout the state, stakeholders noted that these resources are not always well-known. Similarly, we observed relatively few community-based self-help organizations, particularly those that are operated and managed by people with lived experience of the behavioral health system. Peer-run organizations can serve as valuable community resources, providing a range of supports, education, and advocacy aimed at improving quality of life for people with lived experience of behavioral health challenges.

Housing. Nearly all stakeholders indicated that unstable housing and homelessness has a negative impact on behavioral health outcomes as well as access to appropriate treatment for many North Dakotans. They indicated that a lack of affordable housing is one of the major barriers that people with behavioral health issues in North Dakota encounter, and a major contributor to homelessness across the state. The second important aspect of housing and behavioral health is a lack of supportive services geared toward helping individuals with behavioral health issues maintain stable housing in the community. As several key informants noted, for many individuals, supportive wraparound services are needed alongside housing to ensure that housing placements can be maintained over time. We identified several major initiatives to develop affordable housing units and increase sustained access to those units, particularly for individuals with complex behavioral health needs. These include expansion of permanent supportive housing in Fargo, Bismarck, and Grand Forks and the Landlord Risk Mitigation Fund (LRMF) in Minot and Fargo, among others.

Harm Reduction. Harm reduction approaches are increasingly recognized as key components of good and modern behavioral health systems. Through reducing the harm associated with problematic substance use, these strategies reduce unnecessary illness and death. In recent years, North Dakota has increased the use of evidence-based harm reduction strategies including naloxone and syringe services.

Community health workers. Stakeholders with experience working with American Indian populations noted that community health representatives (also known as community health workers) were working effectively with individuals—including individuals with behavioral health needs—in several of the tribal nations in the state. Community health workers are playing increasingly prominent roles in health delivery systems throughout the country [8]. One key benefit is that community health workers often have preexisting relationships with community members, which facilitates connection and engagement. Stakeholders saw a need for this service to be expanded statewide and described ongoing initiatives to pursue sustainable funding, including Medicaid reimbursement.

Residential Treatment and Treatment Foster Care

Per capita costs for residential services are among the highest of all service types. While many stakeholders voiced a need for additional residential services across the board (mental health and substance use services for children, youth, and adults), others noted that it is difficult to assess the need for such services when the current community-based service array is insufficient. Several stakeholders saw the

challenges in the residential treatment systems as being inextricably related to shortages in the community-based system, including prevention, outreach, and in-home and community-based treatment and support services. They suggested missed opportunities for diverting relatively lower-need populations from the system entirely, which would create more capacity for those with higher needs. These stakeholders noted that rather than pursuing additional residential capacity, it is essential to address gaps in the community-based service continuum that would address needs before they rise to levels requiring residential or inpatient treatment. Based on our experience and on the literature on best practice in behavioral health system design, we agree with this assessment of residential service need.

Residential treatment for children and youth. Regarding residential treatment for children and youth, stakeholders described a “double bottleneck” in the system—with some children and youth underserved while others are receiving services at a higher level than is needed. Multiple stakeholders expressed concern that some residential treatment facilities “cherry pick” individuals with lower levels of need and are reluctant to take children and youth who have challenging behavior. In general, it appears to be incredibly difficult to find an appropriate placement for children and youth in the state, particularly those youth with the most complex needs. This results in poorer outcomes and greater difficulty reunifying children and youth with their parents. It also results in an inefficient system, with some children receiving a higher level of care than needed and others with high needs receiving no care at all.

Treatment foster care. While treatment foster care is typically considered part of the child welfare system and residential treatment is considered part of the behavioral health system, stakeholders we spoke with described the systems’ populations and services as highly interrelated and overlapping given the high prevalence of behavioral health treatment needs among children and youth involved in child welfare systems. Many of the parents in child welfare-involved families are struggling with behavioral health issues, with cascading effects. Children and youth in North Dakota’s foster care system are exposed to very high levels of trauma, as indicated by Adverse Childhood Event (ACE) data collected by PATH ND. Stakeholders described a cycle in which children are placed in treatment foster care services, only to be returned to a family environment where there are significant unmet behavioral health needs among parents and caregivers, which eventually results in being cycled back into the residential treatment and/or the child welfare system.

Crisis, Inpatient, and Long-Term Care Services

Stakeholders we interviewed saw a need for support services such as peer-run warmlines that can be accessed before a crisis and indicated that having access to these supports could avert the need for life-disrupting and costly emergency and crisis services. Stakeholders also made it clear that first responders—police, fire, and medical—are frequently the front line of response for behavioral health crises in North Dakota. Stakeholders emphasized a need to support first responders to divert individuals with behavioral health needs to treatment rather than bringing them to

jail through increased use of evidence-based strategies like Crisis Intervention Team (CIT) training.

Although crisis response services have long been recognized as an area of need, the lack of these services in North Dakota remains a challenge. Many stakeholders noted the lack of options available to individuals when they are experiencing crisis, particularly outside of the Fargo area. Stakeholders noted that crisis services for children and youth are particularly lacking, and over a quarter of those who visited an emergency room for a behavioral health issue during the study period were under age 18. We observed regional variation in the use of crisis and emergency services. Emergency department utilization per 1,000 is particularly high in the Lake Region; it's lower in the Southeast, where mobile crisis services are available.

In regard to inpatient services, we observed rates that have remained stable over the study period. Despite some stakeholder impressions of a shortage of beds, North Dakota's current inpatient psychiatric capacity is approaching close to twice the US average of 23.6 beds per 100,000 population. Stakeholders described a common challenge of individuals receiving inpatient treatment and then being discharged to the community with inadequate outpatient and community-based supports, evincing a need for more services to support community transitions.

In our analysis, we found that many individuals with behavioral health needs are receiving care in long-term care facilities, a majority of which are specifically designed to meet the needs of older adults. Behavioral health services delivered in long-term care facilities accounted for the largest proportion of costs for a single service in this study; in FY 2017, 16% of all public behavioral health service dollars went to behavioral health services delivered in long-term care facilities, with a per capita cost of \$12,713. Further, approximately 24% of individuals who received a behavioral health service in a long-term care facility in FY 2017 were under age 65, suggesting a need for further review.

Services for Justice-Involved Populations

Several data sources indicated a very high prevalence of behavioral health issues in the state's criminal justice systems for both adults and youth in North Dakota, which is consistent with national trends. We also observed a great amount of energy and attention in the state to improving the system's capacity to meet the needs of justice-involved individuals with behavioral health needs, particularly within the DOCR and the Department of Juvenile Services. For example, multiple state entities are collaborating on a Dual Status Youth Initiative to improve policies and practice related to youth involved in the justice and child welfare systems.

A common theme in stakeholder interviews was that, in many cases, judges are sentencing individuals with behavioral health conditions for low-level crimes to provide them access to treatment they would be unable to access in their communities. Many stakeholders stressed that individuals with justice involvement experience multiple barriers to accessing services. A common theme was that, in general, community-based treatment providers are resistant to serving individuals

with criminal justice histories. Stakeholders said that the need for community-based services is high among the re-entry population, although the newly implemented Free Through Recovery program and other initiatives are expected to expand capacity.

Additional System Challenges and Strengths

In addition to service gaps, we identified a number of challenges facing the North Dakota behavioral health system related to coordination and collaboration, data systems, workforce issues, telebehavioral health services, and population-specific issues.

Almost universally, stakeholders described good-quality relationships between government entities. However, these same stakeholders identified systems siloing as a challenge for ensuring a coordinated behavioral health system. When asked about the quality and type of interdepartmental collaboration, a common stakeholder response was that they have a lot of meetings together, but that translating talk to action once the meeting adjourns is a challenge.

Stakeholders saw a need to harmonize data across services and systems and to ensure that data that are collected are analyzed and used to inform system design and development. Ideally, process and outcome information are collected to inform system improvement efforts in an ongoing manner.

Multiple stakeholders described challenges finding and retaining a qualified behavioral health workforce throughout the system. Issues with certification and licensing, as well as staffing and retention, were frequently raised as key barriers to ensuring a well-qualified workforce.

Telemedicine is a nationally recognized approach to increasing access to care, including behavioral health care. Many stakeholders described innovative approaches to telebehavioral health and endorsed them as opening up access to rural regions of the state that were previously underserved. Telebehavioral health approaches have steadily increased in North Dakota, both in services delivered through HSCs and in other settings that receive Medicaid reimbursement. In SFY 2013, fewer than one person per 1,000 population received at least one telebehavioral health service; in SFY 2017, the penetration rate was four times higher: 4.1 individuals per 1,000 population.

In our interviews, we learned that the DHS and organizations in North Dakota have a strong commitment to values of person-centeredness, cultural competency, and trauma-informed approaches—principles that should be at the heart of any effort to coordinate and improve behavioral health services. Individuals who receive services, however, are not yet necessarily experiencing the system as reflecting these values. Our findings point to opportunities for better engaging service users and their family members as active participants in their care. We also documented significant disparities in this study, particularly for American Indian populations, LGBTQ individuals, and New Americans.

We documented significant differences in service utilization among key population groups, particularly among American Indian populations in the state. American Indian populations are overrepresented in HSC service settings and the Medicaid data—and also in child welfare and criminal justice settings—compared to census estimates. This speaks to a need for more culturally appropriate services—a finding that was backed by members of the Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians, and Mandan Hidatsa Arikara Nation who participated in a Talking Circle and stakeholder interviews for this study. A number of our recommendations center on the need for such services and the need for a greater proportion of American Indians within the behavioral health workforce and in behavioral health leadership positions. We also documented a need for stronger partnerships within and between the tribal nations, the Indian Health Service, and the state and counties to identify shared goals, fill knowledge gaps, share information resources, and coordinate action.

Other racial and ethnic minorities—particularly New Americans, many of whom are refugees—comprise a growing proportion of North Dakota’s population, and these groups have their own specific behavioral health-related strengths and challenges. Stakeholders described a range of barriers to accessing appropriate and culturally responsive behavioral health services for New Americans, who they saw as an underserved population. We also documented that LGBTQ youth and adults face barriers to behavioral health treatment that include provider stigma and discrimination and a lack of culturally sensitive services.

Recommendations

HSRI applauds the tireless efforts of North Dakota’s behavioral health stakeholders to prevent and treat behavioral health challenges and promote social and emotional wellbeing across the population. Drawing from the state’s unique strengths and assets as well as the needs identified through this study, these recommendations are intended to serve as a roadmap for improvement efforts. This set of recommendations is intentionally broad and far-reaching; we do not expect, nor do we suggest, that stakeholders in North Dakota will endeavor to implement all of these recommendations at once. Rather, our purpose is to present a range of possible options that stakeholders—including legislators, other public officials, provider organizations and the public—may consider in addressing the challenges, filling the gaps, and improving the system of behavioral health care for North Dakotans in the years to come.

The table on the following pages presents a summary of recommendations based on key informant interviews and analysis of qualitative and quantitative data.

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 education and employment among behavioral health service users	Short & Long Term
4.7 Restore/enhance funding for Recovery Centers	Short Term

RECOMMENDATION	STRATEGY TIMEFRAME
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
8 – Expand the use of telebehavioral health	
8.1 Support providers to secure necessary equipment/staff	Short Term

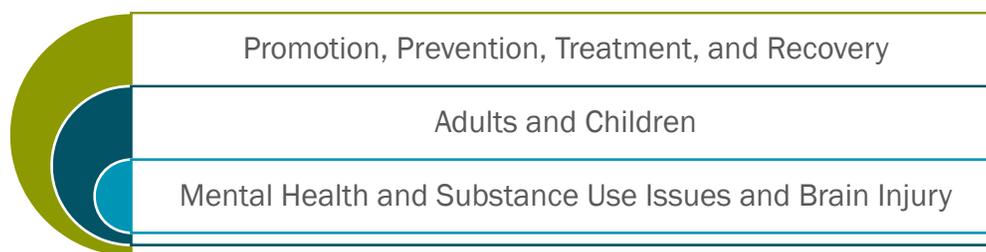
RECOMMENDATION	STRATEGY TIMEFRAME
8.2 Expand the reach of services for substance use disorders, children and youth, American Indian populations	Short & Long Term
8.3 Increase types of services available	Short & Long Term
8.4 Develop clear, standardized regulatory guidelines	Short Term
9 – Ensure the 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
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

RECOMMENDATION	STRATEGY TIMEFRAME
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

Approach

This study’s scope is intentionally broad and is designed to aid the North Dakota Department of Human Services in gaining a better understanding of the system—or systems—that promote the social and emotional well-being of all North Dakotans. Therefore, the study covers social and emotional wellness promotion, prevention, treatment, and recovery supports for individuals across the lifespan, regardless of whether there is a primary mental health or substance use disorder diagnosis (Figure 1). Individuals with brain injury who have behavioral health-related needs are also included in the scope of this study.

Figure 1
North Dakota Behavioral Health Study Scope



We believe this scope is appropriate because each of the dimensions depicted in Figure 1 are interrelated, and decisions regarding one aspect of the system are likely to impact others. For example, focusing on early intervention for young people experiencing psychosis for the first time will have long-lasting repercussions for their involvement in the adult treatment system.

Unaddressed behavioral health problems impact not just the individual, but the whole community. Our scope allows for an examination of the behavioral health system to employ a multi-pronged approach that encompasses:

- Primary prevention to reduce the incidence of behavioral health needs across the population
- Targeted prevention for those at risk of developing behavioral health issues
- Identification and early intervention for behavioral health problems
- Recovery-oriented, trauma-informed, and person-centered services and supports for those with identified behavioral health problems

Beginning in the spring of 2017, a team from HSRI began gathering data from a variety of sources, depicted in Figure 2. Each of these sources and the methodologies for data gathering and analysis are described in detail in the “Background and Approach” section of this report, and a list of key informants and partners can be found in Appendix A. This report is a result of a synthesis of data from these multiple sources. It presents a blend of quantitative and qualitative information to provide as comprehensive a picture as possible of the treatment and prevention needs, resources, utilization, and gaps in North Dakota.

To the extent possible, we corroborated information gained from stakeholder interviews with other types of data to determine accuracy and completeness of this qualitative data.

Figure 2

Behavioral Health Systems Analysis Data Sources



Notes About Language

In this report, behavioral health refers to both mental health and substance use–related issues. Those who receive services are typically referred to as “service users.” Those stakeholders who participated in stakeholder interviews as part of the study are referred to as “stakeholder interviewees.” Other individuals who gave informal feedback are referred to as stakeholders. The term “peer” is used to refer to individuals with personal lived experience with mental health or substance use issues who use their lived experience as part of their work providing peer support.

Findings



In recent years, stakeholders in North Dakota have increasingly called for improvements in the State’s behavioral health system, citing unmet treatment needs and insufficient investments in prevention [9, 10, 11, 12, 13, 14]. These challenges are not unique to the State. The lived experience of people with serious mental health conditions and substance use disorders is characterized by lower rates of employment and education [15, 16, 17] and a lower quality of life [18] than the general population. Additionally, people with significant behavioral health needs have a higher incidence of preventable medical conditions [19, 20]. In fact, people receiving publicly funded behavioral health services die an average of 25 years earlier than the general population [21]. At least 7% of the population with serious mental illness are in prison or jail each year, and adults with psychiatric disorders are at substantially increased risk for reincarceration compared to individuals with no history of psychiatric disorders [22].

Mental health and substance use disorders are highly disabling, ranking #1 in years lost to disability worldwide [23]. Not counting losses associated with incarceration, homelessness, co-morbid medical conditions, and early mortality, the economic burden of serious mental illness in the form of lost earnings, healthcare expenditures, and public assistance amounts to \$317.6 billion per year, which is approximately \$1,000 per person nationwide [24].

Across the nation, an estimated 32.7% of people receive minimally adequate treatment for behavioral health disorders. Levels of unmet service needs are higher among more disadvantaged sub-groups, including older adults, racial and ethnic minorities, people with lower socioeconomic status, and individuals living in rural areas [25, 26]. There is a clear “quality chasm” for services and supports for behavioral health disorders, as documented by the Institute of Medicine. Those who do receive care experience a fragmented service system, with separate silos delivering mental health, substance use, general health, and social welfare services [27]. Furthermore, health and behavioral health systems allocate the lion’s share of their resources to treatment with relatively few investments in prevention activities that promote social and emotional wellbeing, address the root causes of behavioral health problems, and prevent them from occurring in the first place [28]. A failure to make upfront investments in proven prevention strategies results in missed opportunities to promote population wellbeing.

Behavioral Health Needs in North Dakota

The following section describes known prevalence of mental health and substance use disorders in North Dakota and presents additional indicators of behavioral health for the state’s population. When examining prevalence of behavioral health conditions, it is important to keep in mind that, for most people, behavioral health issues are not static.

There are multiple ways of understanding the prevalence of behavioral health related-needs in a community. Understanding rates of diagnosable conditions is a starting point, but it is also important to examine factors that put individuals at risk for developing disorders in the future. A comprehensive behavioral health system attends not only to the intensive needs of

An Optimal System

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
- Identify and intervene early when behavioral health issues are present
- Provide person-centered, trauma-informed, and recovery-oriented services and supports to those with identified behavioral health-related needs.

When focusing on population health, rates of diagnosed conditions among the population provide an important starting point but do not capture the complete picture. The proportions of the population without a diagnosis can include:

- Individuals with undiagnosed behavioral health challenges, including those from hard-to-reach populations.
- Adults and children at risk of developing behavioral health conditions for whom low-cost, proactive prevention strategies could avert the need for behavioral health services

those with serious mental health conditions and substance use disorders but also to the sub-acute needs of individuals who carry other behavioral health diagnoses and, critically, to the social and emotional well-being of the majority of the population who have not been diagnosed with a behavioral health condition, including children and young adults. This section explores prevalence of mental health disorders, rates of substance use and substance use disorders, and additional community indicators of behavioral health need.

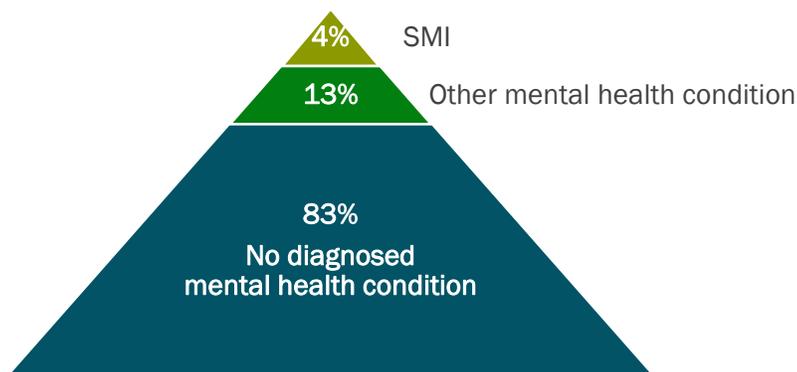
The general population figures presented in this section are based on the 2016 census estimates of the resident population [29].

Prevalence of Mental Health Conditions

In 2016, an estimated 17% of adults aged 18 and older (about 99,199 people) in North Dakota met the criteria for any mental illness in the past year. This is less than the national annual average (18.3%) [30]. A total of 4.0% of North Dakota adults aged 18 or over (about 23,454 people) in 2016 had a serious mental illness (SMI) in the past year; this figure is similar to the corresponding national annual average percentage (4.1%). The remaining 83% who have not received a diagnosis are nonetheless an important population for consideration—both in this report and in any efforts to improve North Dakota’s behavioral health system—as this population includes young adults who may have behavioral health needs in the future, individuals from hard-to-reach populations who may be struggling with undiagnosed behavioral health challenges, and others for whom low-cost, proactive prevention strategies could prevent mental health conditions from occurring.

Figure 3

The estimated **83% of adults in North Dakota with no diagnosed mental health condition** includes, among others, individuals with undiagnosed mental health challenges and individuals who could benefit from primary prevention and early intervention strategies.



Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016, and U.S. Census Bureau, Population Division Release Date: June 2017.

Among children and youth, prevalence of mental health conditions is similar to national estimates. An estimated 12% to 25% of North Dakotan students have an emotional or behavioral disorder [31].¹ In 2016, the annual average proportion of North Dakotan adolescents aged 12 to 17 with a major depressive episode² in the past year was 11%, slightly lower than the corresponding national annual average percentage of 12.8% [30].

Prevalence of Substance Use Issues

This section provides a general overview of substance use-related needs in North Dakota. However, far more extensive data can be found on the Substance Use North Dakota (SUND) website,³ produced by the North Dakota State Epidemiological Outcomes Workgroup (SEOW). SEOWs are groups of data experts and prevention stakeholders responsible for bringing data on substance use and related behavioral problems to the forefront of the prevention planning process. The mission of the North Dakota SEOW is to identify, analyze and communicate key substance use and related behavioral health data to guide programs, policies and practices. ND's SEOW has built a broad representation of diverse partners and continues to provide leadership in identifying data needs. The SUND site contains detailed data on substance use and its consequences in a searchable format.

The national averages for substance use presented in this section are from the 2016 National Survey on Drug Use and Health [32].

In 2016, 9% of North Dakotan adults aged 18 and older (about 52,247 people) had a substance use disorder⁴ in the past year, which is slightly higher than the annual national average of 7.8%. Several data points suggest that alcohol use is a significant problem in the state; 34% of adults in North Dakota reported binge drinking⁵ alcohol in the past month in 2016, well above the annual national average of 27%. In fact, North Dakota ranked second-highest in the nation in the percentage of adults who reported excessive drinking which includes binge drinking or chronic drinking in

¹ Definition of emotional disorder (ED) (34 CFR 300.8(4)(i)): A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: A) An inability to learn that cannot be explained by intellectual, sensory, or health factors; B) An inability to build or maintain satisfactory interpersonal relationships with peers and teacher; C) Inappropriate types of behavior or feelings under normal circumstances; D) A general, pervasive mood of unhappiness or depression; E) A tendency to develop physical symptoms or fears associated with personal or school problems.

² Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

³ <https://sund.nd.gov>

⁴ Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

⁵ Binge drinking is defined as drinking 5 or more drinks (for males) or 4 or more drinks (for females) on the same occasion (at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. In 2015, the definition for females changed from 5 to 4 drinks.

2016.⁶ In 2017, the percentage of motor vehicle crash deaths which had alcohol-involvement in North Dakota was 47%, much higher than the national percentage of 30.0% [33].

Data suggests that illicit drugs are an increasingly significant issue in the state. The 2016 Comprehensive Status and Trends Report by the Attorney General [34] reported that from 2012 to 2015, adult heroin use in North Dakota increased from 1% to 6%, and adult methamphetamine use nearly doubled from 21% to 39%. The increase in use was mirrored in the criminal justice system where heroin violations increased from 4 in 2010 to 177 in 2015, and methamphetamine violations grew from 246 in 2010 to 1,633 in 2015. From 2011 to 2015, the number of individuals with drug and alcohol offenses and the number of drug offenders under supervision by parole and probation doubled (334 to 779 and 1,306 to 2,507, respectively). Also, the number of drug cases involving heroin that were submitted to the State Crime Laboratory increased by more than 400%. According to the Centers for Disease Control (CDC), the number of drug overdose deaths in North Dakota has steadily increased in recent years—from 20 in 2013, to 43 in 2014, to 61 in 2015, to 77 in 2016 [35].

Additional Indicators of Behavioral Health Needs

Other individual- and community-level indicators provide a more detailed picture of behavioral health needs in North Dakota. These include factors that impact people's physical health, employment, housing, and quality of life as well as rates of suicide and violent crime.

A growing body of literature documents the importance of social determinants of health [36] and mental health [37], pointing to a complex relationship between the health of communities and of individuals. Factors that are likely to have a bearing on behavioral health include physical wellness, access to physical and behavioral healthcare, educational attainment, and socioeconomic status. Table 1, on the following page, depicts key health indicators identified by the Robert Wood Johnson Foundation in 2017 for the United States and North Dakota,⁷ including the minimum and maximum values by county within the state.

When comparing state and national indicators, North Dakota's median health outcomes are generally similar to or more positive than national figures. However, an examination of the minimum and maximum values by county demonstrate that there is significant variability in health factors by region across the state.

Suicide, a significant health issue nationwide, is a serious concern in North Dakota. In 2016, 134 North Dakotans died by suicide, which was the ninth leading cause of death

⁶ Chronic drinking is defined as having 8 or more drinks per week for women, or 15 or more drinks per week for men.

⁷ The Robert Wood Johnson Foundation County Health Rankings are based on a model of population health that highlights health factors and outcomes that influence the overall well-being of communities across the nation. County-level measures from an array of national and state data sources are standardized then combined using weights. Counties are then ranked based on these measures within states. <http://www.countyhealthrankings.org>

in the state that year [38]. Suicide is the second leading cause of death in the state for those between the ages of 15 and 24 [39]. The annual average percentage of North Dakotan adults aged 18 or older with serious thoughts of suicide in the past year was 4%, similar to national annual average, and 16% of North Dakota's high school youth considered attempting suicide in the past year, which is slightly lower than the national average of 18%. Rates of suicide among veterans and military service have risen higher than the rates of suicide among the general population in recent years. Since 2001, more North Dakota National Guard members have died by suicide than in combat [40]. American Indian populations and members of LGBTQ communities also experience far higher rates of suicide than the general population due to a number of risk factors [41].

In terms of overall health rankings, North Dakota saw the largest rank decline compared to all other states in the 2017 *America's Health Rankings*—falling seven places to the number 18 in the country—driven by increases in adult smoking and adult obesity, a high occupational fatality rate, and low immunization coverage among children [42]. In 2017, North Dakota ranked number 49 in occupational fatalities with 9.5 per 100,000 workers compared to the national rate of 4.3 per 100,000 workers [42].

Table 1

North Dakota fares well as a state in terms of health indicators but shows significant variability at the county level

Outcome	National Median	ND State Median	ND County Minimum	ND County Maximum
Premature Death per 100,000 population, age-adjusted	7,700	6,660	4,440	28,100
Poor or Fair Health % of adults reporting poor or fair health	16%	13%	11%	30%
Poor Mental Health Days average # reported in last 30 days	3.8	3.3	2.6	4.8
Preventable Hospital Stays per 1,000 Medicare enrollees	56	46	31	136
Adult Obesity % of adults with body mass index \geq 30	31%	31%	27%	41%
Physical Inactivity % of adults age 20 and over reporting no leisure time physical activity	26%	23%	19%	34%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	294.8	477.1	89.9	2,776.5
Teen Births per 100,000 female population ages 15-19	38	27	16	96
High School Graduation % of ninth graders that graduate in 4 years	88%	85%	71%	96%
College Attendance % of adults aged 25-44 with some post-secondary education	57%	73%	48%	81%
Unemployment % of population aged 16 and older unemployed but seeking work	5.3%	2.7%	1.8%	10.1%
Children in Poverty % of children under age 18 in poverty	22%	12%	7%	45%
Children in Single Parent Households % of children that live in a household headed by a single parent	32%	27%	9%	65%
Social Associations Number of membership associations per 10,000 population	12.6	16.2	4.5	60.4

Source: Robert Wood Johnson Foundation County Health Rankings, 2017

Available Resources, Capacity, Utilization, and Gaps

Information regarding available resources, capacity, and utilization was gathered from multiple data sources, including Medicaid claims and service utilization data, HSC service utilization and contract data, existing reports, other data provided by stakeholders, and stakeholder interviews. This section is organized by service/prevention activity category and includes 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 (Figure 4)—reflecting national best practices for a comprehensive behavioral health service array [43, 44].

Figure 4

A comprehensive behavioral health service array spans numerous program types and agencies to provide the right mix of services at the right time.



This section is not meant to be an exhaustive catalog of all resources in the state. Rather, we seek to provide a general sense of available resources and highlight the use of evidence-based and promising practices [45].⁸ In conducting this study, the HSRI research team made every effort to verify the information presented here, and the team corroborated information using multiple sources when possible. We have been impressed by the richness and breadth of the ongoing work of stakeholders throughout North Dakota to enhance and improve the behavioral health system, and this section represents our best effort to characterize this work.

Much of the data presented in this section draws on two datasets: HSC service utilization data and Medicaid claims data. Both datasets span state fiscal years 2013 to 2017, from July 1, 2012 to June 30, 2017. The HSC data include all service events delivered during that period. The HSC data also contain information on place of service, costs, and demographics. Because this study focuses on behavioral health services, we removed 4,837 individuals who received HSC services only for an intellectual or developmental disability (individuals who received both behavioral health and DD services were retained in this sample). It is important to note that the HSC data contain uninsured persons and persons with a mix of insurance types, including Medicaid. Because of this, some persons appeared in both data sources; a

⁸ The Institute of Medicine defines evidence-based practices as the integration of best-researched evidence and clinical expertise with the values of service users. Promising practices are defined as interventions that are less thoroughly documented than evidence-based practices but are promising based on preliminary data and local context.

point that was taken into account during analysis. For more detail on the two data sources and our methodology, see Data Sources and Methods in the “Background and Approach” section of this report.

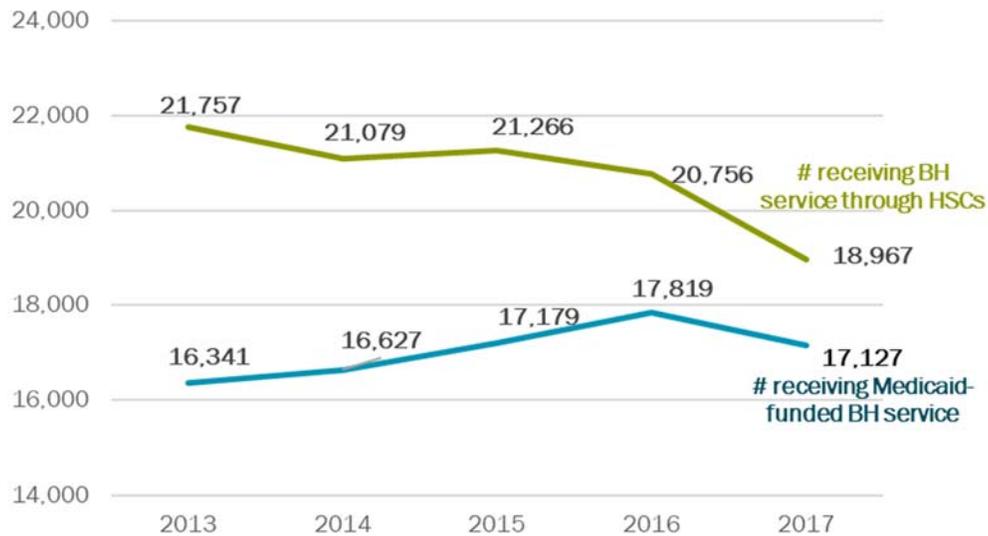
The Medicaid claims data presented in this report include all behavioral health-related service claims for the 39,845 individuals who received a Medicaid-funded behavioral health service during the study period.

Figure 5 describes the numbers of individuals who received any behavioral health services through the HSCs and the numbers who received any Medicaid-funded behavioral health service during the study period.

Over the five-year period, 51,539 people received at least one behavioral health service at an HSC. This number likely under-represents the total number of individuals who receive publicly funded behavioral health services as it does not include those who received behavioral health services only through an HSC-contracted provider during the period. There has been a small reduction in the total numbers of individuals with behavioral health issues who were served at HSCs over the five-year study period; in FY 2017 HSCs served 2,790 fewer individuals than in FY 2013.

Figure 5

The number of individuals served through HSCs declined slightly over the study period while the number receiving a Medicaid-funded behavioral health service rose slightly.



Source: HSC event and demographics data extracted January 2018 from the ROAP system; North Dakota Medicaid claims and enrollment data extracted October 2017; n = 39,845

Notes: The HSC count excludes 4,837 persons who received services for a developmental disability but not behavioral health services during the study period. These counts do not include individuals who received services only through an HSC-contracted provider during the study period.

Table 2 presents demographic characteristics of the 18,967 individuals who received HSC behavioral health services in the most recent fiscal year. A more detailed breakdown by service type can be found in Appendix B (Service User Characteristics by Service Type). Overall, the HSC service population is predominantly age 18 to 64. American Indian populations are overrepresented in HSC service settings; they are 14% of the HSC service user population, and according to census estimates, American Indian populations comprise 5.5% of the population.

Table 3 presents characteristics of the 17,127 individuals who received a Medicaid-funded behavioral health service in FY 2017. Compared to the HSC population, the population in the Medicaid data are younger and more likely to be female. As with the HSC data, American Indian populations are overrepresented in the Medicaid data compared to census population estimates.

Table 2
HSC service users
in SFY 2017

Characteristic	N	%
Gender		
Female	8,910	47.9%
Male	9,698	52.1%
Age		
0 to 11	1,449	7.8%
12 to 17	1,908	10.2%
18 to 24	2,397	12.8%
25 to 44	7,392	39.6%
45 to 64	4,485	24.0%
65 or Older	1,042	5.6%
Race/Ethnicity		
Latino/Hispanic	512	2.9%
American Indian or Alaskan Native	2,390	14.0%
Black or African American	493	2.9%
White	13,770	80.4%
Other Race	467	2.7%

Source: HSC event and demographics data extracted January 2018 from the ROAP system, n=18,967

Notes: Data were missing for the following categories: gender (n=373), ethnicity (n=1,545), race (n=1,847), age (n=294). Other race includes Asian, Native Hawaiian or Pacific Islander, and individuals who designated more than one race.

Table 3
Medicaid recipients who received
behavioral health service in SFY 2017

Characteristic	N	%
Gender		
Female	9,731	56.8%
Male	7,392	43.2%
Age		
0 to 11	3,771	22.0%
12 to 17	3,080	18.0%
18 to 24	1,562	9.1%
25 to 44	4,088	23.9%
45 to 64	3,044	17.8%
65 or Older	1,579	9.2%
Race/Ethnicity		
Latino/Hispanic	539	3.4%
American Indian or Alaskan Native	3,240	19.5%
Black or African American	739	4.4%
White	12,296	73.8%
Other Race	376	2.3%

Source: North Dakota Medicaid claims and enrollment data extracted October 2017; n=17,127

Notes: Data were missing for the following categories: gender (n=4), age (n=4), ethnicity (n=1,375), race (n=476). Other race includes Asian, Native Hawaiian or Pacific Islander, and individuals who designated more than one race.

In the following sections, data on utilization, penetration rates, service costs, and demographics are displayed alongside information we gathered through the stakeholder interview and document review processes. Table 4 summarizes FY2017 penetration rates per 1,000 population and estimated proportion of total behavioral health system expenditures for the primary service types discussed in the sections that follow.

Table 4

Penetration rates and estimated proportion of total behavioral health system expenditures by service type. Statewide behavioral health system expenditures were approximately \$90 million in FY2017.

Service Type	N	Penetration Rate per 1,000 of ND state population	Estimated Proportion of Total System Expenditures
MH Evaluation & Assessment	9,549	12.6	7.1%
SUD Evaluation & Assessment	3,927	5.2	3.0%
Information & Referral	3,492	4.6	-
Youth MH Outpatient	8,017	10.6	6.9%
Adult MH Outpatient	17,662	23.3	9.7%
Youth SUD Outpatient	288	0.4	0.2%
Adult SUD Outpatient	3,626	4.8	3.0%
Youth Case Management	2,304	2.7	5.4%
Adult Case Management	6,921	9.1	1.1%
Family Support Services	453	0.6	-
Other Community-Based Services	953	0.6	-
Crisis Intervention	5,556	7.3	-
Youth MH Residential	602	0.3	7.4%
Adult MH Residential	1,059	1.4	5.9%
SUD Residential	2,102	2.8	16.4%
MH Inpatient	2,385	3.1	12.9%
SUD Inpatient	556	0.7	1.4%
Long-Term Care Facility	1,142	1.5	16.1%

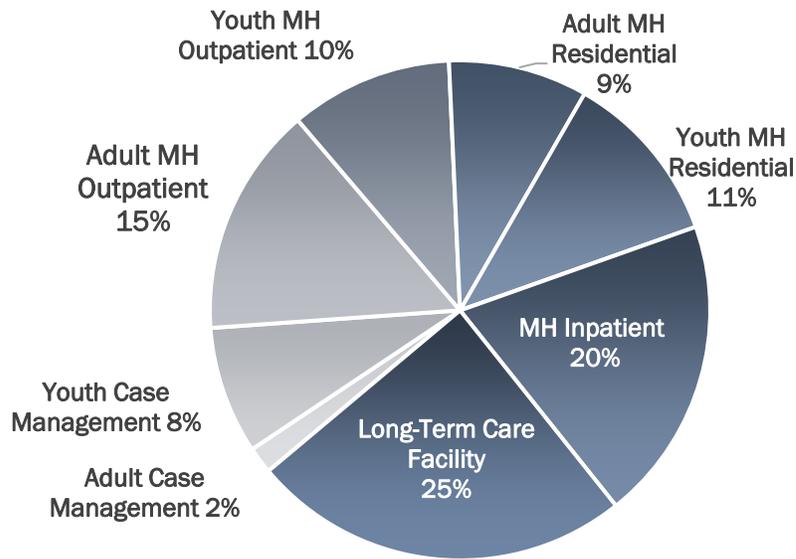
Sources: North Dakota Medicaid claims and enrollment data extracted October 2017. HSC event and demographics data extracted January 2018 from the ROAP system. North Dakota Department of Human Services, HSC Behavioral Health Contract data, July 1, 2015 through June 30, 2017 and counts of unduplicated individuals receiving HSC-contract services in SFY 2017. Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Notes: Reliable cost estimates were unavailable for crisis intervention, information and referral, other community-based services, and family support services, and are therefore not presented and not factored into the calculation of proportion of system expenditures. Other system expenditures presented in this table do not include those related to emergency department, ambulance, and other services for which penetration rate estimates were not calculated, and these expenditures comprise fewer than 5% of total system costs. Counts of unduplicated individuals receiving HSC-contract services were available for 7 of the 8 HSC regions.

Figures 6 and 7 represent information about the distribution of total behavioral health system expenditures by major service types for mental health and substance use disorder treatment services separately. In FY2017, approximately \$59 million were spent on mental health treatment services, and \$19 million were spent on substance use disorder treatment services. For mental health and substance use, a majority of expenditures were used for services delivered in residential, inpatient, and long-term care settings.

Figure 6

Residential, inpatient, and long-term care facility services accounted for a majority of mental health system treatment service expenditures in FY2017.

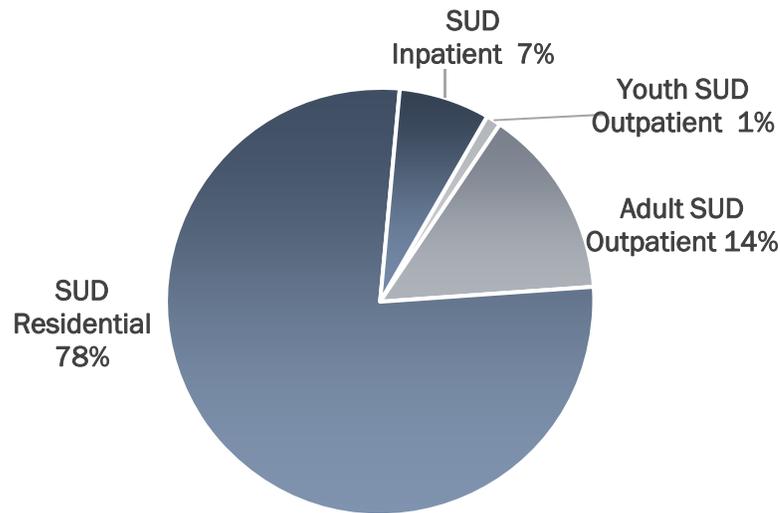


Sources: North Dakota Medicaid claims and enrollment data extracted October 2017. HSC event and demographics data extracted January 2018 from the ROAP system. North Dakota Department of Human Services, HSC Behavioral Health Contract data, July 1, 2015 through June 30, 2017.

Notes: Total system expenditures for mental health services for FY 2017 are estimated as \$59,007,095. Reliable cost estimates were unavailable for crisis intervention, information and referral, other community-based services, and family support services, and are therefore not presented and not factored into the calculation of proportion of system expenditures.

Figure 7

Residential and inpatient expenditures accounted for about 85% of substance use disorder treatment services in FY2017.



Sources: North Dakota Medicaid claims and enrollment data extracted October 2017. HSC event and demographics data extracted January 2018 from the ROAP system. North Dakota Department of Human Services, HSC Behavioral Health Contract data, July 1, 2015 through June 30, 2017.

Notes: Total system expenditures for substance use disorder treatment services for FY 2017 are estimated as \$19,015,496. Reliable cost estimates were unavailable for crisis intervention, information and referral, other community-based services, and family support services, and are therefore not presented and not factored into the calculation of proportion of system expenditures.

Community Education and Awareness Initiatives

Community education and awareness activities are typically designed to reduce stigma associated with behavioral health conditions. In theory, stigmatized views of people with behavioral health conditions result in experiences of discrimination and marginalization for people who are diagnosed, and they also prevent people with behavioral health issues from proactively seeking treatment.

Stakeholders identified a need for public education to combat misperceptions and stereotypes regarding mental health and substance use disorders so that members of the public understand that these disorders impact many Americans, and that those with behavioral health conditions can participate meaningfully in society. Several efforts have been launched in recent years to raise community awareness of behavioral health issues. These include Face It Together, a social enterprise organization designed to create public-private partnerships to transform how communities deal with addiction.⁹ With a Community Innovation Grant from the Bush Foundation, the organization launched a statewide initiative in North Dakota; the initiative has included listening sessions and the establishment of a leadership

⁹ <http://www.wefaceittogether.org/about-us>

task force.¹⁰ Recovery Reinvented¹¹ launched in the fall of 2017 with a daylong community education event spearheaded by the governor and first lady of the state. The Dream Again communication campaign, launched in late 2017, includes ads on radio, television and online emphasizing addiction is not a choice but a disease. Public health departments in counties and cities throughout the state have also recently launched or plan to launch community awareness initiatives related to substance use issues. Stakeholders indicated that their agencies were actively involved in targeted efforts to raise awareness of behavioral health issues among certain groups. Examples include the Department of Veterans Affairs' ND Cares¹² outreach services in every region, events targeting post-9/11 veterans. In the spring of 2017, the DHS held trainings for providers to raise awareness about behavioral health issues experienced by military service members and their families, including post-traumatic stress disorder, brain injury, and suicide. More information about the recent events and initiatives designed to raise awareness about behavioral health issues can be found in Appendix D.

A lack of awareness and education of the importance of mental health and the impact of drug and alcohol problems were identified as a particular challenge within American Indian communities, both in a Talking Circle meeting of representatives from four tribal nations convened for the purposes of this study (see Appendix C for meeting notes and details) and during stakeholder conversations. Another stakeholder noted that it is sometimes difficult to reach the individuals they intend to reach—noting that public education and advocacy events tend to draw the same crowds event after event, and that the people who really need to be reached are not attending the events and are not willing to work with them. Notably, recent awareness initiatives have focused more on substance use than on mental health promotion. Stakeholders expressed a need for helping communities, service users, and families to understand mental health and trauma as well as substance use issues.

Prevention and Early Intervention

In recent years, leaders in healthcare have increasingly called attention to the critical importance of prevention and early intervention to promote population health, including behavioral health [46]. Population health principles hold that mental health and substance use disorders result from a combination of genetic and environmental factors. The landmark Adverse Childhood Events (ACEs) study documents the key role of traumatic or toxic stress—including abuse, neglect, and exposure to violence—on health and behavioral health [47, 48]. When children experience multiple risk factors, this results in a “cascade of risk” which, in turn, predisposes them to a variety of general health and social problems, including mental health and substance use disorders. Emerging research in neuroscience demonstrates that prevention and early intervention can help build resilience, avert the development of behavioral health problems, and prevent existing behavioral health problems from beginning or

¹⁰ <http://www.wefaceittogether.org/north-dakota>

¹¹ <https://recoveryreinvented.com>

¹² <https://ndcares.org>

worsening [49]. And failing to intervene represents a lost opportunity to avoid the enormous personal and societal costs associated with behavioral health conditions [50].

This section describes a variety of prevention and early intervention strategies currently taking place in North Dakota. They range from primary prevention strategies designed to prevent the incidence of behavioral health problems to targeted interventions designed to intervene and avert the need for more intense services.

Wellness Promotion and Drug and Alcohol Prevention

A large body of research has documented the effectiveness of a range of policy interventions that discourage underage alcohol and drug use, reduce adult binge drinking and drug misuse, and promote social and emotional wellness in young children, adolescents, and pregnant women [51]. Best practice in prevention dictates that preventing behavioral health problems before they occur offers the greatest return on investment because of its potential to head off the significant costs associated with behavioral health conditions over the lifetime [52]. Studies of primary prevention activities have documented benefit-per-dollar cost ratios as high as \$64 per each dollar invested [53].

Stakeholders described current and planned prevention activities, or small-scale prevention activities that may be expanded in the future; however, they were also quick to state that there is a need for prevention activities on a larger scale, coordinated across systems, within the state. Such work would require a greater investment in prevention. Multiple stakeholders noted that prevention activities remain woefully underfunded. Many noted that the system philosophy needs to shift from being reactionary (waiting until people have a behavioral health problem to act) to one focused on preventing the behavioral health problems from occurring in the first place. In general, stakeholders emphasized a need for a system that incentivizes wellness rather than focusing only on sickness. They saw a system that invests large amounts of funding into high-intensity services and relatively little into wellness promotion and prevention as being misaligned and short-sighted. One reason for this misalignment could be that it is difficult to devote funding to prevention activities when other areas of the system—particularly treatment services—are also seen as underfunded.

In North Dakota, a number of activities across the spectrum of prevention are taking place. A majority of the funding in North Dakota for primary prevention of substance use disorders is federal and discretionary, and the BHD seeks out and applies for this funding to continue efforts on an ongoing basis. The behavioral health division of Department of Human Services (DHS) operates the federally funded ND Prevention Resource and Media Center (PRMC)¹³, a source of behavioral health promotion and substance use prevention efforts, information and resources. The PRMC provides many free materials and services to North Dakota individuals and communities, including training and technical assistance to individuals and communities across the

¹³ <https://prevention.nd.gov/>

state interested in implementing effective substance use prevention. Based on the assessment of needs and readiness, the PRMC focuses efforts on the following areas: underage drinking, binge drinking and prescription opioid misuse and overdose. A more complete listing of currently funded prevention initiatives can be found on the ND PRMC website.¹⁴

The behavioral health division of DHS also operates Parents Lead¹⁵, an evidence-based underage drinking prevention program targeting parents through statewide, web-based communication. The Parents Lead program began with the primary focus as underage drinking; however, recently work has shifted towards a shared risk and protective factor framework. The 2017 DHS budget reduced the Parents Lead program funding from \$360,000 to 100,000, even though this evidence-based program showed effectiveness in the state. One stakeholder noted a Department of Justice grant-funded coalition called Safer Tomorrows,¹⁶ which has a focus on reducing childhood exposure to violence. The initiative, which includes more than 40 partners in the Grand Forks area, involves coaching for boys, prevention of domestic violence, mental health promotion, and anti-bullying. Stakeholders also spoke positively of Restorative Justice programs that teach conflict resolution skills in several of the state's schools.

Stakeholders noted a need for expanding and improving current school health and wellness programs through the implementation of evidence-based curriculums. Although they did not allocate new financial resources for teacher training, the state legislature passed bills in 2015 and 2017 that broadened teacher training requirement options, representing an opportunity to expand educator knowledge about trauma, social and emotional learning, suicide prevention, and bullying in North Dakota's public schools (information about behavioral health legislative actions can be found in Appendix E).

One challenge facing drug and alcohol prevention efforts is a lack of payment options for prevention and early intervention work. While some

A lack of payment options makes it difficult for providers to plan and deliver prevention services.

efforts have been made to braid treatment and prevention dollars, increasing access to prevention dollars, this lack of payment options makes it difficult for providers to plan and deliver these services. One thing identified as facilitating prevention efforts is having the effort come from the community itself, not as a mandate coming from the state. While some small state initiatives address drug and alcohol prevention, we did not find any information about specific social and emotional wellness or mental health promotion efforts taking place in the state. When we asked stakeholders about these efforts, they acknowledged that this is an area that is underdeveloped. This finding resonates with a gap identified in the 2016 DHS *Behavioral Health*

¹⁴ <https://prevention.nd.gov/get-involved/find-resources>

¹⁵ <http://www.parentslead.org>

¹⁶ <https://www.safertomorrows.com/about-us/coalition>

Assessment that noted there are limited resources that support mental health promotion and mental health-related prevention.

Suicide Prevention

The North Dakota Suicide Prevention Coalition and the North Dakota Department of Health Suicide Prevention Program coordinate multiple suicide prevention initiatives that are funded through local and state dollars.¹⁷ These include teacher training requirements related to suicide and prevention efforts that incorporate approaches like Sources of Strength, a locally developed peer-to-peer and adult-to-youth mentoring program designed to prevent suicide as well as bullying and substance use [54]. Notably, North Dakota's most recent Suicide Prevention Plan includes efforts to enhance the state's responsiveness to American Indian and LGBTQ populations, groups at elevated risk for suicide.

Suicide prevention support services in the state are offered by FirstLink, which handles local National Suicide Prevention Lifeline calls. FirstLink is funded through the Department of Health, holds an approximately \$40,000 per year contract with the Southeast Human Service Center to provide crisis response services, and also receives funding from ND Cares for military suicide prevention. FirstLink reported that in 2016, it fielded 2,512 calls related to suicide, and that 62 of those calls resulted in actions to actively prevent suicide [39].

While stakeholders saw current efforts as important resources, they also identified areas that could expand suicide prevention activities. Namely, they noted opportunities to implement healthcare-based suicide prevention initiatives such as Zero Suicide,¹⁸ an evidence-based program designed to support health systems in changing organizational culture, providing staff training, and implementing screening and treatment activities to identify and support those at risk of suicide.

Services for Families of Substance-Exposed Newborns

In 2015 and 2016, the legislatively established Task Force on Substance Exposed Newborns was composed of state agency administrators, legislators, medical and community-based service providers, and representatives from the tribal nations, law enforcement, and the foster care community [55]. According to data presented in the Task Force's 2016 report, approximately 120 newborns in the state were diagnosed with Neonatal Abstinence Syndrome (NAS) in FY 2013, and an additional 183 newborns were reported as having been born with NAS in the tribal nations that year. The authors of the report also estimated that 6% of women admitted to SUD treatment programs are pregnant. Finally, it was expected that the average Medicaid costs for the first year of life for a newborn with NAS is approximately \$19,300, compared to \$8,200 for newborns without NAS. These statistics likely underrepresent the full extent of the negative impacts of SUD in pregnancy and NAS

¹⁷ Recent, current, and planned suicide prevention efforts are described in the state's Suicide Prevention Plan, available at http://www.ndhealth.gov/suicideprevention/image/cache/ND_Suicide_Prevention_Plan_2017_to_2020.pdf

¹⁸ <http://zerosuicide.sprc.org>

as many instances of these issues go underreported, undiagnosed, and untreated. Moreover, these statistics do not reflect the fact that NAS continues to negatively impact the child and family throughout the life course. The Task Force identified four goals:¹⁹

1. Collect and organize data concerning the nature and extent of Neonatal Withdrawal Syndrome/Neonatal Abstinence Syndrome (NAS) from substance use in the state.
2. Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from substance use.
3. Identify available federal, state, and local programs that provide services to mothers who use drugs or alcohol and to newborns who have NAS and evaluate those programs and services to determine if gaps in programs or ineffective policies exist.
4. Evaluate methods to increase public awareness of the dangers associated with substance use, particularly to women, expectant mothers, and newborns.

Currently, pregnant women are priority populations for organizations receiving federal funding and therefore face fewer barriers to accessing treatment (for example, HSCs prioritize pregnant women with substance use disorders). However, many of the treatment access barriers discussed in later sections of this report apply to pregnant women as well. Moreover, women with substance use disorders face additional barriers associated with stigma, including past experiences or fears of being judged negatively by treatment providers and internalized stigma or shame that limit motivation for change. The criminalization associated with drug use was similarly identified by key informants as a barrier to accessing services during pregnancy; pregnant women or women who've recently given birth may not pursue substance use disorder treatment for fear of criminal charges and child welfare system involvement. In response to this barrier, DHS conducts "alternative response assessments," which enable DHS involvement to connect a family to supports and services without a finding of child abuse.²⁰

The 2016 Task Force report stressed that, fundamentally, the best way to address NAS is to prevent occurrences in the first place. This involves enhancing both prevention efforts across the system. For example, women entering into the substance use treatment system could be screened for plans of pregnancy and assisted with obtaining birth control. Addressing NAS also involves enhancing the substance use disorder treatment system more generally (discussed in detail later in this report).

¹⁹ An infographic describing the goals can be found at <https://www.nd.gov/dhs/info/testimony/2015-2016-interim/judiciary/2016-6-6-substance-exposed-newborns-task-force-summary-recommendations.pdf>

²⁰ <https://www.nd.gov/dhs/info/pubs/docs/cfs/brochure-alternative-response.pdf>

First Episode Psychosis Initiatives

The landmark Recovery After an Initial Schizophrenia Episode (RAISE) project, funded by the National Institute of Mental Health, has led to an increasing focus on identification and early intervention in first-episode psychosis.²¹ The interventions tested in the RAISE project, coordinated specialty care programs, involve multidisciplinary team-based treatment that includes psychosocial supports and family education. Coordinated specialty care has been found to reduce symptoms and improve quality of life for people experiencing early psychosis [56]. Such interventions alter the course of illness through outreach and engagement with individuals before years-long duration of untreated psychosis occurs [57] and through the early provision of comprehensive services. By providing low-dose medications and psychosocial and rehabilitative interventions, coordinated specialty care programs can reduce impairment related to symptoms and increase skills and supports, enabling more effective functioning and a reduction of disability. Finally, by providing evidence-based practices such as supported employment and emerging practices such as supported education, coordinated specialty care programs support individuals in pursuing desired roles such as student or worker that are interrupted by the emergence of psychosis during such a critical developmental time in individuals' lives, helping to maximize recovery.

In 2014, SAMHSA directed states to use 5% of their mental health block grant dollars to address early episodes of serious mental health conditions, and in 2016 SAMHSA increased that set-aside to 10% with an added requirement that efforts focus specifically on first-episode psychosis using evidence-based approaches such as those tested in the RAISE project [58]. Prairie St. John's operates a first-episode psychosis program based on the NAVIGATE model, a type of coordinated specialty care program.²² Administered through the Behavioral Health Division and funded through the mental health block grant 10% set-aside, it is the only such program available in the state. NAVIGATE targets individuals aged 15 to 25 with schizophrenia spectrum disorder and/or less than a year's duration of untreated psychosis. The program began a one-year planning phase in August 2016 and is designed to serve 25 individuals over a two-year period, with a catchment area encompassing Cass, Sargent, Richland, Ransom, and Steele counties. The program is staffed by a program director, prescriber, individual resiliency trainer, family education clinician, and a supported employment/education specialist. Staff are trained on the NAVIGATE system and manuals, first-episode psychosis and early intervention, the effects of psychosis and its ongoing management on the family, and evidence-based treatment models.

When asked about offering first-episode psychosis programs in other parts of the state, stakeholders identified a lack of a sustainable funding source outside of the mental health block grant and workforce shortages of providers trained to provide wrap-around services to individuals experiencing early psychosis as major barriers.

²¹ <http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml>

²² <https://prairie-stjohns.com/first-episode-psychosis-program> and <http://navigateconsultants.org>

Outpatient Treatment

For the purposes of this report, we define outpatient treatment services as those delivered in outpatient settings, including eight regional Human Service Centers (HSCs), which are part of the DHS Division of Field Services. In the most recent biennium, the Division of Field Services has undertaken significant improvements in its organization and delivery of services. HSCs are the primary entities that deliver behavioral health services across North Dakota, including to Medicaid beneficiaries and to the uninsured. HSCs also provide services for individuals with developmental disabilities—but these services were not analyzed for this study.

Stakeholders representing the HSCs described a range of initiatives currently underway. These include transitioning to an Open Access model and expanding the array of outpatient and community-based service offerings, including Assertive Community Treatment (ACT), Wraparound Case Management, and other psychosocial rehabilitation practices. Given the recent nature of some of these initiatives, they may not be fully reflected in the data presented here, which span state fiscal years 2013 to 2017.

Behavioral Health Resource Directories

Several stakeholders voiced a need for greater awareness of behavioral health resources, a finding that is consistent with past needs assessments of the behavioral health system in North Dakota [12].

There are various resources that are designed to serve as directories of behavioral health service options, such as the 2-1-1 help line²³ operated by FirstLink and funded through several sources, including the DHS, Department of Health, and the United Way. According to the 2016 FirstLink Annual Report, 992 (5.5%) of the 18,051 calls fielded by FirstLink in 2016 involved information needs related to mental health and assessment, and another 272 (1.5%) were related to substance use disorder services [59].

Other resources include a DHS-created licensed addiction treatment program directory,²⁴ organized by region and defining the levels of treatment offered by each program, and a list of LGBT affirmative therapists maintained by North Dakota State University.²⁵ The Treatment Collaborative for Traumatized Youth (TCTY) website includes a clinician directory of those clinicians that are Trauma Focused Cognitive Behavioral Therapy (TF-CBT) trained in the state.²⁶ In 2017, Heartview launched a new initiative to create a service registry called the North Dakota Behavioral Health Locator.²⁷ This online tool, which is not currently comprehensive, is designed to help people find public and private behavior health providers. Each listing is designed to

²³ <http://myfirstlink.org/services/2-1-1-helpline>

²⁴ <https://behavioralhealth.dhs.nd.gov/addiction/locator>

²⁵ https://www.ndsu.edu/hdfs/ftc/lgbtmha/resources_for_clients/lgbt_affirmative_therapists_list

²⁶ <https://www.tcty-nd.org/>

²⁷ <http://locator.fyi>

include methods of payment, licensure and accreditation, operating hours, as well as telehealth services and locations.

Although behavioral health directory resources exist or are in development, they did not seem to be widely used by the stakeholders we interviewed. One challenge that stakeholders noted with regard to service registries was that, despite marketing efforts and the registries themselves, individuals in the community still often don't know about service options. Service registry resources are also like any other program; state politics can influence what resources are supported and the level of financial support behind them. Another challenge that stakeholders noted was that just because a registry exists, it does not necessarily mean that all services listed within have been vetted or are providing quality, evidence-based services.

Screening for Behavioral Health Issues

Nationwide, screening for mental health and substance use issues have been proven to be a critical step toward population health. Screenings are key in identifying and eliminating disparities in access to treatment [1]. We were unable to identify a universal screening process that focused specifically on behavioral health in the state, and stakeholders echoed the findings of the 2016 DHS needs assessment that the state could improve its capacity to conduct screenings and provide appropriate referrals to services [12].

Many different screening issues are taking place in North Dakota. The early childhood "Health Tracks" was identified as a screening system that can also be used to monitor referral patterns and potential unmet needs. Health Tracks is the state's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, funded through Medicaid, and follows the screening schedules identified by the American Academy of Pediatrics.

Currently, HSCs conduct screenings for brain injury for all individuals except those seeking only IDD services; and all individuals living in state correctional facilities undergo assessments for various risks and needs. There is currently work underway to establish a children's trauma screening tool. This initiative is a collaborative effort between the Department of Human Services Field Services, Children and Family Services, the Behavioral Health Division, and other partners. The Juvenile Court will be the first to implement this new initiative.

One provider-led screening initiative highlighted was the Screening, Service Planning and Referral (SSPR) portal developed by the Heartview Foundation. SSPR is a secure, web-based portal where individuals can complete behavioral health screens and treatment planning/readiness questionnaires, and then receive a referral packet and access to a portal that helps them connect to services. SSPR includes validated and widely-used screening tools for depression, anxiety disorder, suicide behaviors, post-traumatic stress, brain injury, anger, drug and alcohol problems, and nicotine dependency. The SSPR has a printable report including findings, recommendations, referral tools, and a release of information.

Stakeholders also mentioned efforts related to the expansion of Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based tool commonly used to identify substance use issues in the general population, provide brief preventive interventions when appropriate, and connect individuals with substance use disorders to appropriate treatment services [60]. Small numbers of SBIRT screenings appeared in the Medicaid data, but we were unable to locate information about widespread use of this or other screenings in the state. There were a very small number of Medicaid claims related to different behavioral health-related screenings, including mental health screenings (103 claims during the five-year study period), tobacco use screening (59 claims), and alcohol use screening (65 claims). The Medicaid claims data for this study only included individuals who received a behavioral health-related service, so screenings conducted with Medicaid-funded individuals who did not receive a behavioral health service are not counted here.

A number of legislative bills incorporating various types of screening have been attempted recently but did not pass. In 2017, HB 1308 and SB 2279 attempted to add addiction screening for Temporary Assistance for Needy Families (TANF) participants. That same session, SB 2208 attempted to enable school district personnel to be screened for alcohol or controlled substance use.

Stakeholders identified several challenges impacting screening practices. These stakeholders cited data challenges, noting that providers can see in the records whether a screening took place, but they cannot see the result of the screening. A lack of cross-department collaboration and communication on screening-related initiatives was also identified as a barrier. However, the most frequently cited challenge with screening concerned referral after positive screenings. Numerous individuals noted that there are a limited number of options for referral, that screenings are being done and then referrals aren't being made, and that if providers

felt they had options to refer to after screening, screening practices would be more widely adopted.

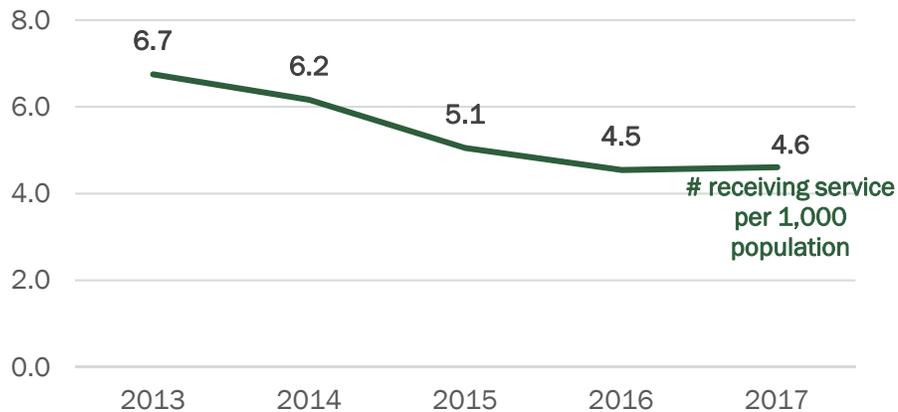
Open Access and Information and Referral

Beginning in September 2015, the DHS began phasing in the use of an Open Access model in HSCs. Region 1 was the first HSC to implement this, followed by Region 2 in January 2016, Region 6 in March 2016, Region 5 in September 2016, Regions 3, 4, and 7 in April 2017, and Region 8 in August 2017 [61]. Stakeholders who were in regions where Open Access had been instituted spoke favorably of the recent changes, endorsing them as more effectively connecting individuals to treatment in a timely manner. Some stakeholders pointed out that although initial assessments were more accessible because of the Open Access model, barriers to receiving treatment (e.g., wait lists, transportation issues) persisted.

Figure 8 displays the penetration rates for information and referral services delivered through the HSCs during the study period. The penetration rates for this service dropped by almost 2 individuals per 1,000 population across the period; however, it is possible that the development of Open Access will result in higher rates of this service once fully implemented. Of the 17,069 individuals who received information and referral services at HSCs during the study period, approximately three of four (73.4%) received some type of HSC service, suggesting that information and referral events usually result in some kind of connection to services.

Figure 8

Penetration rates for **information and referral services** provided by HSCs decreased across the five-year study period.



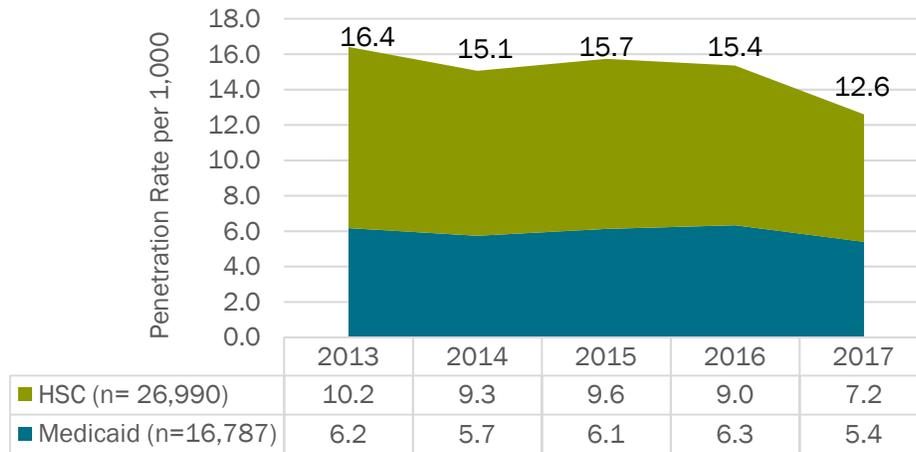
Source: HSC event and demographics data extracted January 2018 from the ROAP system, n=17,069

Mental Health and Substance Use Disorder Evaluations and Assessments

Figure 9 portrays the numbers of mental health evaluations and assessments delivered during the study period by HSC and Medicaid data source, and Figure 10 displays the numbers of substance use disorder evaluations completed during the period. Evaluations for substance use disorders did not appear in Medicaid claims and appear to be funded through general revenue and delivered within the HSCs.

Figure 9

Penetration rates for mental health evaluation and assessment also declined across the five-year study period.



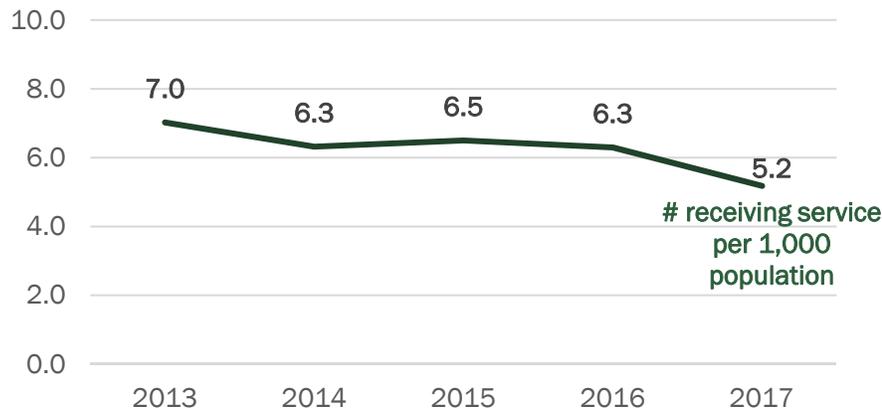
Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=43,777.

Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Notes: The type of insurance for 31.7% of HSC service events could not be determined resulting in possible duplication of service users across the data sources.

Figure 10

Penetration rates for substance use disorder evaluation also decreased across the study period.



Source: HSC event and demographics data extracted January 2018 from the ROAP system, n=17,352.

Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

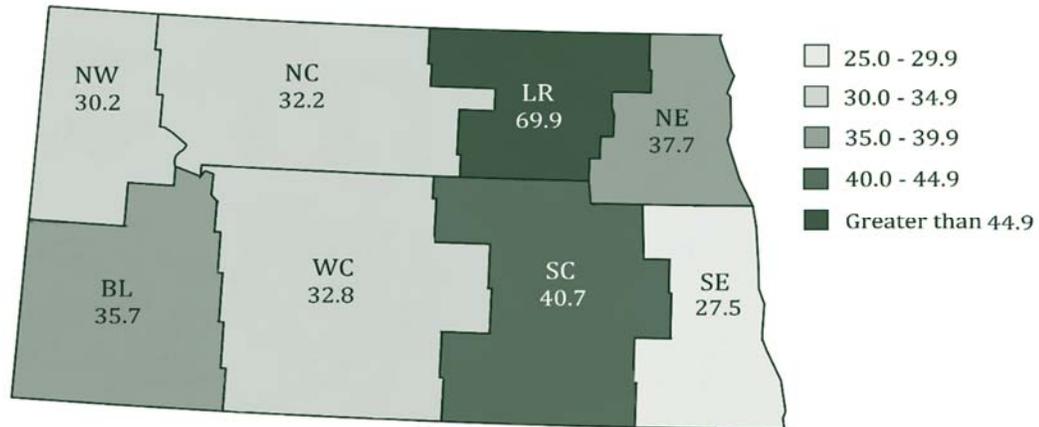
As with the information and referral decrease, it is possible that penetration rates for evaluations and assessments will rise in coming fiscal years as the Open Access model is fully implemented.

Outpatient Mental Health Services

Outpatient mental health services include individual and group psychotherapy services as well as psychiatry, medication management, and the provision of psychiatric medications. Adult day treatment is also discussed in this section. For adults as well as children/youth, we observed significant regional variation in penetration rates. Figure 11 displays penetration rates per 1,000 North Dakotans for all outpatient mental health services by region for FY 2017.

Figure 11

Regional penetration rate for outpatient mental health services, SFY 2017



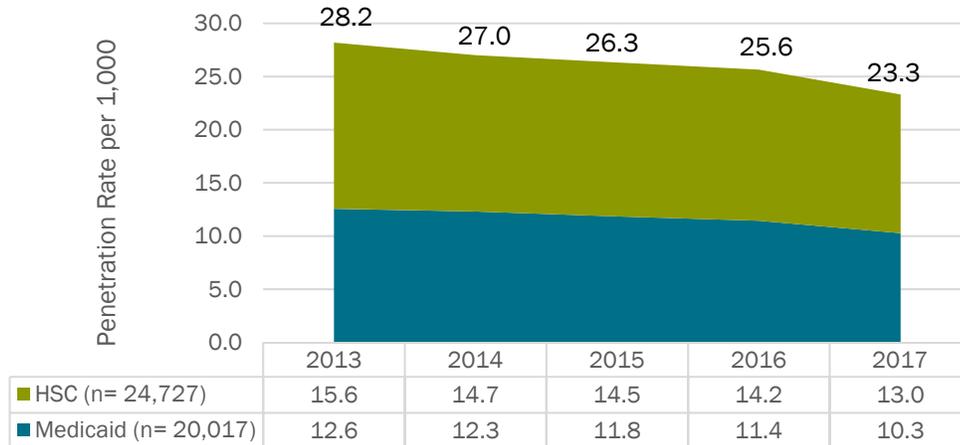
Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=25,679
Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Depending on the data source, regional location is defined as the place of service or the service users place of residence. Individuals may be counted in multiple regions during a single fiscal year.

Adult Mental Health Outpatient Services. Figure 12 presents penetration rates per 1,000 North Dakotans for adult outpatient services.

Figure 12

Penetration rates for adult outpatient mental health therapy services have dropped slightly—and steadily—in the past five years, by 4.9 per 1,000.



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=44,744

Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Notes: Persons with missing age (n= 309) were not included in this figure. The type of insurance for 72.0% of HSC service events could not be determined resulting in possible duplication of service users across the data sources.

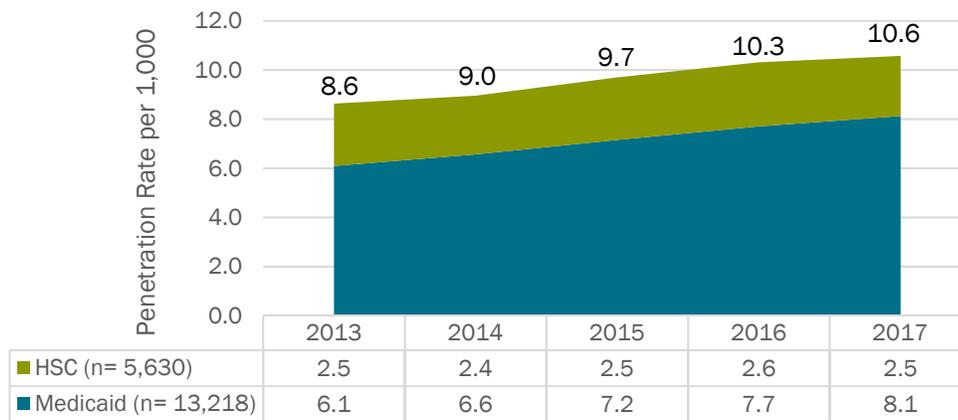
Adult outpatient mental health services made up approximately 9.3% of all publicly funded behavioral health service costs, and the state spent an average of \$498 per person in FY 2017. A large proportion of mental health outpatient services were funded through non-Medicaid sources.

In FY 2017, the HSCs delivered adult day treatment services to 392 individuals, and penetration rates for this service remained steady over the study period. In general, behavioral health systems have shifted emphasis on day treatment models to recovery-oriented approaches like clubhouse, peer support, and supported employment and education services that focus more explicitly on psychosocial rehabilitation and community engagement. In addition to being more in line with principles of the social determinants of health, these services are evidence-based or promising practices with proven outcomes associated with greater health and wellness, community inclusion, self-sufficiency, and independence.

Children and Youth Mental Health Outpatient Services, Including School-Based Services. A common theme in stakeholder interviews was a need for a more comprehensive continuum of services for children and youth. Stakeholders noted that children and youth services are often “swallowed up” by a systems emphasis on adult services. Multiple stakeholders—and previous system reviews—have indicated a need for more child psychiatrists in the state. There is currently a nationwide shortage of these services [62], and it appears North Dakota is no exception. Figure 13 displays penetration rates for outpatient mental health services delivered to children and youth during the study period.

Figure 13

In contrast to adult services, penetration rates for children and youth mental health outpatient treatment services increased across the study period.



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=18,848
 Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Notes: Persons with missing age (n= 309) were not included in this figure. The type of insurance for 61.5% of HSC service events could not be determined resulting in possible duplication of service users across the data sources.

In another positive development, and in contrast to the adult outpatient mental health services, a greater proportion of children and youth outpatient services are financed through Medicaid relative to HSC-funded services. Estimated per capita cost for children and youth outpatient treatment for SFY 2017 was \$774.

Stakeholders discussed a lack of infrastructure and coordination to support early childhood mental health for very young children. Social and emotional wellness promotion services are very limited, according to stakeholders with expertise in this area, and there is minimal coordination between childcare providers and special education services when children reach school age. One stakeholder noted that it is common for childcare providers to reject children with behavioral health problems without providing families with information or resources for connecting to treatment services. While pediatricians track general social and emotional development, there is

no comprehensive screening program for social-emotional concerns (although the Health Tracks program does include some screenings related to behavioral health for Medicaid-funded children). We were not able to find evidence of any working early childhood mental health specialists in the state, and stakeholder assertions supported this finding.

Stakeholders noted the importance of the availability of mental health services in schools and saw school-based services as a system gap. Table 5 presents the proportion of services with 'school' as the place of service.

Table 5

Proportion of Medicaid claims and HSC services delivered to children and youth in a school, SFY 2017

Service Type	N	%
Speech-Language Pathology	4,696	42.2%
Medication Administration	1,723	15.5%
Youth Case Management	1,636	14.7%
Foster Care Case Management	1,125	10.1%
Youth Outpatient MH	1,021	9.2%
Community-Based Services	671	6.0%
Other	111	1.0%
Referrals	82	0.7%
MH Evaluation and Assessment	34	0.3%
Wraparound Services	21	0.2%
Youth Outpatient SUD	15	0.1%
Total	11,135	100.0%

Source: North Dakota Medicaid claims and enrollment data extracted October 2017. HSC event and demographics data extracted January 2018 from the ROAP system.

Note: In SFY 2017, 5.0% (n=11,135) of all claims for persons ages 0 to 17 were delivered in a school.

Based on available claims data, only 5% of all services of any type for persons under age 18 were delivered in a school-based setting, and very few substance use disorder treatment services were delivered in school settings during FY 2017. Notably, a new initiative established through HB 1040 in 2017 includes funding for a school-based early intervention pilot that is currently being developed through a statewide collaborative effort, which could result in increased numbers of school-based services.

Outpatient Substance Use Disorder Treatment

In North Dakota and around the United States, the numbers of individuals accessing treatment for a substance use disorder is far lower than those who have a diagnosed (or diagnosable) substance use problem. A common theme in stakeholder interviews was related to a lack of substance use disorder treatment (both outpatient and inpatient, which is discussed in a later section) across the state, and particularly in rural areas of the state.

According to the *2016 Behavioral Health Barometer* report, 2,404 individuals were enrolled in substance use disorder treatment in ND in a single-day count in 2015—an increase from 1,785 in 2013 [63]. Of the individuals enrolled in substance use disorder treatment in the single-day count in 2015, 57.6% were enrolled for both an alcohol and drug problem, 16.6% for a drug problem only, and 25.8% for alcohol problem only.

The 2017 DHS budget included a significant increase in substance use disorder voucher funding. The 2017 to 2019 budget for the substance use disorder voucher includes \$1 million from the state general fund, \$1.7 million in additional funding to support medication-assisted treatment, and \$2.3 million from the previous Robinson Recovery contract to support residential substance use disorder treatment, which expands the range of residential treatment options (discussed in a later section).

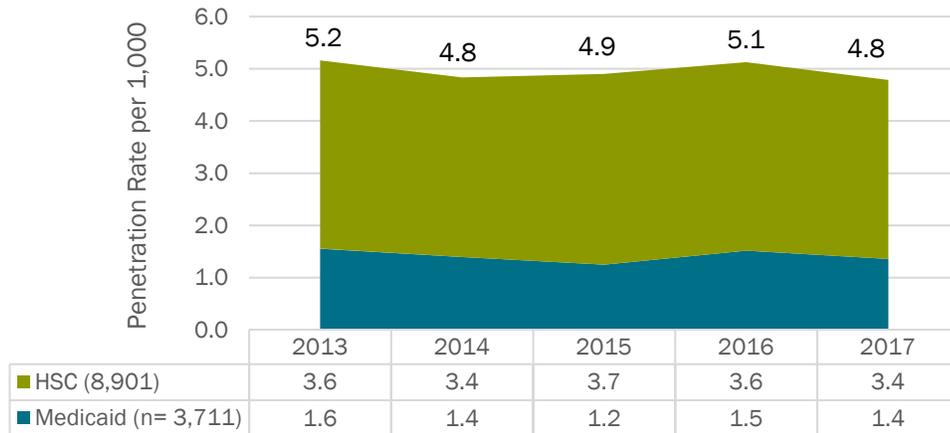
The most recent DHS budget also included a \$4 million investment in expanding opioid treatment infrastructure. While the opioid epidemic was clearly a concern for stakeholders we interviewed, many with direct experience working in communities impacted by substance use problems emphasized that alcohol use disorders are still the most significant challenge faced by North Dakotans, and that methamphetamine use is also a significant concern.

Due to actions in the most recent legislative session (described in Appendix E), LACs may now provide support for gambling harm and nicotine use disorders.

Adult Substance Use Disorder Outpatient Treatment. Figure 14 presents the penetration rate for outpatient substance use disorder treatment for adults over the study period.

Figure 14

Penetration rates remained relatively steady, and **HSCs** continued to provide most publicly funded adult substance use disorder outpatient treatment services.



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=12,612

Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Persons with missing age (n= 203) were not included in this figure. The type of insurance for 37.0% of HSC service events could not be determined resulting in possible duplication of service users across the data sources.

The Heartview Foundation provides a range of SUD outpatient and residential services and is the largest single provider of SUD services outside of the HSCs, serving 350 to 400 individuals with Medicaid Expansion and the privately insured in Cando and Bismarck (they also offer services via telehealth in Dickinson). Heartview has provided buprenorphine, naltrexone, and Antabuse since 2011 and added the ability to provide methadone to individuals in 2015 after becoming licensed as an opioid treatment program. While traditionally a substance use/chemical dependency services-oriented organization, Heartview has undergone expansion on the mental health side, adding a psychiatrist, contracted psychologists, and mental health counselors on staff to support individuals with co-occurring mental health issues. Community Medical Services is another major provider of medication assisted treatment (MAT) in the Minot and Fargo areas.

Several stakeholders noted that, historically, substance use disorder treatment services in North Dakota have focused on abstinence-only and 12-step approaches, to the exclusion of other modalities and services. While 12-step approaches are highly effective for some, they do not work well for everyone. This contrast was particularly stark when discussing substance use disorder treatment options within and outside of the criminal justice system. One service user stakeholder we spoke with noted having

had a positive experience with cognitive-behavioral therapy while in prison, saying it was an effective therapy for them; however, these services were not available to them when they returned to living in the community. This person described frustration at not having support in the community to maintain the positive gains they experienced while incarcerated.

Stakeholders we interviewed with expertise in this area noted that an inability to pay for MAT is a significant barrier for many individuals in the state. Although the substance use disorder voucher can be used to cover the costs of MAT, many MAT participants are required to pay for services out of pocket with no general assistance funding for these services. Another key barrier to MAT is transportation, particularly for individuals in rural areas who need to travel long distances each day to maintain regular dosing. The 2017 budget increase in substance use disorder treatment vouchers will cover costs associated with transportation to MAT and may reduce transportation barriers for some individuals.

Children and Youth SUD Outpatient. As with mental health services, many stakeholders were concerned about a shortage of substance use disorder treatment services, including outpatient treatment services, for children and youth. In SFY 2017, only 288 children and youth received Medicaid or HSC-funded outpatient substance use disorder treatment services. American Indian youth comprised over one-third of the service user population for this service, and black or African American youth (6.8%) and Hispanic youth (5.6%) were similarly overrepresented.

Stakeholders noted that because of significant shortages of Licensed Addiction Counselors—there are only two Licensed Addiction Counselors who treat children in the Southwest region of the state, for example—families' only option to access substance use disorder treatment is through a residential facility. In general, stakeholders expressed concern that the state has an overreliance on residential treatment services for youth substance use disorder treatment, missing opportunities to intervene early and address substance use problems before they rise to a level of severity that warrants life-disrupting residential treatment. One stakeholder noted that there appears to be an erroneous and unchecked assumption among many treatment providers and other stakeholders that residential services are the best option for youth with substance use problems.

Services for Co-Occurring Mental Health and Substance Use Disorders

The primary service for individuals with co-occurring mental health and substance use disorders in the state is Integrated Dual Disorder Treatment (IDDT), which is available in seven regions (the Williston area does not have IDDT services). Key informants indicated that IDDT teams are available through some of the HSCs. For example, the Southeast HSC has two IDDT teams serving 75 to 80 individuals with co-occurring SMI and SUD, with annual fidelity reviews and consultation provided by Case Western Reserve University. However, such programs seem to be the exception rather than the rule, with key informants noting that there is significant regional variation in fidelity. One challenge to fidelity identified was maintaining recommended caseload ratios; for example, one HSC noted that though they try to

maintain a client-to-staff ratio of 12:1, they often operate at 20:1 due to workforce shortages and vacancies. Stakeholders at HSCs indicated that IDDT services are being converted to Assertive Community Treatment approaches, which serve a broader spectrum of the population. While this is a positive development given the high levels of unmet need for intensive community-based services, it will be important that limited resources currently dedicated to co-occurring service approaches are not reallocated away from this underserved population.

Outpatient Behavioral Health Services in Primary Care

The rationale for integrating behavioral and physical health services is well-established, as are the benefits of integrated physical and behavioral health care. With a bifurcated physical/behavioral health system, there is no single point of accountability for the health and wellness of the whole person. Individuals with behavioral health conditions experience high rates of chronic health conditions such as diabetes, heart failure, and hypertension, but they also face a variety of barriers to consistent primary care. In addition, a high percentage of individuals presenting at emergency departments with acute medical symptoms often are suffering with undiagnosed and/or untreated anxiety, depression, substance use, and other behavioral health disorders.

Behavioral health services are difficult to access through primary care, resulting in lost opportunities to proactively identify and address behavioral health issues before they become serious. For persons with serious behavioral health conditions, inadequate coordination of behavioral and physical health care likely contributes to a dramatically lower life expectancy (25 years lower on average, nationwide, compared to the general population). Moreover, bi-directional integration (integrating physical health into specialty behavioral health settings in addition to integrating behavioral health services into physical health settings) has the potential to increase access to behavioral health services for those with mild and moderate issues who receive their care only in physical health settings; it also could increase access to physical health services for those with serious behavioral health conditions, who often have co-occurring chronic medical conditions. In rural communities, where physical and behavioral health resources are in short supply, integration is even more relevant.

Based on our analysis of the data, integrated physical and behavioral health services in North Dakota are still in the early stages of development, with some notable standouts. One federally qualified health center (FQHC) we interviewed for this study, Valley Community Health Centers, appears to be innovating in this area. Valley Community Health Centers operates medical clinics in a predominately rural Northeast corner of the state. In recent years, the Center has transformed who they are providing care to and how care is delivered. One facilitator to this progress is the inclusion of a licensed addiction counselor on staff who had experience in integrated health settings from another state. Using braided funds, the Center offered training to administrators, providers, and nursing staff in integration principles through the Cherokee Health System in Tennessee and with the University of North Dakota PhD in Counseling program. At the time of our interview in 2017, the Center was finishing

the final component of being a fully integrated health center by adding psychiatry. Staff at the Center have SBIRT training from UND, and Valley Community Health Centers is one of the few FQHCs that offer on-site training for SBIRT. All primary care patients are screened using SBIRT, and anyone with an identified need sees a counseling student or psychologist. Counselors have been trained in suicide prevention and also offer trainings to the community at large. FQHC patients with complex behavioral health needs are referred to specialty behavioral health services. Valley Community Health Centers has also partnered with the local public health department and the local housing authority to coordinate services and initiatives.

Although the Valley Community Health Centers stood out as a good example of what integration could look like in the state, it appeared to be an outlier in terms of the extent to which services are integrated in FQHCs.

Stakeholders with expertise in integration with whom we spoke noted that, at present, there are limited incentives to deliver behavioral health services in primary care settings, and minimal collaboration between behavioral and physical health stakeholders to move toward systems integration. Stakeholders also identified unique benefits and challenges for rural clinics. In rural settings, the anonymity of receiving behavioral health treatment in an integrated setting reduces the negative impact that stigma may have on help-seeking. However, rural clinics face significant workforce barriers; maintaining adequate behavioral health staff can be challenging outside of urban areas. These stakeholders noted that telemedicine is particularly important for this reason.

Community-Based Services

Social determinants of health are defined as “the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age” [64]. Key informants emphasized the importance of services that support social determinants of health, including housing stability, economic well-being, and community integration. This assertion is consistent with the conclusions from seminal reports released at the federal level in recent years—notably SAMHSA’s *Description of a Good and Modern Mental Health and Addictions System*, which outlines a rationale for a continuum of social support services that includes employment, housing, and self-help alongside clinical treatment [65]. It is also consistent with the research literature; consensus among healthcare experts is that roughly 10% to 20% of health determinants—including behavioral health determinants—derive from medical care; social, behavioral, and environmental factors account for the remaining 80% to 90% of health outcomes [66, 67, 68].

Previous needs assessments in the state have identified gaps in community-based services, particularly those that address the housing, employment, and transportation needs of people who use publicly funded behavioral health services [11, 12, 14]. Stakeholders similarly noted that the current behavioral health system is primarily crisis-oriented and pays inadequate attention to rehabilitative and community-based services. Notably, however, current leadership at DHS appears to be committed to

reversing this dynamic and recognizes the critical importance of supporting the social determinants of health through rehabilitative, community-based services.

Wraparound, Case Management, and Other Community Supports for Children and Youth

North Dakota offers a range of services to support coordination of services for children and youth, with an emphasis on services that support children and youth in foster care or at risk of foster care placement. These include Medicaid-funded Targeted Case Management services, which involve comprehensive assessment, care planning, and ongoing connection to services and supports for children and youth with complex needs. Although existing services appear to meet critical community needs, a common theme in stakeholder interviews was that current levels do not meet community demand.

Figure 15 shows the penetration rate for all case management services delivered to children and youth during the study period.

Figure 15

Case management services for children and youth were delivered as **Medicaid-funded** Targeted Case Management and through **HSCs** without Medicaid funding, and there has been a decrease in numbers served in FY 2017, dropping 0.5 individuals per 1,000.



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=6,679
 Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Persons with missing age (n= 12) were not included in this figure. The type of insurance for 17.6% of HSC service events could not be determined resulting in possible duplication of service users across the data sources.

In addition to the case management services referenced in Figure 15, 894 children and youth received foster care case management services through the HSCs in FY2017.

One in three children and youth receiving case management services in North Dakota is American Indian, suggesting a particular need for culturally responsive services.

In total, 323 children received Medicaid-funded Wraparound services during the study period. A majority of these services were delivered in office settings, with 15% delivered in families' homes and 9% delivered in schools. The Transition to Independence²⁸ program (TIP), administered through the HSCs, offers case management services for older children and youth up to age 24 to support transitions from the child- to adult-serving systems; a total of 176 youth received TIP services in FY 2017. The TIP program also provides technical assistance to other providers who work with the transition-aged population.

The Partnerships Program for Children's Mental Health, administered through the HSCs and funded through the mental health block grant, employs Wraparound approaches and involves a case worker or family aide that works with a family. Many stakeholders noted that current Wraparound approaches were insufficient to meet the needs of children and families in the State. Stakeholders noted that the fidelity to Wraparound services varies greatly across the state in terms of the composition of Wraparound teams, intensity of supports, and implementation of trauma-informed approaches. We did not find any information about regular fidelity assessments or other related information for Wraparound services in the state. Stakeholders noted that in many instances, services attached to Wraparound programs have been cut over time, leaving only care coordination and minimal supports. They saw a need to reinvest in these approaches to ensure that intensive in-home supports are available in adequate supply.

Serving Justice-Involved and Transition-Age Youth

The **Community Day Treatment Program**—operated by the Department of Juvenile Services, the Department of Public Instruction, and the Division of Child and Family Services—is designed to address the needs of students at risk of out-of-home placement and into Juvenile Services.

This school-based interdisciplinary program served 137 students in middle and elementary school in the 2016-2017 school year, 85% of whom were able to avoid out-of-home placement that year.

The **Chafee Independent Living Program**, delivered through a contract with the state, serves youth 16 to 21 as they age out of foster care. Through this program, youth and young adults have access to crisis management, education, employment, and life skills supports. There are currently just over 500 youth in this program.

²⁸ <http://www.nd.gov/dhs/policymanuals/64201/64201.htm>

Social services agencies play an important role in supporting the transition to and from foster care, and in preventing children and youth from entering into the foster care system in the first place. For example, they have the flexibility to provide in-home support services before foster care placement rather than after. In recent years, there has been a shift to reduce waitlists for in-home and parent aid services so that families can connect with those services before foster care involvement is necessary. Stakeholders identified a number of other programs that support children and youth at risk of out-of-home placement and support community transitions (see sidebar).

Family Support Services

In addition to a need for more community-based care coordination services for children and youth, multiple stakeholders described a need for enhanced family support and stabilization services in

North Dakota. In FY 2017, 12 families received HSC-funded family stabilization services, and 453 received family support services. Ideally, a family should receive support services in the home for as long as possible before turning to residential treatment as an option. This orientation makes sense from a family-centered perspective and from a cost-savings perspective.

PATH ND operates a family support program that involves parent-to-parent mentoring as well as family respite services. However, stakeholders noted that Medicaid requires that families expend \$15,000 on other services before accessing this program. Stakeholders expressed concern that this requirement results in a child needing to be placed in high-intensity service environments before accessing services that were designed to be preventive.

Stakeholders also expressed general concern regarding the consistency with which individuals and their families are included in decisions about services for children and youth. They also cited a lack of transparency around the process of service delivery and approval that made it difficult for families to understand and navigate the behavioral health system.

Adult Case Management

A majority of case management services in the North Dakota are delivered through the HSCs using general funds; outside the HSCs, Medicaid funded case management services are typically targeted to specialized populations. Very few health centers offer case management services, and private insurance does not typically reimburse these services. Medicaid expansion plans do not reimburse for case management either. Although past reports have called for efforts to privatize case management, there has been little movement in this regard, particularly from the private sector. Stakeholders we interviewed expressed the opinion that case management is a service that is best

The requirement that families spend **\$15,000 on prior services** makes it likely that children will have been in high-intensity service environments **before they're able to access PATH's preventive services.**

delivered directly by HSCs, and that privatization is a better option for other services that do not involve coordination.

The utilization rate for case management services has dropped more than 2 individuals per 1,000 during the study period. This reduction is not necessarily concerning, particularly if it reflects part of a larger strategy to replace case management services with a broader range of other community-based services and supports.

Figure 16

Penetration rates for adult case management dropped by more than 2 individuals per 1,000 over the study period.



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=22,052

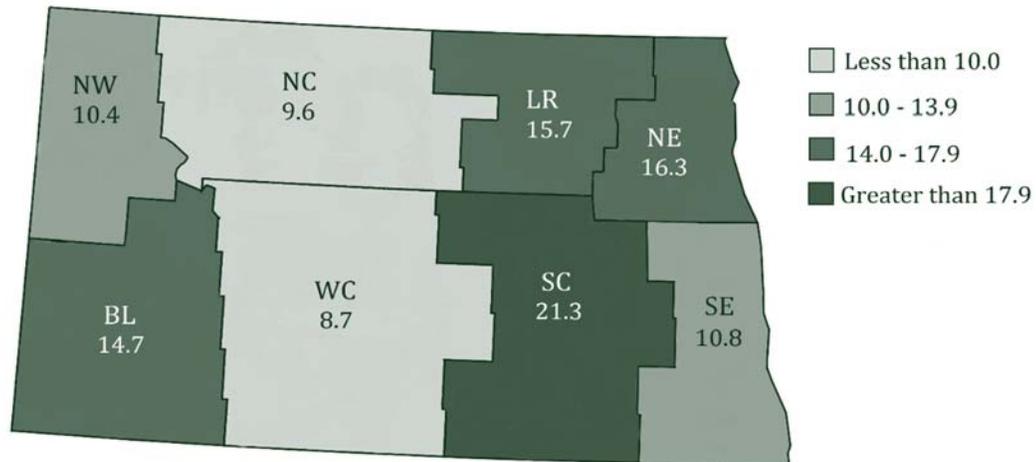
Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Persons with missing age (n= 12) were not included in this figure. The type of insurance for 74.7% of HSC service events could not be determined resulting in possible duplication of service users across the data sources.

In our analysis, we found significant regional variation in case management utilization, which is supported by stakeholder observations about regional variation in how services are organized and delivered in HSCs. Figure 17 presents the penetration rates by region for adult and youth case management services (variation was similar across adults and youth, so figures are presented together).

Figure 17

Regional penetration rate per 1,000 population for adult and youth case management, SFY 2017



Source: HSC and Medicaid data North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system; n=8,955. Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Depending on the data source, regional location is defined as the place of service or the service users place of residence. Individuals may be counted in multiple regions during a single fiscal year.

Many stakeholders described challenges with accessing case management services, particularly for individuals with complex needs including co-occurring mental health and substance use problems, and brain injury, as well as justice-involved individuals and those experiencing homelessness. Several stakeholders were concerned about attitudinal barriers to working with people with complex needs, describing a culture in which individuals seeking services must prove they are “motivated” as a precondition for receiving support. One service user stakeholder described experiences with a “judgmental” case manager.

One stakeholder noted that current case management practices tend to focus on setting up appointments and transporting individuals to appointments. This stakeholder felt that case management focus should be on skills building and training rather than doing things for people. When we asked five service user stakeholders about setting and reaching goals with their case managers, three said that they were not currently working on any goals, another said they had a goal but had given up, and another noted that they let the case manager know what they want to work on. None of the service users we spoke with said their case managers had raised the possibility of working toward employment-related goals.

Stakeholders said the quality of case management is unknown, that fidelity is not assessed, and that the extent to which case management services foster recovery and independence is unclear. Stakeholders also saw a need for more coordination between

case management services within HSCs and coordination services offered through social service agencies.

Stakeholders we interviewed noted that some individuals receive case management services when they do not have a clear need for those services while others who would benefit from case management are unable to access the services. Similarly, stakeholders saw a need for different levels of case management based on need. One stakeholder noted that some individuals receive more case management services than necessary because of a lack of team-based care; when the case manager is the primary provider of services, there is no one to encourage case managers and those they work with to move on to other less-intensive services. On a related note, stakeholders mentioned that, if case management is one of the only community services available, it is difficult to discharge the person from something to nothing.

Notably, the DHS Division of Field Services has been in a year-long process of evaluating functional needs for individuals receiving case management and ‘graduating’ them from such a service if it is no longer medically necessary. In addition, there has been an expansion of skills training services so that case managers provide only case management and licensed and trained providers do skills training.

Peer Support Services

Peer support services are delivered by individuals with personal experience as service users of behavioral health services. Those providing peer support services are referred to by a range of terms, including peer specialists (often mental health-focused), recovery coaches (often used in the substance use recovery community), and family partners (individuals with lived experience supporting a family member with a behavioral health issue).

Peer support services are theorized to help service users to develop self-advocacy skills and build confidence to pursue their goals through establishing trust and rapport built on shared experiences. A review of 20 studies of peer support services concluded that peer support is associated with improved quality of life, hopefulness, activation,²⁹ and therapeutic relationships and reduced inpatient hospital use [69]. Peer services can be implemented across the spectrum of clinical services to include crisis, inpatient, and outpatient services. According to recent national review of peer support services commissioned by the U.S. Department and Health and Human Services Assistant Secretary for Planning and Evaluation, the infusion of peer support services within one managed care network in Pierce County, Washington, has resulted in an estimated \$21.6 million cost savings, with much of this savings attributed to reduced hospitalization [70]. In a program where peer specialists assisted persons transitioning from hospital to community in Wisconsin, there was a 24.3% decrease in overall behavioral health costs per person in the six months after enrollment [71]. In Texas, a whole-health peer support program that targeted older adults with mental

²⁹ “Patient Activation” is a widely recognized concept that describes the knowledge, skills and confidence a person has in managing their own health and health care.

health conditions resulted in a 70% decrease in hospitalization, and participants were more engaged in their communities [72].

Nearly all states have established peer training and certification trainings, and a majority of state Medicaid programs reimburse peer support services.³⁰ Currently, peer support services and peer support training opportunities in North Dakota are limited, though there has been considerable progress toward increasing peer support trainings and establishing a statewide certification program in recent months. Stakeholders we spoke with expressed strong interest in expanding peer support, with several initiatives underway. In 2017, the North Dakota legislature established modest funding to expand peer support and family support (the original budget included \$1.9 million, but it was reduced to only \$100,000 in the approved version of HB1040). The \$7 million alternatives to incarceration initiative include in SB2015 also includes funding for expanding peer support for individuals returning to the community after incarceration. Peer support expansion is also part of the State Targeted Response to the Opioid Crisis (STR) grant activities. In July 2017, the state contracted with the Center for Rural Health to do a national assessment of peer support, make recommendations for standards, and develop a statewide certification program. Peer support training was held for Free Through Recovery initiative in February 2018, and additional trainings are planned for the summer of 2018. Free through Recovery³¹ is a community behavioral health initiative that focuses on care coordination, recovery services, and peer support for individuals with high behavioral health needs and high-risk of recidivism. Nine individuals that attended the Free Through Recovery peer support training went on to attend a train-the-trainer training. In the coming months, they will work with the state to conduct peer support trainings across the state.

At present, Medicaid does not reimburse peer support services, although the substance use disorder voucher covers some peer support services. While quantitative data describing the penetration rates and staffing of these services are not available, stakeholders described these services as not widely available throughout the system. While some provider stakeholders we interviewed noted that they have people with lived experience working as behavioral health professionals, most were not working in roles that specifically involved using their lived experience as part of the service delivery. The Recovery Talk line was mentioned as a resource that was intended to function as a peer support warmline. However, one stakeholder noted that it is currently being administered by a treatment provider and, in practice, is often staffed with clinicians, leaving the need for a peer-supported oriented warmline unfulfilled. Despite the limited availability of peer support services, stakeholders who had received peer support services reported that working with a peer support person made them feel more understood.

³⁰ The University of Illinois at Chicago Center for Health and Self-Directed Care maintains a listing of peer support training and certification programs nationwide:

<https://www.center4healthandsdc.org/map-of-national-peer-training-programs.html>

³¹ <https://behavioralhealth.dhs.nd.gov/addiction/free-through-recovery>

In interviews, stakeholders identified some potential challenges for expanding peer support services. Multiple stakeholders noted that stigma within the provider community remains so strong that many working in the field are not willing to disclose their own experiences. A significant challenge is to ensure that peers are utilized appropriately and are compensated with a livable wage so that people may be encouraged to pursue peer support as a career. Stakeholders we interviewed were concerned about a limited number of paid peer support positions within provider organizations. Moreover, stakeholders noted that the peer support positions that are currently available tend to be low-wage positions, and many are only part-time. They also noted that there are few peer advocacy organizations and peer-run organizations in the state, and that the peer community has limited resources to devote to activities that would promote the development of a stronger peer community.

Recovery Centers

Eight Recovery Centers (one in each region throughout the state) employ peer staff and are contracted through the HSCs or, in the case of Williston, run by the local HSC. These voluntary community-based centers are typically open Monday through Friday, with some operating during the weekends as well. The Recovery Centers offer structured and unstructured activities including job coaching, wellness groups, educational programs, and skills training as well as volunteering opportunities. Service user stakeholders who use the Recovery Centers endorsed them as supportive environments that promote recovery and provide individuals with a strong sense of community. One described the Recovery Center as a judgment-free place that helps people to avoid isolation and promote socialization. Another person described the Recovery Center as a “haven” that gives them a sense of community.

In the most recent biennium, the state provided Recovery Centers with a total of \$2.15 million, which is \$685,000 less than the funding in the previous biennium. Stakeholders from the Recovery Centers noted that because of this 25% reduction in funding, they have had to reduce hours and staffing. They noted that they are limited in the numbers of individuals they can support given the current levels of resources. Stakeholders also expressed concern that Recovery Centers are incorrectly seen as places for people to just “hang out” by legislators and other behavioral health leadership. They discussed a vicious cycle in which Recovery Centers are unable to implement robust recovery-oriented services because of limited resources, which then reinforces the misperception that they’re just a social club.

Based on our document review and conversations with stakeholders, it appears there may have been an original intention for Recovery Centers to function as peer-run organizations. Although some documents reference Recovery Centers as peer-run, they do not meet the widely accepted definition of peer-run organizations, and the existing state licensure standards do not stipulate that they be peer-run. A peer-run organization is defined as a program or organization in which all direct support staff and management are peers with personal lived experience of life-disrupting behavioral health problems and or/as service users of the behavioral health system. In addition, a majority of persons who oversee the organization’s operation and are in

positions of control (such as board members) must identify as peers [73]. While most Recovery Centers have a part-time peer specialist on staff, the Director—the only full-time position in some cases—is not required to be a person with lived experience. Moreover, most Recovery Centers are operated by traditional provider organizations and not peer-run organizations.

Employment Supports

In 2016, 64% of North Dakota Medicaid enrollees under age 65 had at least one full-time worker in the family, and 22% had no family members employed [74]. For those receiving publicly funded behavioral health services, however, there is a higher prevalence of unemployment. In the *2016 Behavioral Health Barometer* it is reported that 26.0% of adult mental health service users in the public health system in North Dakota are unemployed, but 35.2% are not in the labor force; in 2016, only 41.7% of working-age adults (ages 21 to 64) who received publicly funded outpatient mental health services were employed.

Research suggests that people with serious mental health conditions—even many who are psychiatrically disabled—want to work. Further, research suggests that if given adequate supports, people with serious mental health conditions are capable of attaining and maintaining competitive employment and that employment is associated

People with **psychiatric disabilities** have the highest rates of **unemployment** among those with disabilities.

In North Dakota, 41.7% of working-age adults who received publicly funded outpatient mental health services were employed in 2016.

with increased recovery, wellness, and self-sufficiency for this population [75, 76]. However, despite the desire and capacity to work, people with psychiatric disabilities have the highest rates of unemployment among those with disabilities; nationally, an estimated 15% of people with psychiatric disabilities are employed, while 65% of this population name employment as a goal [77].

Nationwide, people with behavioral health conditions face significant challenges finding and maintaining employment, including a lack of appropriate support services, labor force discrimination, work disincentives caused by state and federal policies, and ineffective work incentive programs [78]. Key informants identified several of these issues as significant in North Dakota. Several service user stakeholders described past attempts at pursuing employment supports that were met with family discouragement, concerns about losing public benefits, limited provider support, and negative interactions with the Department of Vocational Rehabilitation. In general, service user stakeholders we spoke with seemed to have limited knowledge of existing employment supports and programs such as Ticket to Work that are designed to remove barriers to employment for people with disabilities.

There are few employment support services available in North Dakota, and supported employment is not currently a Medicaid reimbursable service in the state. Supported employment involves provision of support services to assist individuals with serious mental health conditions to locate, attain, and maintain competitive employment in the community. Some limited employment supports are offered through the HSCs and contracted community providers. These include some job counseling supports, job skills training, and part-time or volunteer employment opportunities arranged through providers outside of the competitive workforce. Currently, 124 individuals in IDDT programs receive Individualized Placement and Support (IPS) provided by Community Options in two regions in the state. IPS is an evidence-based supported employment program that has been shown to help individuals achieve employment and retain that employment over time [79]. Community Options also offers supported employment for individuals with brain injury through its Return to Work program (discussed on page 100). The Recovery Centers offer some job training and support groups and services as well.

The Human Service Centers report some collaboration with local vocational rehabilitation programs. Another key informant indicated there is minimal collaboration and coordination between behavioral health services and the Department of Vocational Rehabilitation. Several stakeholders referenced attitudinal barriers within the Department of Vocational Rehabilitation, including an overemphasis on work readiness and “motivation” as a precondition for employment support services and a tendency to focus efforts on individuals who already have work histories and job skills (which excludes many individuals with long-term behavioral health problems). One stakeholder wondered why privatized vocational rehabilitation services are not available in the state, in the way that there are private licensed addiction counselors and therapists.

Housing Supports

Nearly all key informants indicated that unstable housing and homelessness has a negative impact on behavioral health outcomes as well as access to appropriate treatment for many North Dakotans. This was one of the most commonly cited challenges in our key informant interviews. Reliable data on the rates of homelessness in a rural state like North Dakota are difficult to find, although several data sources provide information on estimated numbers of people experiencing housing instability and trends in homelessness in the state over time. The most recent point in time homeless count in the state found 1,089 homeless individuals in North Dakota, 178 of whom were children under age 18 [80].

Table 6 presents numbers and characteristics of individuals who reported living in a homeless shelter or who received an HSC service related to homelessness during the study period.

Table 6

Demographic characteristics of people who are homeless and utilizing HSC services, SFY 2013 – 2017

Characteristic	N	%
Gender		
Female	695	40.3%
Male	1,030	59.7%
Age		
Age 0 to 11	15	0.9%
Age 12 to 17	10	0.6%
Age 18 to 24	154	8.9%
Age 25 to 44	825	47.8%
Age 45 to 64	672	38.9%
Age 65 or Older	50	2.9%
Race/Ethnicity		
Latino/Hispanic	64	4.0%
American Indian or Alaskan Native	281	18.2%
Black or African American	102	6.6%
White	1,121	72.6%
Other Race	40	2.6%

Source: HSC event and demographics data extracted January 2018 from the ROAP system; n=1,735

Notes: Homelessness was defined when an HSC service user self-reported their last known living arrangement as "in a homeless shelter" and/or if the service user received a PATH case management service. Data were missing for the following categories: gender (n=10), age (n=9), ethnicity (n=152), race (n=191). Other race includes Asian, Native Hawaiian or Pacific Islander, and individuals who designated more than one race.

The figures in Table 6 likely underestimate numbers of individuals with behavioral health needs who are homeless as they include only those who received some outpatient treatment and, importantly, do not include those with unmet behavioral health treatment needs and those who received a behavioral health service outside of the HSC. Based on available data, individuals who are homeless in North Dakota are predominantly male and aged 25 to 64. Racial and ethnic minorities, including Hispanics, African Americans, and American Indian populations are overrepresented in the homeless population.

There at least two important aspects of housing and behavioral health: availability of housing units and support services to help people with behavioral health needs maintain their housing.

Affordable Housing. Stakeholders indicated that a lack of affordable housing is one of the major barriers that people with behavioral health issues in North Dakota encounter, and a major contributor to homelessness across the state. Stakeholders noted multiple challenges facing North Dakota in terms of affordable housing. One such factor is the rapidly changing economic conditions in some parts of the state related to the oil boom. With these local surges in population and demand for housing, rents sky-rocketed and vacancy rates plunged. Landlords became unwilling to rent to Section 8 voucher holders. These rapidly changing economic conditions wreaked havoc on affordable housing access in those areas. As the oil boom has subsided some and vacancy rates are increasing, landlords may have become more willing to accept these vouchers. Even in areas with available housing units, however, the wait for assistance can be long, stakeholders reporting of a waitlist for Section 8 housing of up to three years. Numerous individuals noted that people with poor tenant histories, poor credit, and/or felony charges can have an especially difficult time finding housing units. Other key challenges are related to the rural nature of many parts of the state and geographic variations among the regions. In many rural regions, there is simply limited housing stock. It was also noted that the larger geographic areas to cover in rural areas can limit access to types of housing: It is easier to provide housing supports to individuals when they are located close together rather than spread out in the country. As a result, rural areas have been seeing an increase in the number of “mini-institutions” with 16 or fewer beds rather than seeing people remain in their homes with supports wrapping around them.

Stakeholders did note several recent efforts to address affordable housing shortages. For example, the North Dakota Housing Finance Agency (NDHFA) Housing Incentive Fund had made significant investments in affordable housing projects across the state in recent years before being defunded by the legislature as of June 30, 2017. Because of local flooding, the Minot area was able to access \$74.3 million in HUD National Disaster Resiliency funding, \$30 million of which must be spent on affordable housing. NDHFA’s Rural Housing Development Program was also mentioned by stakeholders as an ongoing initiative to increase the number of affordable housing units in the state.

In addition to the development of affordable housing units, stakeholders noted initiatives to help increase sustained access to existing housing units. The most frequently mentioned was the Landlord Risk Mitigation Fund (LRMF) in Fargo. The LRMF encourages landlords and property owners to rent to people experiencing homelessness or behavioral health issues, acting as an insurance fund for the first two years of their tenancy. It is a partnership among housing providers, service providers, and the tenant—providing tenants with stable housing and landlords with reassurance that they will be reimbursed for any damages or expenses. The LRMF was created in 2014 by the Coalition for Homeless Persons to overcome barriers that tenants with behavioral health histories and criminal justice involvement face when applying for housing. Stakeholders noted that the program has been working well, as it has given landlords peace of mind. Such assurances help overcome stigma and combat negative assumptions about people with behavioral health issues, as the

program demonstrates that the actual incidence of damage by these tenants is small. For example, the LRMF fund has had over 60 individuals covered by the program and only four claims filed as of 2017. Building on momentum for expanding the program statewide, the Money Follows the Person program recently received approval to fund a statewide Landlord Mitigation fund (\$150,000) for the ND Housing Finance Agency.

Another stakeholder mentioned a similar initiative to the LRMF that is in the planning stages by the Department of Corrections and Rehabilitation (DOCR), the Department of Commerce, and other agencies. The Department of Commerce would administer the program, which would provide unspecified incentives to landlords for renting to individuals with felonies and other housing barriers. The group is trying to find the \$300,00 to \$500,000 in estimated needed funding.

Stakeholders also highlighted resources meant to promote access to housing. The Department of Labor Human Rights Division has a website with numerous resources related to housing discrimination.³² The website has information on landlord and tenant rights, legal resources, and housing discrimination in general. One stakeholder also noted that a services collaborative had created a tenant resource guide based on conversations with service and housing providers. They learned that tenants often don't understand how to apply for housing, how to fill out applications. The guide was created to educate tenants on "housing 101" and create a common language for service providers. It was noted that such collaboration among services is critical to identify barriers, and that Permanent Support Housing projects (described below) would not exist without regional collaboratives.

Supportive Services. The second important aspect of housing and behavioral health is a lack of supportive services geared toward helping individuals with behavioral health issues maintain stable housing in the community. As several key informants noted, for many individuals, supportive wraparound services are needed alongside housing to ensure that housing placements can be maintained over time. Case management services specifically tailored to individuals who are homeless or at risk of homelessness are available in limited quantities in the state, funded by a SAMHSA grant.³³ In FY 2017, 367 individuals received PATH case management services.

Permanent Supportive Housing (PSH) is an evidence-based practice involving the provision of support services alongside independent housing for individuals with serious mental health and substance use disorders. Numerous studies, including seven randomized controlled trials, have documented that PSH decreases homelessness, lengthens housing tenure, and reduces inpatient and emergency department utilization. Moreover, service users consistently rate PSH as preferable to other housing models [81].

³² <https://www.nd.gov/labor/human-rights>

³³ <https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services>

Stakeholders identified several challenges related to finding and maintaining PSH. They indicated that one of the challenges is that most PSH units are centered in Fargo and other higher-population areas. It was indicated that since Fargo has more housing than any other city in the state, individuals will be sent to Fargo—regardless of where they originally came from—as part of their discharge plan from a mental health or substance use treatment facility.

Stakeholders noted that figuring out where to best locate new PSH projects and units has been a challenge, particularly because of the rural nature of the state. Yet stakeholder interviewees also noted the development of Housing First programs in Bismarck and Grand Forks. For example, the Grand Forks Housing Authority has been looking at best practices in other communities in the region, such as Cooper House in Fargo and New San Marco Apartments in Minnesota, resulting in the building of Housing First units and enhanced local coordination among some community providers. The community is also implementing the HUD-mandated Coordinated Entry approach for individuals and families experiencing homelessness to access housing and supportive services.

Documents and stakeholder interviews highlighted several efforts focused on further increasing access to PSH and other supportive housing. The North Dakota Housing Finance Agency has identified PSH projects as one of the types it will give priority points to in its 2018 Allocation Plan for the Low-Income Housing Tax Credit program [82]. The Housing Trust Fund 2017 Allocation Plan also identified PSH projects as receiving priority points. The NDHFA also helped create the Supportive Housing Collaborative³⁴ to further statewide development of supportive housing. This effort brings together representatives from the Housing Authorities, Money Follows the Person Housing Initiative, AARP, domestic violence and homeless coalitions, division directors from each division within DHS, non-profit developers, senior management staff at the housing finance office, HUD director, USDA rural development, and the Department of Commerce.

The financial case for provision of supportive housing services within North Dakota is demonstrated by a study of the Cooper House, a project of the Fargo Housing and Redevelopment Authority and the first PSH project in the state [83]. Cooper House is a 42-unit building for individuals who are chronically homeless, with priority given to those with disabilities. Mental health technicians are on-staff 24 hours per day. There is a licensed addiction counselor and a full-time case manager onsite daily, and also a part-time nurse. The study consisted of 66 tenants who resided at Cooper House between May 2010 and October 2011 and looked at their total service costs one year prior to entering the supportive housing project and one year after, finding a cost savings of \$204,140 for those tenants, representing a 37% reduction in service costs.

³⁴ <https://www.ndhfa.org/RentalAssistance/SupportiveHousing.aspx>

The Money Follows the Person (MFP) program was also highlighted as a successful initiative, having helped 262 people transition from nursing homes to supported housing in the community. The state contracted with the Center for Independent Living to help individuals with the transition.

Stakeholders also noted challenges related to the adjustment to being housed after years of homelessness, and of challenges navigating landlord/tenant and tenant/tenant relationships. Some noted that these challenges are magnified for New Americans, who are often individuals with histories of emotional or physical trauma who come from different cultural backgrounds and are tasked with navigating complex systems that are foreign to them. Others noted additional financial support would be helpful to individuals who are new to supportive housing as even when supportive services and assistance with housing goods are provided, they often do not cover things like appliances or utility bills.

Stakeholders also noted workforce issues as impacting the ability to provide supportive housing services. Case management and direct support positions have significant turnover, and there simply are not enough people in the field interested in filling these positions. Positions are often filled by recent graduates with limited experience, who often need to learn how to develop strong communication skills with landlords and tenants. The workforce shortages also make it more difficult for providers to provide services to scattered-site units, which requires more travel between sites.

Harm Reduction Strategies

Harm reduction approaches are increasingly recognized as key components of good and modern behavioral health systems. Through reducing the harm associated with problematic substance use, these strategies reduce unnecessary illness and death. In recent years, North Dakota has increased the use of evidence-based harm reduction strategies including naloxone and syringe services.

The state has instituted numerous harm reduction approaches in recent years in response to the aforementioned increase in overdose deaths. In April 2016, the DHS Behavioral Health Division in conjunction with the Non-Medical Use of Pharmaceutical Narcotics Task Force launched the Stop Overdose campaign.³⁵ Using authority given by North Dakota lawmakers, the North Dakota Board of Pharmacy began allowing all North Dakota pharmacists to prescribe naloxone to patients at risk of an overdose, their friends and family members, or other individuals in a position to assist in the event of an overdose. In 2017, with the passage of SB 2320, Syringe Access Programs³⁶ became legal in the state of North Dakota for communities who are deemed at risk for HIV and viral hepatitis infections due to people in that community who inject and are sharing injection equipment. SB 2320 established the development of syringe needle exchange programs designed to provide the opportunity to engage

³⁵ <https://prevention.nd.gov/stopoverdose>

³⁶ <https://www.ndhealth.gov/hiv/sep>

and educate individuals about recovery and reduce the incidence of HIV and hepatitis C among those who inject drugs

State and local efforts have resulted in a greater number of first responders carrying and using naloxone to reverse drug overdoses. For example, the Bismarck Mayor's Gold Star task force brings together representatives from the community to adopt evidence-based practices to address addiction, including distributing naloxone and training first responders.

Other Community-Based Services

A range of other community-based services were provided through the HSCs and through other Medicaid-funded sources in community settings. These services include skills integration, mental health technician supports, psychosocial rehabilitation, occupational therapy, and other similar supports. One service user stakeholder endorsed the case aide services they had received and was concerned that the service might be reduced, noting it was a primary source of support.

Stakeholders with experience working with American Indian populations noted that community health workers (also known as community health representatives) were working effectively with individuals—including individuals with behavioral health needs—in several of the tribal nations in the state. Community health workers are playing increasingly prominent roles in health delivery systems throughout the country [84]. States and tribal nations have discretion to formally define community health worker roles, but typically these workers are community members who receive training and certification to perform outreach, support wellness, and coordinate linkages to services for individuals with complex needs. Community health workers typically come from the same culture as those they work with and can provide in-home and community-based supports for a range of health and wellness issues.

One key benefit is that community health workers often have preexisting relationships with community members, which facilitates connection and engagement. Stakeholders saw a need for this service to be expanded statewide and described ongoing initiatives to pursue sustainable funding, including Medicaid reimbursement.

Several stakeholders noted that supported education services are extremely limited in the state and saw a need for expanding supported education alongside supported employment and other community-based services that address the social determinants of health. Community Options offers supported education to individuals enrolled in the Prairie St. Johns first episode psychosis program.

Self-Help and Mutual Support Groups

The Centers for Independent Living (CILs) offer mutual support groups, including groups for people with behavioral health–related needs. The CILs provide a variety of free or low-cost community services to people with disabilities, including people with mental health–related disabilities. These include support groups, assistance applying for services, and other assistance programs. In some cases, transportation to attend

groups is also provided. The North Dakota chapter of the National Alliance on Mental Illness (NAMI) maintains a website³⁷ that mentions three active affiliates in Fargo, Grand Forks, and Minot; however, it does not appear to be updated with any recent or upcoming events. Self-help groups for people in recovery from substance use problems, including Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, and others take place throughout the state as well. Stakeholders noted that these resources are not always well-known, particularly among behavioral health service users. There could be opportunities to partner with CILs and HSCs and health care providers to increase awareness of these groups in the community.

Residential Treatment

Residential treatment services are provided by a mix of direct HSC service provision, private programs, and contracted services. Because information about private programs was unavailable for this study, and information about contracted services was limited, it is difficult to offer a comprehensive picture of utilization and penetration rates for these services. Detailed information about the types of contracted residential treatment (substance use disorder vs. mental health, mix of adults and youth, etc.) were unavailable for this study, making a comprehensive account of these services difficult and beyond the scope of this report.

Figure 18 presents penetration rates for residential treatment for different service types. Because demographic data for many substance use disorder residential services were unavailable, we were not able to break substance use disorder treatment services into those for adults and those for youth, although it is likely that these services are predominantly delivered to adults. We were unable to obtain data on lengths of stay in residential services.

Figure 18

Penetration rates for residential services, SFY 2017



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system. Counts of unduplicated individuals receiving HSC-contract services in SFY 2017. Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

³⁷ <http://www.namind.org>

Notes: Counts of unduplicated individuals receiving HSC-contract services were available for 7 of the 8 HSC regions. The type of insurance for the following proportion of HSC service events could not be determined resulting in possible duplication of service users across the data sources: 27.7% adult mental health residential and 1.7% youth mental health residential. Persons with missing age (n=4) were not included in the penetration rate for mental health residential services.

Per capita costs for residential services are among the highest of all service types. Using best available data, FY 2017 per capita costs for residential substance use treatment were \$7,018, per capita adult mental health residential services were \$5,021, and per capita youth mental health residential services were \$11,052. Adult residential services are funded predominantly through the HSCs, which represents a significant additional cost because they are not supplemented with federal Medicaid dollars.

While many stakeholders voiced a need for additional residential services across the board (mental health and substance use services for children, youth, and adults), others noted that it is difficult to assess the need for such services when the current community-based service array is insufficient. These stakeholders noted that rather than pursuing additional residential capacity, it is essential to address gaps in the community-based service continuum that would address needs before they rise to levels requiring residential or inpatient treatment. Based on our experience and on the literature on best practice in behavioral health system design, we are in agreement with this assessment of residential service need; given the current gaps in the community-based system, it is difficult to determine whether North Dakota's residential and inpatient capacity is sufficient.

Residential Mental Health Treatment for Adults

Adult residential mental health treatment services are financed primarily through contracts throughout the state. Providers offer a continuum of services ranging from supports for people living independently to intensive 24-hour staffed programs. Many residential treatment services include psychosocial rehabilitation services, community engagement, and skills training.

Stakeholders saw a gap in residential mental health services for individuals with complex needs, particularly those who are just transitioning from the state hospital, individuals who are homeless, and individuals with co-occurring substance use issues. Several residential programs appear to require a period of sobriety as a precondition for enrollment, which precludes individuals with active substance use problems from receiving the service.

Residential Substance Use Treatment

Multiple stakeholders described challenges in receiving reimbursement for residential substance use services. Mental health and addiction parity legislation theoretically dictates that residential substance use treatment services should be covered by insurance; however, there is inconsistent enforcement of parity laws in North Dakota and nationwide. Residential substance use treatment providers described significant difficulty with maintaining financial sustainability given the current funding streams,

which include HSC contracts, substance use disorder voucher funding, private insurance, and—for facilities with 16 or fewer beds—Medicaid funding. Larger residential substance use treatment providers are unable to receive Medicaid reimbursement because of the federal Institutions for Mental Diseases (IMD) exclusion that prohibits Medicaid funding for facilities larger than 16 beds that serve adults with behavioral health issues.

Approximately 31% of individuals receiving inpatient substance use disorder treatment in North Dakota are American Indian. This figure spotlights a particularly high need for a continuum of services that are culturally responsive for American Indian populations. Currently, members of the Mandan Hidatsa and Arikara Nation are working to develop a 16-bed residential SUD treatment facility in Bismarck, which will expand options for American Indians with a need for this level of treatment throughout the state. However, some stakeholders were concerned about the availability of a SUD treatment workforce to staff the new facility.

One stakeholder noted a need for services such as sober living environments that serve as a step-down to smooth the transition from inpatient and residential services to community living. This stakeholder noted that, currently, many individuals simply return to the environments they were in before treatment, which frequently results in relapse and a “revolving door” dynamic. Stakeholders also noted that individuals with co-occurring serious mental health problems face difficulty being admitted to residential substance use disorder treatment facilities.

Residential Treatment for Children and Youth

Many stakeholders believed there was a shortage of residential treatment for children and youth in the state. However, others noted that a lack of community-based services and inappropriate placements across the service continuum made it difficult to determine whether there is a shortage of beds or whether other structural issues made it appear as though capacity is inadequate.

A 2007 Minot State University study examined mental health symptom severity of 200 North Dakotan children in treatment foster care and residential treatment facilities [85]. Interestingly, the authors found no correlation between mental health symptom severity and level of care in the sample. The study also documented a high level of inconsistency among providers regarding the appropriateness of placements for children and youth, and a significant number of children held at a level of care that was inconsistent with the severity of their mental health symptoms [86]. Several stakeholders echoed these findings, describing a “double bottleneck” in the system—with some children and youth underserved while others are receiving services at a higher level than is needed.

Stakeholders with experience placing children and youth in residential treatment said that, in current practice, a family needs to receive a rejection letter from each open placement before looking elsewhere. This process was experienced as complex, time-consuming, and burdensome by stakeholders, who described a need for a streamlined application process for residential placements. Stakeholders expressed concern that

residential treatment facilities “cherry pick” individuals with lower levels of need and are reluctant to take children and youth who have challenging behavior. Social service agency staff described scenarios in which children and youth with significant needs are placed in an inappropriate setting, kicked out the same day, end up in a hospital, and are then returned home because of a lack of hospital beds. Children and youth in these situations, which some stakeholders referred to as “limbo,” have restricted access to services and education. Stakeholders noted that this dynamic may be related to inadequate staffing (in terms of numbers of staff as well as staff competencies) and capacity to manage challenging behaviors within residential facilities. One stakeholder expressed concern that this dynamic results in children and youth with behavioral health issues being inappropriately placed in residential treatment facilities. This dynamic also results in open beds in facilities that serve lower-need individuals because they will not accept high-need individuals on waitlists. In general, it appears to be incredibly difficult to find an appropriate placement for children and youth in the state, and many end up in inappropriate placements. This results in poorer outcomes and greater difficulty reunifying children and youth with their parents. It also results in an inefficient system, with some children receiving a higher level of care than needed and others with high needs receiving no care at all.

Several stakeholders saw the challenges in the residential treatment and foster care systems as being inextricably related to shortages in the community-based system, including prevention, outreach, and in-home and community-based treatment and support services. Stakeholders described a dynamic in which the lack of community-based behavioral health services for youth results in children and youth needing to enter into the custody of the state in order to access any services. They suggested missed opportunities for diverting these relatively lower-need populations from the system entirely, which would create more capacity for those with higher needs. They also described a cycle in which children receive out-of-home services, only to be returned to a family environment where there are significant unmet behavioral health needs, which eventually results in being cycled back into the residential treatment and/or the child welfare system.

Treatment Foster Care

In North Dakota, foster care services are overseen by the state and administered regionally through HSCs and County Social Services agencies. If parental rights are terminated, the DHS Children and Family Services Division becomes the custodian of the child and works to secure permanent placement or adoption. The County and State entities have systems of collaboration in place to support these transitions. Although there are multiple foster care providers in the state, PATH ND is the state’s only treatment foster care provider. According to PATH ND, between 2013 and 2017, 1,842 children and youth received treatment foster care services—in comparison, just 216 children and youth received regular foster care services during this period. The numbers of treatment foster care referrals remained consistent over the period, ranging from 360 to 375 referrals per year. The average length of stay in a PATH ND treatment foster care placement when the youth is not in the adoption process is 12 months; for youth in the adoption process, the average length of stay is 30 months.

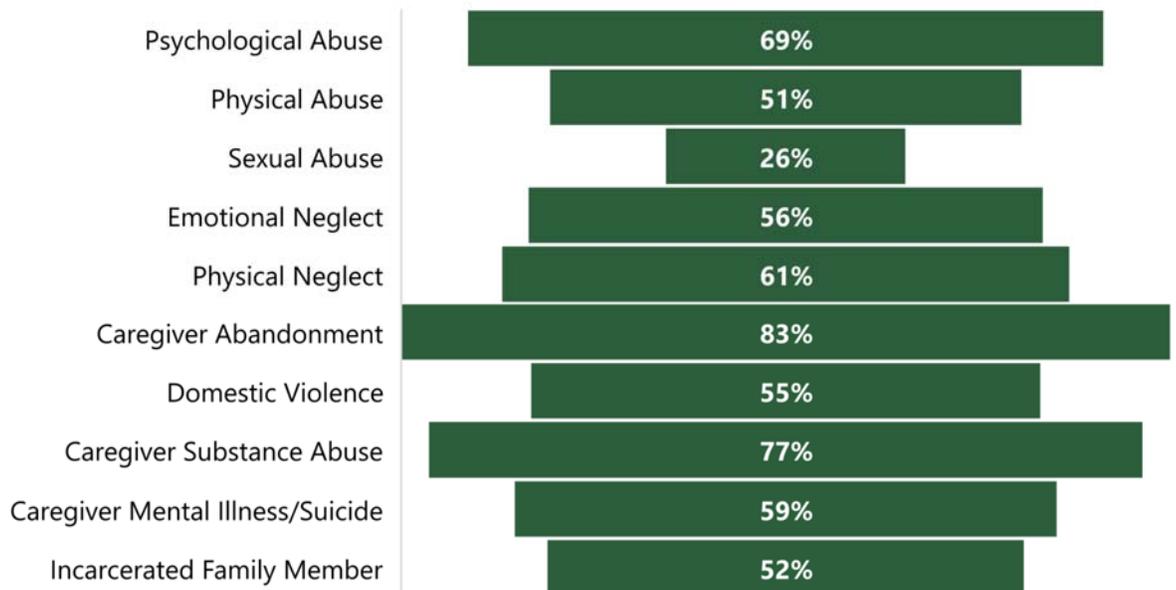
About 50% of children and youth in treatment foster care are female, with a small number identifying as transgender. Over half (58%) are under age 13, and 18% are aged 0 to 5. A majority of those served in the treatment foster care system are children and youth of color; 51% are racial and ethnic minorities, the largest being American Indian (38%). Many stakeholders noted this highly disproportionate representation, and this was also raised in the Talking Circle with representatives from each of the tribal nations in North Dakota (described in Appendix D).

While foster care is typically considered part of the child welfare system and residential treatment is considered part of the behavioral health system, stakeholders we spoke with described the systems’ populations and services as highly interrelated and overlapping given the high prevalence of behavioral health treatment needs among children and youth involved in child welfare systems.

Several data points indicate that the population in treatment foster care have complex needs: Children and youth in North Dakota’s foster care system are exposed to very high levels of trauma, indicated by Adverse Childhood Event (ACE) data collected by PATH ND for all children entering into the system in 2016 and 2017 (Figure 19). A robust literature documents the positive correlation between ACEs and a range of negative behavioral health outcomes [87].

Figure 19

A high proportion of foster care children and youth admitted in 2016 and 2017 had indicated **adverse childhood events**.



Source: PATH ND; n=366; Children and youth in the sample endorsed an average of 5.9 ACEs.

In 2016, PATH ND screened 70 children in treatment foster care using the Trauma Symptom Checklist for Young Children, and average scores for each subscale were within the clinical range. In addition to very high levels of trauma and trauma-related behavioral health issues, children and youth in the foster care system experience high

levels of residential instability; in 2017, 44% of children and youth newly placed in foster care had been placed in four or more settings prior to coming to PATH ND, while only 7% had no prior placement. Prior settings include other foster care settings, residential treatment, and the corrections system.

A high proportion of youth involved in the child welfare system are also involved in the justice system. In 2017, approximately 25% of youth placed in foster care had at least one legal charge prior to placement, and 7% had four or more legal charges at the time of placement. Between 2013 and 2017, 53 newly placed youth were in the custody of the Division of Juvenile Services (an average of 11 youth per year).

Currently, there is one treatment foster care provider in the state, PATH ND.³⁸ Foster parents in these programs are highly trained. As of 2017, there are 230 children and youth in treatment foster care, with a state-wide waitlist of approximately 75 children and youth. Stakeholders noted that there is a high proportion of children and youth entering into treatment foster care relative to regular foster care, and, as in other states, the numbers in foster care have been steadily rising. PATH ND has developed specialized foster homes where youth can transition from the corrections system to a home while maintaining services and going to school.

Several stakeholders felt that the current foster care system capacity was inadequate to meet the needs of the community. They cited lengthy waitlists and high numbers of new referrals each month. Treatment foster homes in the state are only authorized for two placements per home, which some stakeholders saw as a challenge. One stakeholder noted a treatment foster home in another state that is licensed to support up to six individuals, and the stakeholder noted a positive experience with this provider. There is evidence that children in the foster care system move in and out of placements with considerable frequency. In 2017, 44% of the 245 children being placed in foster care or treatment foster care in North Dakota had four or more placements—only 7% of had no prior placement.³⁹

The 2016 *Child and Family Services Reviews: Final Report*, produced by the U.S. Department of Health and Human Services Administration for Children and Families, details findings based on foster care case reviews and interviews and focus groups with state stakeholders and partners [88]. The review concluded that barriers to accessing critical services—including behavioral health services—affects permanency in foster care and, ultimately, child and family safety and wellbeing. The report concluded that there is inadequate funding, long waitlists, and low availability of providers within the foster care system. They also found that services were not sufficiently individualized to meet specific needs. PATH ND indicated recruitment of additional foster homes as a priority and has made internal changes in the past year to increase recruitment and licensure of full-time qualified treatment foster care homes. Recruitment can be challenging because it is a stressful position for families

³⁸ <http://www.nexus-yfs.org/sites/path/index>

³⁹ Source: PATH ND; Prior placements included other foster care homes, residential child care facilities, PRTFs, youth correctional centers, out-of-state placements, and extended psychiatric hospitalizations.

(stakeholders indicated that there are stresses related to raising a family as well as the emotional toll associated with developing an attachment to a child and then seeing them go).

Additional Challenges Related to Child Welfare Systems

Although leadership in the child welfare system in North Dakota appeared to value the importance of supporting families and preserving community connections, stakeholders noted that, currently, the child welfare system is fundamentally crisis-oriented, focusing more on child protection than on child and family wellbeing. Multiple stakeholders expressed consternation that families are unable to access needed services for their children unless they relinquish custody. Stakeholders also expressed a need for child welfare systems to intervene earlier and provide more in-home and preventive services to support child and family wellbeing stem the negative consequences of long-term child abuse and neglect.

Parental Behavioral Health Use Issues. Stakeholders pointed out a high correlation between parental substance use issues and foster care involvement. Many parents of children in the foster care system have substance use issues, including opioid use disorders, which are on the rise, as well as alcoholism, which has been a longstanding community challenge. These stakeholders stressed that parents of children in foster care have their own behavioral health treatment needs. Stakeholders also noted that the needs of children and youth entering into foster care have changed over recent years, with increasing numbers of children who are born drug-exposed. As drug epidemics hit communities, there is a “ripple effect” in which children born during these drug epidemics appear in the child welfare system as they are older. Stakeholders stressed the importance of the system adapting to meet the changing needs of these children and families. One stakeholder representing a social service agency said that half of the children in foster care in that region at the time of the interview (9 out of 18 children) were under age two and drug-exposed.

Access to treatment for parents is often poor, which presents a barrier to family reunification, particularly if participation in treatment is a condition of reunification. Stakeholders described dynamics in which parents expressed readiness for treatment, were told that treatment options weren’t available, and were no longer engaged or interested in treatment once those options became available. There is some indication that there has been an increase in the number of children and youth in foster care with parents who have substance use issues. For example, in 2015, 63 foster care episodes in Grand Forks were related to substance use issues, which is more than twice the amount of substance use–related foster care entries in 2011 [86]. One stakeholder identified an assumption among some social service staff that parents who are in treatment for substance use disorders aren’t fit to have custody of their children, which may result in children being inappropriately placed in foster care.

Disparities by Race/Ethnicity and Sexual Orientation/Gender Identity. Racial and ethnic minorities, especially American Indian families, are overrepresented in the foster care system in North Dakota and in many other communities in the United States [89]. Stakeholders reported wide regional variation

in the types and quality of relationships between tribal nations and social service agencies. In general, stakeholders identified a need for increased cultural competency among social service agency staff in working with American Indian families. While there appears to be an attempt to place American Indian children in foster homes with American Indian parents, there is very limited availability of these homes, and it is even more difficult to place an American Indian child in a family from the same tribal nation. In November 2017, just 15% (13 out of 84) of American Indian youth in foster care were placed in American Indian foster homes.⁴⁰

Stakeholders also noted that current licensing requirements for treatment foster care lack sensitivity to and acknowledgment of cultural differences. For example, requirements related to furniture inspections, pet vaccinations, and square footage per child may deter some American Indian families from successful licensure. These challenges were also reflected in the 2016 *Child and Family Services Reviews: Final Report* in which the Administration for Children and Families' Children's Bureau identified the following area as "Needing Improvement" in North Dakota: *The foster and adoptive parent licensing, recruitment, and retention system is functioning to ensure that the process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide [88].*

Sexual and gender minority youth may also face cultural barriers to finding appropriate foster care placements. There is extremely limited data on the numbers of LGBTQ youth in the foster care system because information on sexual orientation is not currently collected. Anecdotally, stakeholders described LGBTQ youth experiencing judgmental or intolerant treatment in foster care. PATH ND does have policies designed to support the needs of youth on the gender continuum,⁴¹ although local enforcement of these policies may be challenging given the nature of foster care.

Crisis, Inpatient, and Long-Term Care Services

Services that are designed to support individuals in crisis and to address the most intensive behavioral health service needs can be viewed as falling on a continuum that spans proactive voluntary support for individuals experiencing distress to longer-term residential and inpatient treatment stabilization services. Ideally, services earlier in the continuum are provided in ample quantities to avert the need for costly and life-disrupting inpatient care.

First Responders and Behavioral Health

Stakeholders made it clear that first responders—police, fire, and medical—are frequently the front line of response for behavioral health crises in North Dakota. Stakeholders emphasized a need to support first responders to divert individuals with behavioral health needs to treatment rather than bringing them to jail. It is also critical that first responders understand how to identify when a behavioral health

⁴⁰ Source: PATH ND

⁴¹ <http://www.nexus-yfs.org/sites/path/services/gender-continuum-nd>

issue may be present, and to relate to individuals experiencing behavioral health issues in a trauma-informed way.

Crisis Intervention Team (CIT) training is a police-based model designed to improve police officers' interactions with individuals in mental health-related crisis. Through classroom-based and experiential training, officers learn how to deescalate crises and divert individuals to treatment rather than the criminal justice system. The model is used widely throughout the U.S., and research studies have documented its effectiveness in connecting individuals to treatment, improving officers' attitudes toward and knowledge about mental health issues, lowering arrest rates, and reducing criminal justice system costs [90]. During interviews, stakeholders emphasized the geographic variability in how officers respond to individuals experiencing psychiatric crisis. Widespread training in models such as CIT should help ensure a more consistent, supportive approach for all first responders. Fargo's police department appears to be one of the most active in the state in regard to CIT training: The training is offered frequently to police officers in Fargo and open to officers in surrounding communities as well. Stakeholders noted that one challenge with CIT training is that it lasts a full week, which can make attendance difficult, particularly for officers in rural areas where there is limited staffing. Stakeholders believed that more incentives and support would be needed to increase participation, particularly for rural police departments.

In general, stakeholders saw a need for a more coordinated strategy for first responders to respond to behavioral health-related emergencies. Stakeholders saw a need for coordination across first responders, behavioral health providers, and other entities in the justice system to determine when a person should be transported to a hospital rather than to jail and what to do when there are no services to transport a person to. Stakeholders saw a need for more crisis services to respond to behavioral health-related emergencies alongside first responders.

Warmlines and Crisis Response

Service user stakeholders we interviewed expressed a desire for services such as a warmline, where they could talk to individuals and receive support when distressed but not in need of crisis services. These stakeholders saw a need for support services that can be used before a crisis and indicated that having access to these supports could avert the need for life-disrupting and costly emergency and crisis services.

Stakeholders also noted the 24-hour crisis lines operated by each of the HSCs, as well as a 211 suicide intervention/prevention hotline as other resources that individuals could access when beginning to find themselves in crisis. Some stakeholders indicated that such services are not always useful. One service user spoke of calling the 211 hotline during a crisis and feeling like the crisis line staff didn't know how to help, with the result being that nothing happened; this person had been unable to access any help. And this experience appears to not be unique: According to a Mental Health Advocacy Network survey, 47% of service user respondents indicated they have needed phone crisis services to address emergency mental health needs. However, 44% of them rated their satisfaction as a "1: Worst experience" [10].

Although crisis response services have long been recognized as an area of need, the lack of these services in North Dakota remains a challenge. Many stakeholders noted the lack of options available to individuals when they are experiencing crisis, particularly outside of the Fargo area. Stakeholders noted that crisis services for children and youth are particularly lacking. Several stakeholders expressed concern that calling the police is included as part of a crisis response plan for children and youth because of a lack of alternative crisis response options. Similarly, first responders noted that there are limited resources for children and were concerned about an overreliance on first responders to address behavioral health crises for children and youth. Stakeholders said that if parents and caregivers have the capacity to take their children to the population centers in Fargo, Minot, or Bismarck, there might be more options for appropriate crisis response treatment. For families without access to transportation to these population centers, the result is often that the child in crisis remains in the home, and parents and caregivers do the best they can to help the child. In such cases, stakeholders noted there is often no connection to services.

Multiple stakeholders endorsed the mobile crisis team in the Fargo region as a community asset that supports adults who are in crisis. The program is run by a private provider organization contracted through a local HSC and provides a triage and rapid response by mental health professionals within the community. In April 2018, the Gladys Ray Shelter and Fargo Cass Public Health launched a Mobile Outreach Program for the Fargo area to assist individuals in need of intoxication or withdrawal management and provide outreach engagement services to individuals in the community with a substance use disorder. This program is funded in part by the Behavioral Health Division.

There was a strong desire among stakeholders we interviewed to see such services available throughout the state. Stakeholders noted that there have been prior efforts to expand mobile crisis services, with proposed budget line items funding mobile crisis services in each of the state's eight regions that were not ultimately approved. In the 2015 legislative session, funding was approved for two regions, Fargo and Bismarck. Stakeholders from DHS noted that when the RFP was issued for the Bismarck area, however, there were no responses, so the funding for that area was cut and no crisis mobile response services were established. One stakeholder noted that the success of mobile crisis units in neighboring communities in Minnesota might be hard to duplicate because of Minnesota's comparatively more robust system of wraparound community supports.

Outside the Fargo area, stakeholders indicated that often the only options for service users are to wait until their therapist's office opens (and their therapist can respond) or go the ER or hospitals. While the HSCs do have a 24-hour crisis line, as do some private providers, many stakeholders indicated that more options need to be made available. In the Medicaid data, we identified 4,140 Medicaid claims for ambulance services that were primarily related to a behavioral health issue during the study period. In FY 2017, 323 people had 962 behavioral health-related ambulance claims, an average of three claims per person. We also identified 13,499 behavioral health-

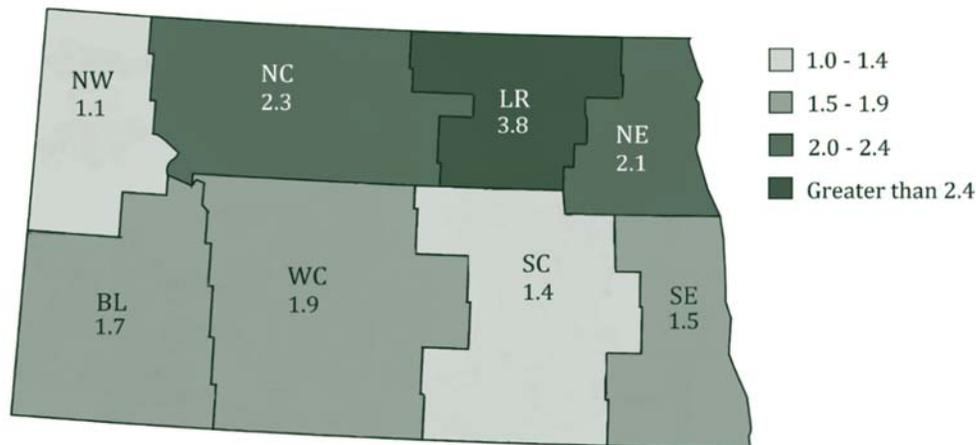
related emergency department claims for 5,638 individuals (an average of 2.4 claims per person).

Approximately 27% of those who visited an **emergency room** for a behavioral health issue were **under age 18**.

Figure 20 shows the penetration rates of behavioral health-related emergency department (ED) use by region. The Southeast region ranked sixth lowest in ED utilization, with only the Northwest and South Central regions ranking lower. Although any number of factors might impact ED utilization, it is possible that the relatively low rates in the Southeast are related to the availability of mobile crisis services in that region. The higher penetration rates in the Lake Region is also notable, suggesting a higher need for crisis response services in that area.

Figure 20

Emergency department utilization per 1,000 is particularly high in the Lake Region; notably, it's lower in the Southeast, where mobile crisis services are available.



Source: North Dakota Medicaid claims and enrollment data, SFY 2017, extracted October 2017; n=1,427

Note: Regional location is defined as the service user's place of residence. Individuals may be counted in multiple regions during a single fiscal year.

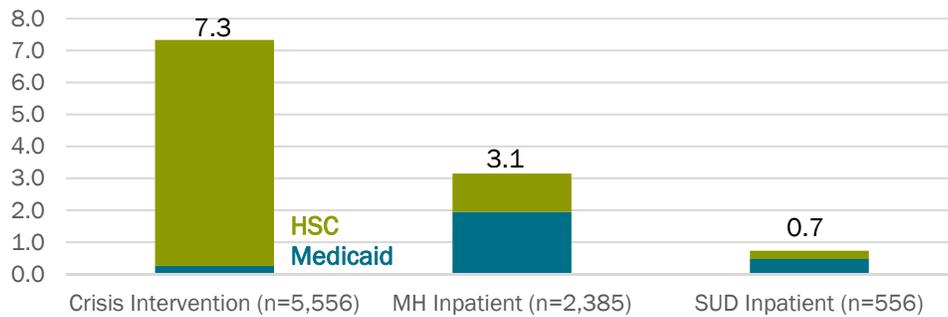
Those who used behavioral health-related ambulance and emergency department services were more likely to be female, and roughly one in four individuals who used one of these services was American Indian. Approximately 27% of those who visited an emergency room for a behavioral health issue were under age 18. (More details about demographic characteristics of service users by service type can be found in Appendix B).

Crisis Intervention and Inpatient Services

Figure 21 depicts utilization rates for crisis intervention and inpatient services. Because a high proportion of these services are delivered by contracted providers, information on length of stay, costs, and service user demographics was limited.

Figure 21

Shorter-term crisis intervention services were the most commonly utilized of the crisis intervention and inpatient services, at rates of 7.3 per 1,000.



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system. Counts of unduplicated individuals receiving HSC-contract services in SFY 2017.

Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Counts of unduplicated individuals receiving HSC-contract services were available for 7 of the 8 HSC regions. The type of insurance for the following proportion of HSC service events could not be determined resulting in possible duplication of service users across the data sources: 100.0% crisis intervention and 4.7% mental health inpatient.

Some past needs assessments and stakeholders we interviewed referenced a need for more inpatient capacity in North Dakota. In addition to the state-operated psychiatric hospital in Jamestown, there are four other private hospitals that have psychiatric units. There is a total of 323 psychiatric inpatient beds in the state, or 42.6 beds per 100,000 individuals [91]. Despite some stakeholder impressions of a shortage of beds, North Dakota’s current inpatient psychiatric capacity is approaching close to twice the US average of 23.6 beds per 100,000 population. Although the “ideal” number of inpatient beds is a highly complicated topic that is inextricably related to the availability of adequate community-based and outpatient services, the current bed numbers in the state do not indicate an obvious shortage.

The state hospital in Jamestown is the major provider of inpatient services for people with serious mental health conditions in the state. The hospital is licensed for up to 125 beds, with staffing for 100 beds and an average daily census ranging from 70 to 95. The 100 staffed beds include a 25-bed unit for substance use treatment services. In addition to serving as the primary inpatient service provider in the home HSC region, the hospital also serves as a secondary inpatient resource for those coming from another hospital setting. As Table 7 indicates, utilization of the state hospital has remained fairly stable over the past five years. Average and median length of stay have also remained stable over the past four years, hovering around 50 days average length of stay.

Table 7

Utilization of the state hospital has remained fairly stable over the past 5 years, averaging roughly 1,150 discharges per year.

	Discharges	Length of Stay (days)	
		Average	Median
FY 13	1077	66	28
FY 14	1179	50	24
FY 15	1186	52	28
FY 16	1143	52	27
FY 17	1172	48	27

Source: AIMS data, n=5,757

Note: These data do not include 577 individuals admitted and discharged the same day during the study period.

The demographic makeup of the population served by the state hospital does show some deviation from the general population in the state. As Table 8 illustrates, those admitted are less likely to be White (75.7% vs. 87.9%) or female (37.2% vs. 48.7%), and more likely to be Black (4.3% vs. 2.9%). Of note, there is significant overrepresentation of American Indian populations, with over three times the number of individuals expected based on state population figures.

Table 8

Demographic characteristics of individuals admitted to the state hospital in FY 2017 and those of the general population of the state

	North Dakota		State Hospital	
	%	n	%	n
Race/Ethnicity				
Caucasian (White)	87.9	666,240	75.7	720
Black	2.9	21,981	4.3	43
Native American or Alaskan Native	5.5	41,687	18.4	182
Other Race or Unknown	3.7	28,044	4.6	46
Gender				
Female	48.7	369,123	37.2	369
Male	51.3	388,829	62.8	622

Sources: AIMS data and U.S. Census, July 1, 2017; n=757,952 for general population, n=991 for individuals admitted to state hospital

Available at <https://www.census.gov/quickfacts/ND>

Note: Other Race includes Asian, Native Hawaiian or Pacific Islander, and those who indicated more than one race.

Stakeholder interviewees identified a number of challenges related to state hospital services. Issues with access and discharge planning were noted. One stakeholder noted there were limited points of entry to the state hospital beyond law enforcement, and no transparency of admission criteria or mechanisms for appealing an admission decision. This stakeholder was also concerned that, after admission, individuals are discharged back to the community with medication but with little to no connection to other services. It was noted that this challenge was particularly frustrating for law enforcement, who will frequently directly place someone in the state hospital to get needed services only to see the individual back on the street soon after with no additional services in place or changes to their service plans. Stakeholders expressed concern that the lack of adequate discharge planning and community reintegration services can result in individuals trapped in a revolving door between the hospital and the street.

Stakeholders also indicated that the state hospital has been especially challenged serving individuals from the criminal justice system, indicating that any sort of violent behavior will result in a return to the non-therapeutic environment of the jail or prison, or the person will be discharged to homelessness. The perception from one stakeholder was that the hospital wants less high-need, less high-intensity individuals than those coming from criminal justice, and that the state hospital staff views this population as less deserving of their services than others.

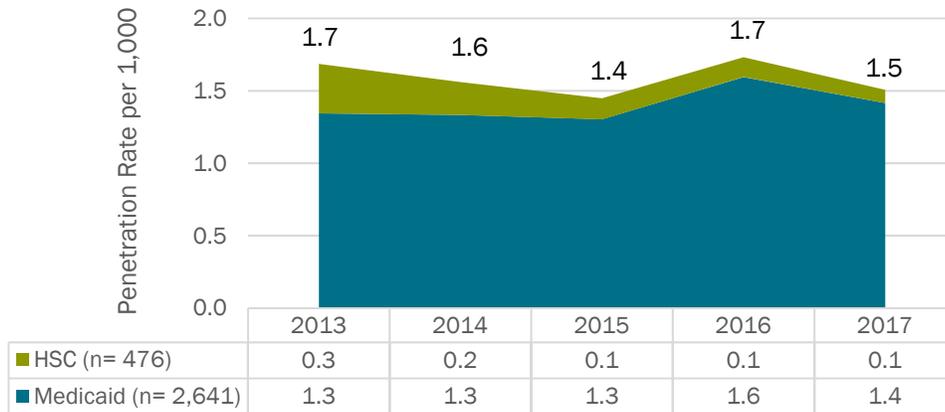
Geropsychiatric Services and Behavioral Health in Long-Term Care Facilities

Many individuals with behavioral health needs are receiving care in skilled nursing facilities, nursing homes, or other long-term care facilities specifically designed to meet behavioral health needs of older adults. The state hospital operates 24 beds designated specifically for older adults with serious mental health conditions, and there are two specialized geropsychiatric nursing homes in the state. These facilities work with the state hospital, mental health facilities, and other skilled nursing facilities to coordinate admissions.

Figure 22 displays the penetration rate for individuals who received a behavioral health-related service in a long-term care facility during the study period. These services include those delivered in the geropsychiatric specialty nursing facilities as well as services delivered within other skilled nursing facilities, nursing homes, and custodial care facilities throughout the state.

Figure 22

Medicaid is the primary funder of behavioral health services delivered in long-term care facilities, and penetration rates remained relatively steady across the study period.



Source: North Dakota Medicaid claims and enrollment data extracted October 2017; HSC event and demographics data extracted January 2018 from the ROAP system.

Penetration rates are calculated using the U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: The type of insurance for 16.2% of HSC service events could not be determined resulting in possible duplication of service users across the data sources.

As Figure 22 demonstrates, HSCs cover the costs of behavioral health services in long-term care facilities for only a small number of individuals. Behavioral health-related long-term care services accounted for the largest proportion of costs for a single service in this study; in FY 2017, 16.1% of all public behavioral health service dollars went to behavioral health services delivered in long-term care facilities, with a per capita cost of \$12,713. American Indian populations were very underrepresented in long-term care facility services, comprising just 1% of the population of long-term care facility service users.

Stakeholders noted that the population of individuals receiving behavioral health services in long-term care facilities has gotten younger over the years, with younger (under 65) populations now comprising a larger share of

In FY 2017, 16% of all public behavioral health service dollars in North Dakota went to services delivered in long-term care facilities, with a per capita cost of \$12,713.

the population. The quantitative data confirmed this observation: Approximately 24% of individuals who received a behavioral health service in a long-term care facility in FY 2017 were under age 65. Stakeholders were concerned that staff competencies and services offered in these settings may be incompatible with the population needs. In particular, stakeholders saw a need for more training and staff competency in the

areas of substance use disorders (including co-occurring mental health and substance use disorders) and suicide and self-harm.

Stakeholders who work with older adults with behavioral health needs experienced access to the state hospital as somewhat restricted and expressed challenges related to their staff's capacity to meet the needs of residents with complex behaviors. They also discussed difficulties in arranging for individuals to be discharged from the state hospital into a geropsychiatric facility, citing long wait times for receiving screenings that are required for admission.

Services Supporting Transition from Institutions to Community

Stakeholders described a common challenge of individuals with SUD receiving inpatient or residential treatment and then being discharged to the community with inadequate outpatient and community-based supports. There is a high prevalence of substance use disorders among individuals on Medicaid receiving institutional treatment. These SUD issues are often part of complex and interrelated needs for the population, who may also have co-occurring chronic health conditions and mental health issues. There are also complicated issues for older adults and people with physical disabilities and intellectual or developmental disabilities, who also have an SUD. There is a clear need for screening, assessment, referral, and transition support to ensure that people are supported before, during, and after transition. Supports should include SUD treatment as well as housing, employment, and mental health treatment needs. Investments in these areas make sense from a human and economic perspective given the high rates of return to institutions if individuals with complex needs and SUD are not connected to needed services and supports.

Services that support transition from inpatient treatment to community-based settings have received increasing focus in recent years. Such services are recognized as a critical step in the provision of inpatient care as they create linkages between inpatient and outpatient care environments and have a goal of reducing recidivism and system costs associated with avoidable readmissions.

The Peer Bridger program is a short-term intervention intended to serve as a “bridge” back to the community after a psychiatric hospitalization. It typically involves visits with a peer specialist to establish a relationship and rapport, create a transition plan, and connect individuals with appropriate outpatient services. Peer Bridger support is typically provided for 7 days but can be extended for up to 14 to 30 days if there's a specific need. Optum reported that its Peer Bridger programs in New York and Wisconsin resulted in 30% reductions in inpatient days and health cost savings of 24% [73].

In 2017, North Dakota took part in the Money Follows the Person SUD learning community, which was involved in developing strategies for team-based, person-centered approaches that involve both pre- and post-transition wraparound support and address concurrent housing, employment, and mental health needs for people with SUD transitioning to the community from institutional settings. Through a similar initiative, Texas saw successful community transitions and improved community tenure and independence (paid employment, engagement in educational

and volunteer activities). In North Dakota, the Learning Community resulted in planning for the development and implementation of screening tools and referral processes for individuals with SUD transitioning from institutions. In the coming years, there will need to be concerted efforts to coordinate with HSCs on this initiative, and there could be a role for the SUD voucher services to meet the needs of this population. Peer support could also be a resource for this population. In future work, it will be important to consider the types of training and expertise that screeners and support staff will need, particularly given workforce shortages and the rural/frontier nature of the state.

Services for Justice-Involved Populations

Several data sources indicated a very high prevalence of behavioral health issues in the state's criminal justice systems for both adults and youth. Key informants indicated that up to 40% of the North Dakota Department of Corrections and Rehabilitation (DOCR) population was receiving behavioral health services in the community before incarceration; this figure only includes those engaged in treatment and does not include those with undiagnosed and/or untreated issues. The DOCR estimates that up to 85% of women incarcerated have a substance use disorder. An estimated 70% of youth in the juvenile justice system nationwide meet the criteria for at least one mental health disorder [92]; stakeholders we interviewed estimated that this prevalence is similar for North Dakota and that the juvenile justice system has seen an increase in the numbers of children and youth diagnosed with serious emotional disturbances in recent years. One stakeholder with expertise in the juvenile justice system noted there is a high co-occurrence of mental health and substance use problems for justice-involved youth, and that a majority of justice-involved youth had another family member who was also justice-involved.

Table 9, on the following page, presents demographic characteristics of the 2,271 persons who utilized an HSC service in a jail or court setting.

Table 9

Characteristics of justice-involved persons utilizing HSC services, SFY 2013-17

Characteristic	N	%
Gender		
Female	764	33.9%
Male	1,492	66.1%
Age		
Age 0 to 11	28	1.2%
Age 12 to 17	230	10.2%
Age 18 to 24	422	18.6%
Age 25 to 44	1,116	49.2%
Age 45 to 64	428	18.9%
Age 65 or Older	42	1.9%
Race/Ethnicity		
Latino/Hispanic	77	3.7%
American Indian or Alaskan Native	335	16.5%
Black or African American	89	4.4%
White	1,563	76.8%
Other Race	47	2.3%

Source: HSC event and demographics data extracted January 2018 from the ROAP system; n=2,271

Notes: Data for all individuals who received an HSC service in the location "jail" or "court." Data were missing for gender (n=15), age (n=5), ethnicity (n=177), and race (n=237).

While not a comprehensive picture of all justice-involved individuals with behavioral health needs in the state, the data in Table 9 provides some information about the characteristics of the state's justice-involved population. As with several other service types discussed in this report, American Indian populations are overrepresented relative to population demographics. Justice-involved individuals are also more likely to be male and aged 18 to 64, although a sizable number are youth.

Recent needs assessments we reviewed indicate that DOCR has an overrepresentation of people with behavioral health issues because of the lack of community resources. A common theme in stakeholder interviews was that, in many cases, individuals with behavioral health conditions are charged with and sentenced for low-level crimes to facilitate access treatment that would be inaccessible in the community. Stakeholders described instances in which law enforcement personnel purposefully charge people to provide access to treatment, and judges will often sentence high-needs individuals with behavioral health disorders in the hopes that they will be able to get treatment while in prison. It was noted that there can also be a tendency by the public to view law enforcement as the main pathway for accessing services, particularly for children and youth. This has led to the criminal justice system functioning as a default behavioral health provider for many people in North Dakota, and stakeholders rightly saw this dynamic as highly troubling.

Stakeholders viewed the solution as being related to significantly more robust, wraparound services available to individuals within the community. Many stakeholders stressed that individuals with justice involvement experience multiple

barriers to accessing services. A common theme was that, in general, community-based treatment providers are resistant to serving individuals with criminal justice histories. One stakeholder also noted that it is common for individuals to “burn bridges” with community treatment providers, which further limits their options. Another stakeholder described a “caste system” in both inpatient and community-based services, in which people who are justice-involved face greater difficulty accessing services, receive lower-quality treatment, and are generally considered “less deserving” than those with no justice involvement.

We also observed a great amount of energy and attention in the state to improving the system’s capacity to meet the needs of justice-involved individuals with behavioral health needs, particularly within the DOCR and the Department of Juvenile Services. In 2017, the DOCR received an additional \$7 million to partner with DHS and develop community-based services to divert individuals with behavioral health issues from incarceration. Two recent pieces of legislation created additional flexibility in sentencing, reduced drug use charges, and appropriated \$500,000 to develop a behavioral health provider network and process for justice-involved individuals. In the coming years, DHS plans to expand Free Through Recovery upstream to focus on diversion activities in addition to its current initiatives.

In response to disproportionate representation of justice-involved youth in the child welfare system, the RFK National Resource Center for Juvenile Justice Dual Status Youth Initiative was convened in May 2017. The group is a collaboration between the North Dakota Court System, the Department of Human Services Children and Family Services Division, the Department of Corrections and Rehabilitation Division of Juvenile Services, the North Dakota Juvenile Justice State Advisory Group, and other stakeholders.⁴² This group seeks to enhance collaboration and improve policies and practices related to youth involved in both systems. The Juvenile Justice State Advisory group has also been examining disproportionate minority contact in Fargo and Bismarck and exploring effective strategies for reducing disparities in arrests.

Services within the Criminal Justice System

North Dakota had a total of 1,850 people incarcerated in prisons at the state level as of mid-April 2017, according to DOCR staff, with an increase in the prison population since 2013 [93]. Native Americans are greatly overrepresented in prisons, by more than three times the proportion one would expect based on general state population figures. One key informant indicated that this may be due in part to higher rates of substance use disorder and criminalization of associated behaviors. There are no specific programs within DOCR that focus on American Indian populations, but there is currently one multicultural specialist working within DOCR.

The adult services division of DOCR manages the state penitentiary and offers addiction treatment services, a sex offender treatment program, mental health programs through the treatment department, and an education program. There is a women’s facility, the Dakota Women’s Correctional and Rehabilitation Center, as well

⁴² <https://rfkncij.org/dsy-initiative-launched-in-north-dakota/>

as a Division of Juvenile Services consisting of eight regional offices and the Community Services and Youth Correction Center. Programming in the Division of Juvenile Services includes drug and alcohol programming, mental health services, sex offender programming, pretreatment, and security intervention. The Tompkins Rehabilitation and Correction Center is a collaborative effort between DHS and DOCR, with a 120-bed facility located on the grounds of the state hospital. This facility serves individuals in the custody of DOCR, with clinical services provided by state hospital staff.

DOCR implements a detailed process for behavioral health assessment that guides where and when treatment services are offered and informs transition planning. Typically, those assessed as having moderate to high risk are referred to treatment in the prison, and individuals considered low-risk who do not receive treatment while incarcerated are referred for treatment when they are back in the community. While in the prisons, individuals who qualify for treatment have access to evidence-based substance use disorder treatment. DOCR offers cognitive behavioral approaches, such as Thinking for a Change.⁴³ All facilities use a standardized checklist to measure adherence to evidence-based practices, further supporting fidelity. Stakeholder interviewees from DOCR recognized that there would be less recidivism if they employ EBPs, so many of the practices used, both behavioral health and others, are based on research.

In contrast to services offered in prisons, stakeholders indicated that there is a general lack of services available to individuals in jails, and that what services do exist are often special initiatives targeting women. There are currently no licensed social detox services within any jails in North Dakota, and this lack of detoxification beds and services within jails was consistently highlighted by stakeholders.

Services to Support Community Re-Entry

Stakeholders said that the need for community-based services is high among the re-entry population, although the newly-implemented Free Through Recovery program is expected to expand capacity in this area. One stakeholder noted that for those who do not meet the threshold of SMI, medication management is often the only service that individuals have access to (those with SMI are usually eligible for case management). According to a June 2016 DOCR presentation to the Incarceration Issues Committee, half of probations officers reported that 75% or more of their probationers had unmet needs for substance use disorder treatment, and 50% of probationers are in need of mental health services.

Stakeholders identified multiple efforts and initiatives underway to help support individuals re-entering the community from criminal justice settings, including the previously-mentioned Free Through Recovery initiative. Launched in February 2018, the Behavioral Health Division contracted with 14 providers to provide care coordination and recovery support services to participants (an additional seven providers were in the process of contracting with the Behavioral Health Division at

⁴³ <https://nicic.gov/thinking-for-a-change>

the time of this report). Free Through Recovery referrals are currently being made by probation and parole.

The state-wide Transition from Prison to Community (TCP) Initiative⁴⁴ focuses on transitioning individuals in prison back to the community from incarceration in a safe, effective manner. The TCP approach involves a variety of state, local, and private leaders of stakeholder agencies who have an interest in public safety. TCP members meet regularly to review and address issues that impede successful reintegration in the community. Stakeholders also spoke of a related mental health integration effort, where 120 days before release, prison staff will set up appointments with HSCs and other community providers to facilitate access to services upon release.

Stakeholders identified key challenges affecting community re-entry and reintegration, and were quick to emphasize that, currently, access to community-based services are extremely limited for individuals re-entering the community after incarceration. As described above, individuals with justice involvement struggle to find appropriate services in the community for a range of reasons.

Another frequently cited challenge was access to housing. Felony convictions bar individuals from accessing HUD-funded and other publicly funded affordable housing options, and many private landlords are unwilling to consider renting to this population, especially if an individual is a registered sex offender. Access to housing has been especially challenging in areas affected by the oil boom; since demand for housing is so high in these areas, landlords don't even have to entertain the idea of renting to someone with a criminal justice history to fill their units. The situation is better in some of the larger communities, where there are more housing units available. There are some landlords more amenable to renting to felons than others. Stakeholders spoke favorably of the F5 Project,⁴⁵ a non-profit started by a person with lived experience of criminal justice involvement that provides housing and support services to people with histories of involvement with the justice system in Fargo.

Another major barrier to successful reintegration to the community concerns Medicaid eligibility. North Dakota is one of 19 states in which an individual's Medicaid benefits are terminated—rather than merely suspended—as soon as the person is incarcerated.⁴⁶ This means that instead of simply activating coverage upon the person's release, the person must reapply, impeding their successful transition back to the community. Since individuals are not eligible until they are officially released, prison staff assist individuals on what they need to do to get re-enrolled, but the individual themselves has to enroll again within 30 days of release.

⁴⁴ <https://www.nd.gov/docr/adult/tps/tpci.html>

⁴⁵ <https://www.f5project.org/>

⁴⁶ For a map of state policies on Medicaid suspension, visit

<http://familiesusa.org/product/medicaid-suspension-policies-incarcerated-people-50-state-map>

Therapeutic and Juvenile Courts

Therapeutic courts provide an opportunity for individuals charged with crimes to participate in court-monitored treatment instead of incarceration. DOCR supervises multiple sentencing alternatives, most notably the Community Service Programs and Drug Courts. Drug court programs operate at the District Court level in the state. The first was founded in 2000, and there has been a more significant expansion over the past 13 years. There are currently five drug court locations across the state (Bismarck, Mandan, Fargo, Grand Forks, and Minot), with two located in the Fargo area. DOCR employs a full-time drug-court coordinator. Judges and state attorneys often volunteer their time to run the courts, and interested district judges must seek approval from the Chief Justice to run a court in their jurisdiction, as they utilize already strained judicial resources. There have been discussions about expanding beyond drug courts to mental health courts, veteran's courts, and domestic violence courts, but stakeholders indicated expansion has been limited because of concerns about a strain on judicial resources. North Dakota is currently one of two states nationwide that does not have a veteran's court.

Stakeholders noted that the provision of treatment services varies by the drug court. HSCs provide treatment services for four of the courts; the Cass County drug court contracts with a private provider for services. Treatment services are state-funded through the HSC budgets. Even though an individual may be drug court-involved, the delivery of treatment services remains under the purview of the service provider, not the court. There was some question whether the dominant 12-step approach of many community treatment providers is the best approach when more evidence-based options could be employed. Entry criteria also vary depending on the drug court; all drug courts exclude sexual offenders, but some also exclude people who have committed violent crimes. The majority of people going through drug courts have multiple misdemeanors or a felony DUI or some sort of drug case. Risk assessments are conducted both before and after court involvement, with a moderate or high-risk score required to be eligible. Although the courts do gather some information about the effectiveness of the programs, stakeholders indicated that successful capture of these data varies greatly from court to court. In general, stakeholders were unsure whether the specialty courts are producing the desired outcomes in the state. It is unclear whether the lack of demonstrated outcomes is a result of noted data challenges, the model itself, or the noted lack of access to evidence-based practices within community settings.

The general juvenile courts—which include six juvenile drug courts—are responsible for youth ages 7 to 17 who committed a delinquent or unruly act, as well as children from birth to age 17 who are deprived of care from a parent or guardian. Substance use disorder-related issues are often the primary reason for involvement with the juvenile court system. According to the Department of Juvenile Services, in 2016, 9% of delinquent referrals were for possession of drug paraphernalia, 9% for possession of a controlled substance, and 25% for unlawful possession/consumption of alcohol; an untold amount more have some sort of substance use disorder that likely contributed to their incarceration but was not the primary reason for referral.

Additional System Challenges and Strengths

In addition to service gaps, we identified a number of challenges facing the North Dakota behavioral health system through stakeholder interviews and a review of the literature, including state and local reports and national reports and published articles. These system-wide issues and challenges are discussed in this section, and these challenges inform the recommendations presented in this report.

Coordination and Collaboration with Related Systems

Gaps and limitations in behavioral health systems, such as those we documented in this study, are often due, in varying degrees, to fragmentation related to multiple funding sources and diverse organizations with differing missions that provide only certain services to a specific subpopulation of persons needing behavioral health care. These circumstances are the consequence of numerous historical factors and are not easily rectified. However, coalitions, steering committees, task forces and the like can serve to enhance communication or coordination among the various parties involved in providing behavioral health care. Coalitions and related models may or may not have decision-making authority but can be effective at promoting consensus, limiting the negative consequences of competition, and advocating for addressing unmet needs.

Almost universally, stakeholders described good-quality relationships between government entities. However, these same stakeholders identified systems siloing as a challenge for ensuring a coordinated behavioral health system. When asked about the quality and type of interdepartmental collaboration, a common stakeholder response was that they have a lot of meetings together, but that translating talk to action once the meeting adjourns is a challenge.

Stakeholders identified “siloing” between Child and Family Services, the Behavioral Health Division, and Medical Services—even though all are located under the Department of Human Services—and stated that disconnects have contributed to the challenges discussed in this report under “Treatment Foster Care and Residential Treatment for Children and Youth.” These challenges are further complicated by the fact that school districts and the Department of Public Instruction are similarly siloed.

Another common theme from the stakeholder interviews was a need for more collaboration and integration between the behavioral health system and the education system, including systems that support early childhood. This gap was identified in previous system assessments as well [11, 12].

Regarding communication between state and local entities, stakeholders described inconsistencies among HSCs and social service agencies, with some centers/agencies being more collaborative and engaged than others, and often because of individual staff relationships.

In recent years, numerous state and local stakeholder groups have formed to address behavioral health issues. Most recently, SB 2038 established a task force on children's behavioral health. This seems particularly important in light of a commonly cited stakeholder concern that adult service system issues seem to eclipse the focus on child and youth-serving systems. For a detailed list of these groups and initiatives, see Appendix D (Behavioral Health-Related Initiatives).

Limitations of Current Data Systems

As discussed throughout this report and detailed in Data Sources and Methods within the “Background and Approach” section, there are numerous limitations associated with the various datasets with information about behavioral health services in North Dakota. These limitations make it difficult to accurately track overall penetration rates, costs, and service user characteristics over time and could be informative in future efforts to enhance data systems in North Dakota. In 2015, the Behavioral Health Stakeholder group included a recommendation to explore a common data system across health and human service systems in the state. According to stakeholders we interviewed, this recommendation has yet to be implemented, and data systems in different parts of the behavioral health system do not yet “talk to each other.” Stakeholders saw a need to harmonize data across services and systems and to ensure that data that are collected, analyzed, and used to inform system design and development.

Ultimately, payment and service utilization data—which we relied on for this analysis—only describes what was paid for and what was done, but it does not necessarily provide guidance on what should be done in the future. Ideally, process and outcome information are collected to inform system improvement efforts in an ongoing manner. According to stakeholders we interviewed, there have been recent discussions around having all behavioral health providers—both state and contracted providers—submit common process and outcome measures, resulting in aligned cross-system measures that can be used to examine population health over time and inform service delivery and contracting decisions.

There are numerous barriers to implementing an integrated and data-driven system that uses process and outcomes metrics to assure service quality and drive positive change. Providers in general resist mandates to collecting data, and indeed, data collection and reporting can be highly resource-intensive; providers operating on tight budgets facing significant workforce shortages may not have the capacity to readily respond to data reporting requirements. Finding and retaining individuals with expertise in collecting and reporting data may be difficult for providers, and recruiting and retaining skilled data analysts may be difficult for state agencies, particularly if adequate resources for these positions are not available.

Workforce Issues

Multiple stakeholders described challenges finding and retaining a qualified behavioral health workforce throughout the system, and those are discussed in this section. Published data related to workforce and access to behavioral health services

in North Dakota presents a complicated picture. Approximately 92% of North Dakota counties have full or partial designations as medically underserved areas, and 96% of North Dakota counties are designated as mental health shortage areas [94]. North Dakota ranks 37th in the nation in the number of mental health providers, with 165.4 providers per 100,000 population (compared with 218 providers per 100,000 population nationwide) [43]. Most of the state has been classified as being a Health Professional Shortage Area, the exceptions being the Minot, Bismarck, Fargo, and Grand Forks [95].

Notably, the *2016 Medicaid Access Monitoring Plan* report, which involved a survey sent to all Medicaid beneficiaries across the state, documented that 79% of respondents reported that they were usually or always seen by behavioral health providers in a timely manner [96]. This finding runs somewhat counter to stakeholder perspectives on access to treatment, although it is possible that many stakeholder interviewees were referring to access barriers experienced by certain population groups—including justice-involved individuals, children and youth, and individuals with brain injury—that are discussed throughout this report. These population-specific barriers may not be picked up in a survey of the general Medicaid population.

In the 2017 legislative session, North Dakota lawmakers made some positive changes that will likely reduce some of the barriers to achieving a highly qualified and competent behavioral health workforce in the state, and these are described in Appendix E (Summary of Behavioral Health Legislative Actions). Additional and ongoing efforts are likely needed to ensure a robust, highly-qualified, and competent behavioral health workforce in the years to come.

In late 2017, the UND Center for Rural Health disseminated a survey to a wide range of behavioral health stakeholders in the state to gather perspectives on a range of potential interventions to increase the state's behavioral health workforce. The results of that survey, including the list of proposed interventions, are included in Appendix G (Survey of Behavioral Health Workforce Interventions: Impact and Likelihood). The Center for Rural Health survey included a detailed list of potential actions designed to enhance the State's workforce and asked respondents to rate the expected impact of the intervention as well as the likelihood of its implementation within the next two years. A total of 284 respondents completed the survey, representing direct service providers, administrators, advocates, and others with an interest in behavioral health in the state. Approximately half of the respondents indicated they were from rural regions in the state. Stakeholders expected a majority of the suggested interventions to have a positive impact on the workforce, although there was limited perception that interventions would be implemented within the next two years. Although ratings were relatively similar across the range of proposed interventions, stakeholders endorsed the following strategies as having the greatest likelihood of implementation and highest expected impact:

- Provide tuition assistance for behavioral health students
- Integrate behavioral health prevention screenings, which are reimbursable, into primary health

- Increase practices/organizations providing telebehavioral health services

Certification and Licensing

Issues with certification and licensing were frequently raised by stakeholders as key barriers to ensuring a well-qualified workforce. Multiple legislative efforts have tackled the issue (these are described in Appendix E). All bills have attempted to overcome challenges raised with licensing and certification of various human service professions within the state, such as expanding the types of professionals accepted as supervisors for licensing purposes and relaxing requirements on state residency for psychologists. Stakeholders saw these recent changes as being positive developments, but many believed they would not fully address what they saw as significant and complex issues.

One common interview theme was related to differing licensing requirements within the state across professional disciplines. Stakeholders cited differences in terms of administrative processes, educational and supervision requirements, and levels of rigor. They also noted that, often, North Dakota requirements do not align with other state and federal requirements, including those of the U.S. Department of Veterans Affairs and national accreditation bodies. Stakeholders saw a need for cross-training and collaboration across the state's licensing boards, which are currently distinct entities with differing scopes of work. They also saw a need to examine these boards to determine alignment with federal standards and those of other states.

Stakeholders described particular challenges related to licensing and certification for licensed addictions counselors (LAC) as resulting in a more limited substance use disorder treatment workforce. These stakeholders said that the licensing and certification process for LACs is as rigorous as for social workers and other professions, but that LACs tend to be viewed as lesser professionals and have generally lower wages. This dynamic creates a disincentive for individuals to pursue LAC as a career, or for individuals with mental health licensure to also specialize in substance use disorder treatment. SB 2088, which was signed into law in the 2017 legislative session, involved several changes to the scope of practice and licensing requirements for LACs. SB 2088 also removed a barrier related to supervision, allowing LACs to receive supervision from other behavioral health professionals.

Stakeholders also emphasized a need for allowing more reciprocity with other states for licensed behavioral health professionals. Stakeholders noted that some certifications, such as the Certified Psychiatric Rehabilitation Practitioner (CPRP)⁴⁷ could be recognized and accepted as meeting the requirements for the provision of community support services, as it is in the state of Minnesota and 14 other states. The CPRP certification, which is grounded in the ethos of recovery and deinstitutionalization, is compatible with peer support practices and aligned with the values of good and modern behavioral health systems. Similarly, stakeholders noted that the state lacks certification programs for the prevention workforce such as

⁴⁷ <https://www.psychrehabassociation.org/certification/cprp-certification>

certified prevention specialists and infant and early childhood mental health certification specialists, although such certifications are widely used in other states.

Workforce Staffing and Retention

Workforce shortages were a very common theme in stakeholder interviews. In particular, stakeholders remarked about a shortage of addictions counselors. For example, one interviewee noted that there are only two LACs in the entire Dickinson area for adolescents, both working for a residential provider, so the only way to access those services is to go into the residential facility. One individual noted that there is a single LAC for all of Spirit Lake. Housing support staff, and other in-home and community-based support workers were also noted as an area of key shortages. In addition, stakeholders remarked about the lack of providers in tribal nations, and these challenges are discussed further later in this section, under the heading Population-Specific Strengths and Challenges. In addition to mental health professionals, key informants indicated that there is also a shortage of the peer workforce (these were discussed previously in this section, under the headings Peer Support Services and Recovery Centers). Despite the challenges facing the peer workforce, it was suggested that the shortage of clinicians may help promote the peer support role, as it presented an opportunity for peer support specialists to step in and play a more emphasized, supportive role.

Many stakeholders noted a lack of cultural competency and representativeness in the current workforce. These issues are also discussed in greater depth, under Population-Specific Strengths and Challenges. It was noted that not all cultural conceptualizations of behavioral health and wellness align, and that the behavioral health workforce does not reflect the racial and cultural characteristics of the service user population. Stakeholders said that New Americans, American Indian populations, and LGBTQ communities faced additional challenges in finding providers able to deliver culturally competent care.

Another challenge has been retention. The shortage of providers at all levels leads to increased caseloads and pressures on current workers; this in turn can lead to increased burnout, and even more individuals leaving the field. It was noted that many behavioral health professionals are trained in North Dakota, but then leave the state to further their careers. It was speculated that this might be because of the conservative nature of the state, including the lack of legislative support for behavioral health services. Salaries and wages below the national average were also identified as contributors to problems with retention. This was true at all levels of positions: psychiatrists, nurses, therapists, LACs, peer support specialists, and housing and other direct support professionals. Individuals can often make significantly more money crossing state lines (e.g., into Minnesota). Stakeholders noted that providers in rural communities have had particular difficulty filling vacant positions, though the increase in telebehavioral health services (see below) has helped to attenuate the impact of staff vacancies in these communities.

Telebehavioral Health Services

Telemedicine is a nationally recognized approach to increasing access to care, including behavioral health care. In October 2017, the Center for Rural Health completed a study of telebehavioral health services for the DHS. The study included a survey of 109 healthcare facilities, public health departments, and mental health and substance use-related programs to gather information on telebehavioral health services, service user demographics, and payer sources. The full report, which is included in Appendix F, includes detailed information on facilities providing, receiving, and not currently utilizing telebehavioral health services, population groups receiving telebehavioral health services, telebehavioral health practitioners and service types, payment and insurance options, and technologies used.

The Center for Rural Health defines telebehavioral health services as the use of electronic communication and information technologies to provide or support real-time psychiatric, psychological, mental health, marriage and family, social work services, and/or addiction counseling at a distance. This includes the use of video conferencing (i.e., the internet, smartphone, tablet, PC desktop system, etc.) or other interactive communication technology to provide behavioral health assessment, diagnosis, intervention, consultation, supervision, education and information to a service user across a distance. A 2013 literature review of findings published from 60 scholarly sources within the prior 12 years assessed the use of telebehavioral health services in the United States and concluded that it was effective in treating individuals with a variety of behavioral health conditions [97]. The review determined that treatment delivered using telemedicine was comparable to face-to-face service delivery and that most people who received the service were satisfied with their level of care. Other remote health interventions, including social media platforms and smartphone applications designed to equip service users and providers with tools for engagement, coaching, and collaboration have proliferated in recent years.⁴⁸ Consultation models where psychiatrists consult to primary care physicians about the use of psychiatric medications for “routine” cases have also been used successfully in states and counties across the country; these models free up psychiatrists for patients with more complex medication regimes. Strategies such as arranging for eConsults, scheduling psychiatry “office hours” so psychiatrists can provide consultation to primary care physicians, and increasing training for primary care physicians on the use of psychiatric medications have been used to help augment the dearth of available psychiatrists in rural areas.

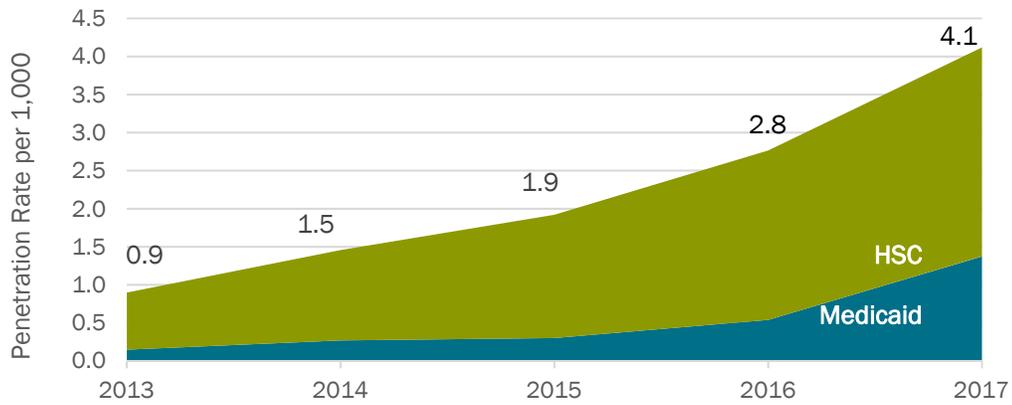
As Figure 23 demonstrates, telebehavioral health approaches have steadily increased in North Dakota, both in services delivered through HSCs and in other settings that receive Medicaid reimbursement. In SFY 2013, fewer than one person per 1,000

⁴⁸ For a discussion of recent trends and tools, see <http://www.nimh.nih.gov/health/topics/technology-and-the-future-of-mental-health-treatment/index.shtml>

population received at least one telebehavioral health service; in SFY 2017, the penetration rate was four times higher: 4.1 individuals per 1,000 population.

Figure 23

Penetration rates for telebehavioral health services rose across the study period

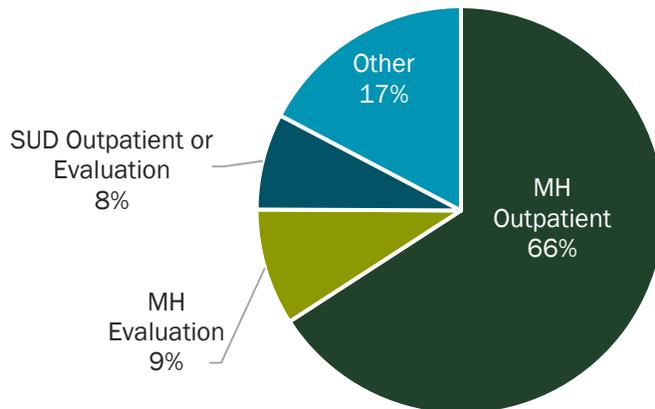


Source: Medicaid (n=1,518) and HSC (n=4,194) data.

Mental health outpatient service was the most commonly delivered service via telebehavioral health in both the Medicaid and HSC data; SUD outpatient and evaluation services comprised only 8% of the total claims and services across fiscal years (Figure 24). Figure 25 displays the geographical distribution of services that were delivered via telebehavioral health in the most recent fiscal year.

Figure 24

Mental health services accounted for 75% of all telebehavioral health services during the study period

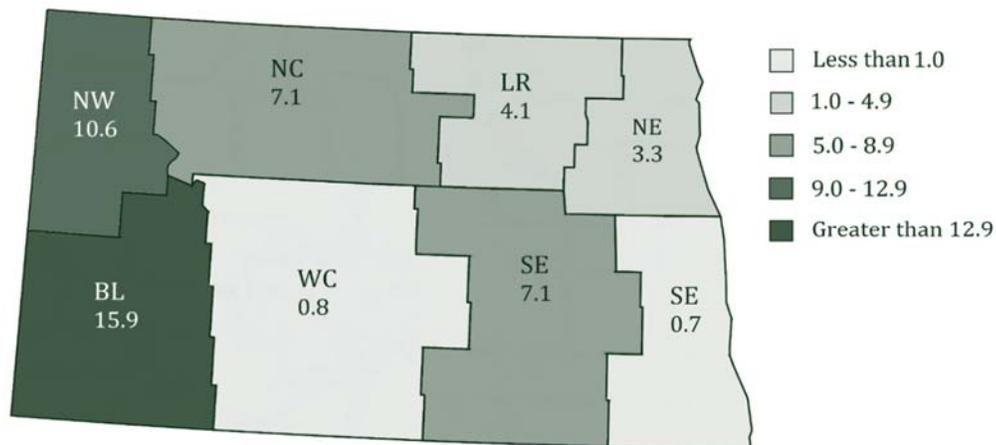


Source: Medicaid and HSC Data, n=22,847

Note: This figure only includes service events and claims with at least 100 events/claims appeared within a data source.

Figure 25

Regional penetration rate of telebehavioral health services, SFY 2017



Source: Medicaid and HSC data.

Many stakeholders described innovative approaches to telebehavioral health and endorsed them as opening up access to regions of the state that were previously underserved. In the Center for Rural Health Survey, a majority of facilities providing telebehavioral health services were located in urban areas whereas a majority of those receiving telebehavioral health services were in rural areas, indicating that telebehavioral health is being used effectively to address access and workforce shortage issues experienced in underserved rural communities. Of concern, however, was that among the 51 survey respondents that were not currently using telebehavioral health services, 34 (66.7%) were located in rural areas.

As shown in Appendix B (Service User Characteristics by Service Type), 8.5% of service users who received at least one telebehavioral health service in FY 2017 were American Indian, which is lower than the proportion of American Indian service users in mental health outpatient (12.1% for adults and 22.7% for youth) and SUD outpatient (23.3% for adults and 34.2% for youth), indicating that relatively fewer American Indians are receiving telebehavioral health services than are whites. Telebehavioral health services were also more commonly delivered to adults than to children and youth; 6.0% of those receiving a telebehavioral health service in FY2017 were under age 11, and 12.5% were aged 12 to 17. This finding was consistent with the Center for Rural Health report, which found that only 15 facilities (36.6% of those surveyed) received telebehavioral health services for children and youth.

In the Center for Rural Health's survey, the most commonly cited barriers to telebehavioral health services were a lack of behavioral health providers and in-house capacity, equipment and staff costs, a lack of clear regulatory guidelines, privacy and security concerns, provider and staff training and familiarity with technology, service user acceptance of receiving telebehavioral health services, limited reimbursement rates, and inadequate technology. A large majority (88.9%) of respondents said they did not have enough staff time to meet the need for telebehavioral health services.

Stakeholders we interviewed echoed these barriers, particularly the issue of provider resistance. One stakeholder familiar with telebehavioral health services noted that the technology is relatively simple to set up, but that it may be perceived as more difficult by already-overwhelmed providers. Some stakeholders noted that it can be more difficult to establish a therapeutic relationship through telebehavioral health and recommended incorporating in-person visits when possible, particularly at the beginning of a treatment episode. These stakeholders were quick to point out that telebehavioral health services are better than no treatment at all and are an excellent option for individuals who are unable to get to a clinic.

Stakeholders we spoke with expressed hope that telebehavioral health services would continue to expand in the state and saw possibilities for expanding telemedicine to include peer support, crisis response services, social work, employment supports, and services for children and youth. Stakeholders noted that there may be a lack of awareness of the extent to which telebehavioral health services have expanded in recent years. There was confusion among some stakeholders about whether telebehavioral health services could be reimbursed, particularly for LAC services. Similarly, provider stakeholders expressed a lack of clarity about state regulations and compliance issues for telebehavioral health services. They saw a need for more communication within and among behavioral health stakeholders so that this important resource can continue to expand, and so that providers can continue to implement innovative approaches to meet the needs of rural communities.

Population-Specific Strengths and Challenges

In the Medicaid and HSC data—and also in the data from the foster care system—we documented significant differences in service utilization among key population groups, particularly among American Indian populations in the state. Because of the relatively small numbers of many racial and ethnic minority groups in North Dakota, and because data on sexual orientation and gender identity are not reflected in our primary data sources, we relied heavily on qualitative interviews to explore the topic of disparities.

Behavioral health disparities are not particular to North Dakota; such disparities are widespread and affect many behavioral health systems [44, 98]. These disparities include less access to services, lower likelihood of receiving needed services, and greater likelihood of receiving poorer quality care. Experts in the field have identified the provision of culturally competent care as an important means of eliminating disparities in behavioral health. There are many definitions of cultural competency, but the classic and most commonly used was developed by Cross, Bazron, Dennis and Isaacs [99]. These researchers defined it as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. While the focus of the cultural competency literature is primarily on individuals from racial and ethnic minority backgrounds and with limited English proficiency, these principles also apply to work with other cultural groups, such as

individuals who are deaf and hard of hearing, individuals with physical disabilities, members of the LGBTQ community, etc.

American Indian Populations

During the Talking Circle with representatives from the four tribal nations in the state (notes from this meeting can be found in Appendix C), the following themes emerged:

- There is significant lack of resources to adequately address prevention, assessment, referral, treatment, and transition back into daily life.
- There is an overall lack of treatment facilities, residential options, providers, navigators (benefits coordinators), transportation providers and transitional housing. Communities need:
 - Better options for moms who are pregnant and who are addicted
 - Services for children and youth with behavioral health needs, including foster care options within tribal communities
 - More integrated options for persons with co-occurring mental health and substance use issues
 - The capacity to provide wraparound and rehabilitative supports and behavioral health services within the primary care setting
 - More services and supports that address men's health and wellbeing
 - A better system for tracking individuals once they are discharged
 - To get eligible individuals enrolled in Medicaid and Medicaid Expansion
- There is a significant lack of culturally responsive and culturally representative providers across the continuum of care.
 - There needs to be training in cultural competency across the board in social/human service systems in the state.
 - Training needs to be ongoing and robust, not one-offs that reach a lot of people and then fall off with attrition/turnover. For cultural competency, it is important to know the principles, values, and customs, as well as the history of American Indians. The training needs to be developed by American Indian people.
- Tribal communities want to take care of their own people.
 - They want help learning which services and programs are available to do that.
 - Because of a lack of services, children are often sent out of state or adopted by non-tribal members.
 - Traditional medicine needs to be part of the solution.
- Tribal communities want healthy communities that include a strong work force and economic development.

- Tribal leaders are often underrepresented in systems change activities. Needs assessment and systems change activities should integrally engage tribal members and should be designed so that the returns/benefits of those activities are seen by the tribal communities.
- Ongoing, meaningful and high-quality communication is needed to identify shared goals, fill knowledge gaps, share information resources, and coordinate action. Communication is needed among all partners, including:
 - Between the state and tribal nations
 - Between tribal nations
 - Within state and county
 - Within tribal nations
 - Between the state, tribal nations, and the IHS

In North Dakota and nationally, American Indian populations have higher rates of mental health conditions and substance use disorders than the general population. For example, American Indian children are 70% more likely to be identified in school as students with an emotional disturbance, and among U.S. adolescents ages 12 to 17, American Indian youth have the highest lifetime prevalence of major depressive episodes [100]. American Indian populations have higher rates of substance use disorders than the general population. In 2013, among persons aged 12 or older, the rate of substance use disorder was higher among American Indians or Alaska Natives than any other population group; 39% of American Indian adolescents aged 12 to 17 years had a lifetime prevalence of illicit drug use. Compared with the national average for adolescents aged 12 to 17, American Indian adolescents had the highest rates of lifetime tobacco product use, marijuana use, nonmedical use of pain relievers, and nonmedical use of prescription-type psychotherapeutics [101].

Relatedly, rates of suicide are far higher among American Indian populations than other demographic groups. According to the CDC National Vital Statistics System, the population adjusted deaths by suicide in North Dakota were 41.5 for American Indians and Alaskan Natives and 15.7 for whites in 2013 [101]. Suicide is the second leading cause of death—2.5 times the national rate—for American Indian male youth in the 15- to 24-year-old age group [101]. The trendline for suicide in the American Indian population in North Dakota is steadily increasing; the rate per 100,000 population is approximately three times that of the whole state population [42]. The North Dakota Suicide Prevention Coalition recently established a Native American Advisory Committee to inform suicide prevention activities in the state, and the DHS partners with leadership from the tribal nations on suicide prevention initiatives.

The above factors, along with higher rates of chronic medical conditions and other factors, likely contribute to the fact that in North Dakota, the average age at death for the White population is 75.7 years, and it is 54.7 years for American Indians [102].

These differences were evident in the service utilization data we analyzed for this study (for detailed information on service user characteristics, see Appendix B: Service User Characteristics). In addition to being overrepresented in treatment settings, American Indian populations are overrepresented in the criminal justice and child welfare systems. Although census population estimates may underrepresent the numbers of American Indian populations in the state, the levels of disproportionality are so high that even if American Indians comprised double that of the census estimate, differences would remain. Importantly, the data presented here do not include all services delivered within the tribal nations that are not reimbursed by Medicaid or delivered through the regional HSCs. Therefore, they do not reflect the full breadth of formal and informal community resources to support the wellbeing of American Indian populations, particularly those that take place in the tribal nations.

The above themes were echoed in stakeholder interviews and in our document review. For example, a 2015 Comprehensive Community Assessment and accompanying Cultural Narrative of the Spirit Lake Nation found high rates of Adverse Childhood Events (ACEs), homelessness, alcoholism, and poverty in the community, and a need for more resources and collaboration to support community wellbeing. Along with challenges, the review identified important strengths, including resiliency and ingenuity, indicating a strong capacity to heal and overcome community challenges [103]. Although each tribal nation is distinct and unique, these findings were reflected in conversations with representatives from many of the tribal nations in the Talking Circle discussion and stakeholder conversations. Many stakeholders also identified issues with transportation and access to services for people living in remote areas as being particularly pronounced for American Indian populations living in some of the most rural parts of the state. Stakeholders also described a need to foster, promote, and develop a stronger sense of cultural identity and community among American Indian populations and across tribal nations. One stakeholder said that although it is important to recognize and appreciate differences, “regardless of tribe, we are about relationships.” They noted that more cultural events and opportunities to connect would support a stronger sense of cultural identity, community, and ultimately greater wellbeing.

One common theme in the qualitative and quantitative data is that American Indian populations are overrepresented in treatment settings but underrepresented in the behavioral health

American Indian populations are overrepresented in treatment settings but underrepresented in the behavioral health workforce and leadership.

workforce and leadership. American Indian service users we interviewed described a need for social service and behavioral health providers who looked like them and shared their cultures and experiences, but they noted that nearly all providers they had worked with were white. Many stakeholders saw a need for increasing cultural responsiveness of services, including incorporating regular cultural competency training for all behavioral health providers and administrators, and enhancing the American

Indian behavioral health workforce by supporting professional development, recruiting, and retaining more American Indian clinicians. As noted above, there is a particularly strong need for more American Indian foster care homes. Stakeholders saw a need for more support for workforce development that takes into account differing cultural practices and education support needs. While there are some programs at local universities that focus on training American Indian clinicians, they appear to be somewhat limited in scope. For example, the University of North Dakota's Seven Generations Center of Excellence⁴⁹ trains American Indian psychologists but not psychiatrists. Further, there is no assurance that providers who receive training in these specialty programs will stay and work in the state.

Stakeholders also saw a need for tailoring EBPs—many of which were tested with white non-Hispanic populations—to be more culturally responsive. Stakeholders also noted that many needed and effective cultural practices are not considered “evidence-based practice” and are not covered by health insurance. In particular, stakeholders saw a need for ensuring that EBPs are appropriate for American Indian populations in partnership with American Indian communities.

Stakeholder interviewees echoed the need for more collaboration and partnership between the state and the tribal nations to address behavioral health disparities across the state. Stakeholders who had experience collaborating with the tribal nations stressed the importance of in-person connection, visiting tribal nations, sitting down with people there, and developing collaborative relationships. They noted that working from afar and not following through on conversations is common and can undermine collaborative relationships. Stakeholders described numerous areas of strong collaboration between the state and the tribal nations, and new initiatives have been developing in recent months, suggesting some positive momentum toward more collaboration. There are currently regular quarterly meetings between the tribal nations and Medicaid, and data sharing and communication appears to have grown in recent months. This development is important given the complexity of federal, state, and tribal health care financing.

New Americans and Other Racial and Ethnic Minority Groups

While the state is predominantly non-Hispanic white with American Indian populations as the largest racial minority group, other racial and ethnic minorities comprise a growing proportion of North Dakota's population. This section focuses primarily on stakeholder-identified needs of New Americans; however, many of these issues likely apply to other racial and ethnic minority groups. North Dakota is home to a diverse New American population, with 3.3% of the population foreign-born, according to the most recent census figures [104]. On its website, Lutheran Social Services of North Dakota reports that the state has welcomed approximately 400 refugees each year since 1997, with the majority resettling in Fargo, Grand Forks, and Bismarck [105]. These populations come from a wide range of countries, including

⁴⁹ https://ruralhealth.und.edu/pdf/article_0113.pdf

Somalia, South Sudan, Burundi, Liberia, Iraq, the Democratic Republic of Congo, Bosnia, and Bhutan.

Stakeholders identified a number of local resources that they viewed as effective in meeting the needs of New Americans, including New American Services at the Valley Community Health Centers (the FQHC in Grand Forks), Family Healthcare in Fargo, the New American Consortium for Wellness and Empowerment in Fargo, and the Refugee Resettlement program at Lutheran Social Services.

Stakeholders also described a range of barriers to accessing appropriate and culturally responsive behavioral health services for New Americans, who they saw as an underserved population. Stakeholders said that individuals with limited English proficiency face an additional set of barriers because of limited bilingual providers and interpreter services and written materials available only in English. They saw a need to support recruitment, professional development, and retention of multilingual and multicultural providers, which may include examining and addressing unique barriers to training and licensure for these populations. Creating a diverse workforce sometimes involves hiring individuals based on a combination of lived experience and formal credentials rather than relying on credentials alone, which some providers may view as a “risk.”

Importantly however, stakeholder-identified barriers were not limited to language. Multiple stakeholders noted that the cultural competency among behavioral health staff could be improved across the state. These stakeholders noted that many providers lack the training to understand and respond to the unique cultural perspectives and needs of many minority groups. Stakeholders saw a need for more cultural competency training, and remarked that these trainings cannot be one-time events, but rather should be part of an ongoing effort to enhance cultural sensitivity across the system.

Stakeholders noted that many New Americans have trouble navigating the complex health and social service systems more generally, including behavioral health as well as education, transportation, immigration, housing, and employment. There are also culturally specific differences that factor into the understanding and identification of behavioral health problems and decisions to seek help. These include differing cultural constructions of mental health and substance use problems and expectations for those problems to be addressed within the home rather than in public, and a lack of familiarity with the concept of talking with a professional about behavioral health issues. One stakeholder with extensive experience working with New Americans said that, just as providers need training, so do New Americans. These targeted trainings should include curricula to promote understanding of trauma and emotional wellbeing, information about how professionals can support individuals experiencing distress, and tools for navigating the state’s behavioral health system.

LGBTQ Populations

A substantial research literature documents that LGBTQ⁵⁰ youth and adults have a higher prevalence of behavioral health problems and face barriers to treatment that include provider stigma and discrimination and a lack of culturally sensitive services [106, 107, 108, 109]. LGBTQ individuals experience higher rates of suicide than many other populations, with LGBTQ youth about 3.4 times more likely to attempt suicide than their non-LGBTQ peers, and transgender individuals 10 times more likely to attempt suicide than the general population [44]. A smaller but developing body of literature suggests that LGBTQ individuals living in rural areas experience an even more complex set of disparities, compounded by issues of geographic access [110]. These disparities experienced in the health and behavioral health spheres are further compounded by more global experiences of work and housing discrimination and public homophobia and transphobia, each of which negatively impacts behavioral health and wellbeing.

Stakeholders we interviewed echoed themes that are consistent with the literature. LGBTQ stakeholders described experiences (their own and those of others in their communities) of behavioral health providers expressing stigmatized views about their gender identity or sexual orientation, toxic and discriminatory behavioral health care environments, and of interacting with providers who had limited knowledge about LGBTQ issues, particularly transgender issues. One stakeholder noted that it is difficult (and in some cases impossible) to know if a provider will be LGBTQ-friendly, and that this uncertainty adds an additional level of anxiety to an already-challenging process of accessing behavioral health treatment. Another stakeholder described work and education discrimination-related challenges that make it difficult for LGBTQ persons to obtain clinical education and licensure. While there are some lists of LGBTQ-friendly providers maintained by national and local organizations, LGBTQ stakeholders noted that they are not always updated and advertised.⁵¹

Numerous LGBTQ advocacy groups can be found in North Dakota, and there are a handful of LGBTQ-friendly social support organizations in the state, although the majority are located in the population centers, particularly Fargo.⁵² Through its *Creating Safe Spaces* program, Dakota OutRight offers free training resources to support professionals—including behavioral health providers—to offer culturally sensitive services to LGBTQ populations.⁵³ The organization is currently partnering

⁵⁰ While lesbian, gay, bisexual, transgender, and queer populations are often grouped together in reports like this one, it is important to note that this group is composed of multiple unique groups with varied demographic profiles and health and behavioral health-related needs.

⁵¹ NDSU maintains a list of LGBT affirmative therapists, though most are located in the western part of the state and in Minnesota:

https://www.ndsu.edu/hdfs/ftc/lgbtmha/resources_for_clients/lgbt_affirmative_therapists_list/

⁵² Dakota OutRight maintains a list of organizations and resources, available here:

<http://dakotaoutright.org/resources/>

⁵³ Information about Creating Safe Spaces, including upcoming training sessions throughout the state, can be found here: <http://dakotaoutright.org/creating-safe-spaces/>

with the North Dakota Suicide Prevention Coalition to increase the extent to which suicide crisis counseling is responsive to the needs of LGBTQ populations.

Persons with Brain Injury

In 2016, the North Dakota Center for Persons with Disabilities at Minot State University was contracted by the ND DHS Behavioral Health Division to conduct a statewide needs assessment on people with brain injury in the state, and the needs, services, and potential gaps for this population [111]. The report's major summary finding is that brain injury services and supports in ND are few, disparate, and disjointed. In particular, the authors concluded: 1) There are insufficient services for people with brain injuries in ND; 2) There is insufficient training and education about brain injury and its impact; and 3) Data systems and reporting processes for determining accurate census information on brain injury are insufficient. Following this report, an ND Brain Injury Advisory Council was formed, and there have been efforts to increase public understanding about brain injury as well as to increase DHS' capacity to meet the needs of this population.

There are a number of recent initiatives and resources to support the behavioral health needs of individuals with brain injury in the state. Beginning in recent years, all individuals receiving behavioral health services at HSCs are screened for traumatic brain injury. In FY 2016, of the 13,793 individuals who were screened, 10% indicated possible brain injury, 18% mild brain injury, 5% moderate brain injury, and 2% severe brain injury [61].

Community Options operates a set of pre-vocational and Return to Work programs for individuals with brain injury, and in 2015, the organization launched an evidence-based Work Start Return to Work program. In this program, participants receive an average of 5.5 hours per month with an Employment Specialist. Employment Specialists in the Work Start program also work to increase community awareness and work on job developments. As of May 2017, there were eight participants job searching and 16 employed. Despite its successes in connecting individuals to work, the program had a 50% cut in funding in April 2017, resulting in a waitlist and staff reductions. The number of brain injury Extended Service slots reduced from 25 to 4.

The North Dakota Brain Injury Network in the UND Center for Rural Health is another resource for brain injury. The network focuses on raising awareness and providing outreach, education, information, and referral and peer support for people with brain injury in the state and features resources and information on its website.⁵⁴

In North Dakota—and in many other states throughout the country—there is no single service system that focuses on the needs of people with brain injury. As a result, it can be difficult for these individuals to access a continuum of services that meets their often-complex needs. Frequently, when a person with a brain injury needs case management services, they are referred to the County Social Services agency; these local case managers typically have limited training and experience with brain injury,

⁵⁴ <https://www.ndbin.org/>

and the four short visits per year may not be sufficient to establish a relationship and connect individuals with appropriate services.

Individuals with brain injury—and particularly those with co-morbid mental health and substance use disorders—face barriers to accessing comprehensive services, particularly comprehensive wraparound case management and independent living/skills training. Stakeholders noted that some individuals have been terminated from services covered by the Medicaid waiver because of behavioral issues, even though these behaviors may be related to the brain injury. Multiple stakeholders described instances in which individuals were turned away from HSCs because of their brain injury. These stakeholders called on the HSCs to be more accommodating of people with brain injury, particularly given the high rates of co-occurrence of brain injury and behavioral health problems. Stakeholders also described a lack of knowledge about brain injury among first responders and the public.

Stakeholders noted that there is a lack of providers who are trained and qualified to work with individuals with brain injury. Stakeholders also cited incidences of individuals being ineligible for behavioral health case management services because of their brain injury or co-occurring substance use problems. One stakeholder who works with individuals with brain injury described a scenario that represents several key challenges for this population: An individual with co-occurring substance use, mental health issues, and traumatic brain injury requested help accessing mental health treatment. The person described themselves as severely depressed and had recently tried to commit suicide but was motivated to seek treatment. The worker called several treatment providers, but none were willing to take the person because of the co-occurring brain injury.

Community Perception of Behavioral Health

A large body of literature documents the deleterious effects of stigma on life chances related to employment, housing, legal status, health, and quality of life [112, 113, 114, 115, 116]. Although understandings of the causes of mental illness among the general public have shifted over the past ten years, with greater numbers attributing mental illness to neurobiological causes rather than personal or moral failings, this changed understanding has not decreased stigma [117]; for example, among the general public, the need for social distance and perceived dangerousness of people with mental illness has remained unchanged. Mental illness stigma is prevalent among the general public but also among those who provide services, with mental health service users reporting high levels of stigma from mental health professionals [118]. Finally, the person diagnosed with the mental health condition may internalize stigma: self-stigmatization is associated with lower self-esteem, lower quality of life, and less life success [118].

Stakeholders we interviewed for this study described levels of stigma that are similar to those documented in the literature, and several stakeholders described this issue as being intractable. Stakeholders also described a local cultural value of “rugged individualism” as being at odds with the idea of needing or seeking help for a mental

health or substance use problem, which is viewed by some as a sign of weakness or moral failing. Importantly, stakeholders noted that this viewpoint appeared to be held by some members of the state legislature who are resistant to acknowledging behavioral health as a health and wellbeing issue rather than merely a public safety issue. They linked this mindset to a reticence among some legislators to invest in behavioral health services, particularly community-based and preventive services.

Stakeholders noted that stigma about behavioral health issues is compounded by geographic isolation for people living in rural areas, where options for help are few in number. Stakeholders noted that stigma and discrimination against individuals experiencing behavioral health issues tends to be higher in rural communities; at the same time, the small, tight-knit nature of many rural communities can make knowledge of behavioral health histories more widespread. These factors can combine to dissuade many from seeking help. For example, one stakeholder mentioned a telehealth effort their agency had taken part in. The church in a small community (churches function as the community center of many small towns) approached the larger agency about arranging for telemedicine services to be delivered at the church. The interviewee indicated that it won't take long for the community to learn that there is a telehealth site there, and so soon anyone seen entering the church outside of normal services might be assumed to have a behavioral health issue by others in the community.

Several stakeholders identified misconceptions about behavioral health within the provider community that reflect those documented in the literature. One described a lack of compassion among some providers who have "lost their way" and are more focused on productivity, policies, and procedures than establishing meaningful connections with service users. Several other stakeholders observed a dynamic in which some providers require individuals to "prove they are worthy" of support services and discharge service users for behaviors that are part of their behavioral health issue (i.e. experience periods of returning to substance use). Other stakeholders—including service users and family members— described experiencing providers as "judgmental." Multiple stakeholders who work with individuals in the criminal justice system described these dynamics as being particularly prevalent among justice-involved populations and individuals with substance use disorders.

Recommendations



Recommendations and Next Steps

HSRI applauds the tireless efforts of North Dakota's behavioral health stakeholders to prevent and treat behavioral health challenges and promote social and emotional wellbeing across the population. Our recommendations build on existing strengths and address gaps while being mindful of limited resources.

Our recommendations are based on information obtained from 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 *Description of a Modern Addictions and Mental Health Service System* [1]. The document presents a vision and describes 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.

While our recommendations are, for the most part, focused specifically on North Dakota's behavioral health services and prevention activities, they are very much rooted in this SAMHSA vision of a comprehensive public health approach to mental health and substance use problems.

Per our contract with the Department of Human Services (DHS), we were asked to identify services and supports that could fill gaps between needs and current resources. Drawing from the community's unique strengths and assets as well as the needs identified through this study, these recommendations are intended to serve as a roadmap for improvement efforts. This set of recommendations is intentionally broad and far-reaching. Although we often suggest that "the DHS" undertake certain actions, we recognize that many of these recommendations cannot be implemented by one single entity. Further, we do not expect, nor do we suggest, that stakeholders in North Dakota will endeavor to implement all of these recommendations at once. Rather, our purpose is to present a range of possible options that stakeholders—including legislators, other public officials, provider organizations and the public—may consider in addressing the challenges, filling the gaps, and improving the system of behavioral health care for North Dakotans in the years to come.

1 – Develop a comprehensive implementation plan

The recommendations in this report are multi-faceted and interconnected. Additionally, many connect to existing initiatives and projects that the DHS and other community partners are currently engaged in. Therefore, we recommend that the DHS work to develop a single, overarching, and comprehensive implementation plan for moving forward. We offer the following concrete steps to support that process.

1.1 Reconvene system stakeholders, including service users and their families

Once the report is released, the system stakeholders involved in earlier stages of this project, along with any other relevant system stakeholders, should be reconvened to discuss the analyses and recommendations in this report and develop a comprehensive and collaborative plan for moving forward with the implementation phase. Because the ultimate goal of this effort is to create a behavioral health system that best meets the needs of the community and promotes recovery at all levels, it is critical that service users and their families are fully involved in all aspects of the implementation phase. Our experience has shown that to reduce the effect of tokenism and promote full and active involvement, it is necessary to have more than one service user and more than one family member represented on committees and workgroups. Because service users and family members are themselves a diverse group, care should be taken to involve individuals who are reflective of the diversity of North Dakota.

1.2 Form an oversight steering committee to coordinate with key stakeholder groups

As part of the implementation plan, a strong foundation of oversight should be established through a steering committee. This committee should include experts who have close working relationships with each of the stakeholder groups that will be involved in implementing the recommendations. The steering committee should be small enough to meet regularly, maintain consistent communication with one another and with stakeholder groups, orchestrate coordinated action across multiple areas, and take responsibility for overseeing progress of various work groups discussed in the next recommendation.

1.3 Establish work groups to address common themes identified in this report

To complement and enhance the implementation and oversight efforts of the steering committee, smaller more focused work groups should be established to create more detailed work plans in key areas that were identified in this report. Some areas include:

- Prevention and Wellness Promotion
- Community Education and Awareness
- Behavioral Health Workforce Issues
- Outpatient and Community-Based Services
- Telebehavioral Health Strategies
- Cultural Responsiveness and Disparities
- Criminal Justice System Strategies
- Peer and Family Advocacy
- Child Welfare and Family Services
- State and Tribal Nation Partnerships
- Financing and Sustainability
- Data Systems and Monitoring

Some of the above topics may already be addressed by existing work groups and task forces (for a list of behavioral health-related work groups and initiatives, see Appendix D). Whenever possible, we recommend that the steering committee work with those existing groups rather than forming new groups and potentially duplicating efforts and creating an additional time burden on work group members.

2 – Invest in prevention and early intervention

There are numerous opportunities to build on current prevention and early intervention efforts in North Dakota. By focusing on prevention, behavioral health problems can be addressed upstream. This proactive approach has the potential to prevent losses and suffering related to unaddressed behavioral health problems that impact all people in North Dakota, not just those with diagnosed behavioral health challenges. Successful interventions should be tailored to specific communities and then scaled up as appropriate so that all North Dakotans can benefit from a prevention-focused system.

Stakeholders emphasized a need for more state investments in prevention given the potential return on investment for these strategies. Public and private foundations such as the Robert Wood Johnson Foundation and Annie E. Casey Foundation are also good sources of funding for prevention activities. Maintaining a roster of local foundations and their current initiatives may provide the state with additional funding opportunities, as discussed in more detail in Recommendation 12 - Diversify and Enhance Funding for Behavioral Health. In the long term, efforts to educate legislators on the value of prevention—and particularly the long-term return on investment of prevention practices—should be undertaken so that a greater priority is placed on this important and undervalued aspect of behavioral health.

2.1 Prioritize and implement evidence-based social and emotional wellness initiatives

In our review, we noted that most of the current prevention activities in North Dakota are focused on substance use prevention, with few initiatives promoting social and emotional wellness and mental health-related prevention. Multiple evidence-based strategies are proven to support social and emotional wellbeing. The National Resource Center for Mental Health Promotion and Youth Violence Prevention⁵⁵ is an excellent resource for information and technical assistance related to social and emotional wellness promotion. We recommend that the state develop a process for selecting and investing in these strategies in the future, in partnership with the Department of Public Instruction, local school districts, and childcare providers.

2.2 Expand existing substance use prevention efforts, and restore funding for the Parents Lead program

The current substance use prevention efforts in North Dakota appear to be meeting a critical community need, and the rising prevalence of substance use issues in the state suggest that these interventions should be expanded in the future. Despite the documented effectiveness of the Parents Lead program, its funding was reduced by more than two-thirds in the most recent DHS budget. Such reductions are short-sighted given the needs for prevention activities documented in this analysis.

2.3 Build upon and expand current suicide prevention activities

The 2017-2020 Suicide Prevention Plan, developed by the North Dakota Suicide Prevention Coalition and the North Dakota Department of Health, includes a comprehensive and actionable set of goals and strategies related to wellness promotion and suicide prevention [41]. The plan includes strategies to implement Zero Suicide, which has been used successfully in other jurisdictions to prevent suicides through health system interventions. We recommend that the Department of Human Services engage and coordinate with these entities to incorporate these strategies into its larger planning process to identify synergies and opportunities to streamline efforts.

⁵⁵ <https://healthysafechildren.org/resources>

2.4 Address the needs of substance exposed newborns and their parents through a continuation of the work of the North Dakota Task Force on Substance Exposed Newborns

The state's legislatively established Task Force on Substance Exposed Newborns identified four goals in 2016:⁵⁶

5. Collect and organize data concerning the nature and extent of Neonatal Withdrawal Syndrome/Neonatal Abstinence Syndrome (NAS) from substance use in the state.
6. Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from substance use.
7. Identify available federal, state, and local programs that provide services to mothers who use drugs or alcohol and to newborns who have NAS and evaluate those programs and services to determine if gaps in programs or ineffective policies exist.
8. Evaluate methods to increase public awareness of the dangers associated with substance use, particularly to women, expectant mothers, and newborns.

These goals represent an important starting point for beginning to address the unique needs of this vulnerable population. The logical continuation of those goals will be to pursue sustainable, effective interventions that raise public awareness of NAS, reduce its negative impacts, and prevent future occurrences. We recommend that these goals be incorporated into larger systems change efforts. Given the high prevalence of NAS among American Indian populations, fostering solid partnerships with the tribal nations will be critical to the success of these initiatives.

2.5 Expand evidence-based services for first-episode psychosis

Despite the evidence suggesting the importance of evidence-based interventions for first-episode psychosis (FEP), there is only one FEP program in North Dakota at Prairie St. John's. We highly recommend building from this work to ensure that that all individuals experiencing early episodes of psychosis have access to these programs, across the state. Investing in evidence-based early intervention such as coordinated specialty care organizations for this high-risk group will prevent and reduce the significant long-term impact of psychosis on individuals, their families, and the healthcare system. We recommend that the DHS work with Prairie St. John's to examine early outcomes and explore strategies for improving upon the current FEP model, scale FEP services out to serve more individuals and additional regions throughout the state, and measure fidelity and outcomes in an ongoing manner. To support ongoing sustainability, the DHS should identify the components of FEP that could be billed to third-party payers, including Medicaid, and blend other payment sources for services not able to be billed to commercial or public insurance (e.g., supported employment).

⁵⁶ An infographic describing the goals can be found at <https://www.nd.gov/dhs/info/testimony/2015-2016-interim/judiciary/2016-6-6-substance-exposed-newborns-task-force-summary-recommendations.pdf>

3 – Ensure all North Dakotans have timely access to appropriate behavioral health services

This analysis identified numerous recent initiatives that are designed to increase access to appropriate behavioral health services for North Dakotans, and the following recommendations emphasize continuing that important work.

3.1 Coordinate and streamline information sources for behavioral health resources

Our review identified multiple different resource directories that currently list different types of behavioral health services in the state. While there appeared to be some overlap in service directories (i.e. multiple substance use disorder treatment directories), other areas seemed to lack comprehensive directories (i.e. youth mental health treatment resources; listings of resources available in tribal nations). It was unclear the extent to which various resource directories were regularly updated, and the levels of public and provider awareness of existing directories were also unclear. In sum, we observed a need to coordinate and streamline various efforts at compiling and maintaining resource directories, and a need to ensure that service users, providers, and leadership in various communities are aware of existing and newly developed resources.

3.2 Expand mental health and substance use disorder screening in all social service systems and primary care

Despite current screening initiatives, stakeholders indicated that there remains a need for more coordinated efforts to systematically screen individuals for mental health and substance use issues in social service and primary care systems. Proactively identifying mental health and substance use issues is a first step in addressing behavioral health needs and can result in connecting to treatment before problems rise to a level of severity that requires specialty behavioral health treatment and/or crisis intervention. Future screening expansion efforts should include expanding SBIRT and ensuring reimbursement for this service throughout the state. The internet-based behavioral health screening tools developed through Heartview's Screening, Service Planning and Referral (SSPR) initiative could be considered for broader adoption in physical and behavioral health and social service settings system-wide.

3.3 Ensure a continuum of timely and accessible crisis response services

A common theme in stakeholder interviews was related to an inadequacy of crisis response services, particularly for children and youth, and for adults outside of the Fargo area where mobile crisis response services are unavailable. Stakeholders also saw a need for alternatives to traditional crisis response services, including peer-operated warmlines, crisis texting, and other widely accessible services to prevent crises before they occur. These alternative crisis services can divert some individuals from emergency services and reduce the need for inpatient care. Stakeholders emphasized a need for more in-person crisis response resources similar to the mobile

crisis response services in Fargo. For individuals with substance use disorders, increased intoxication and withdrawal management services are needed, as are outreach and engagement strategies that support individuals to engage in ongoing treatment after a crisis.

The rates of behavioral health-related emergency department and ambulance use we observed in the Medicaid data similarly indicate an unmet need for more proactive community crisis response services, particularly in the Lake Region and for children and youth throughout the state. We recommend that the state explore options for expanding the mobile crisis response model to include services for children and youth, and to make such services available in other population centers throughout the state, and that access to intoxication and withdrawal management services is expanded.

The state might also explore telebehavioral health options to make real-time video or telephonic crisis response services available in the more rural areas. Given the overrepresentation of racial and ethnic minorities in emergency department and ambulance services that we observed, we recommend that the state partner with tribal nations and groups in the state that represent racial and ethnic minorities to explore ways to ensure cultural responsiveness of these services.

Peer-delivered residential crisis alternative models, called peer respites⁵⁷, are being adopted throughout the country and may serve as an additional resource for individuals in crisis [119]. Peer respites are voluntary, short-term residential programs for individuals experiencing or at risk of experiencing a crisis. Peer respites typically have a non-clinical orientation, are staffed and managed by peer specialists, and have a governing or oversight body with a majority of members having lived experience of the behavioral health system. In peer respites, “guests” are engaged by peer support staff using trauma-informed principles that emphasize building healing, trusting relationships. One recent study, conducted by HSRI, found that peer respite guests were significantly less likely to use inpatient and emergency services compared with a similar group who did not use the peer respite [120]. These and other peer-delivered and trauma-informed alternative approaches to supporting individuals in crisis, and for providing support to individuals before they reach a crisis state, could reduce the need for inpatient and emergency services for many.

3.4 Develop a comprehensive strategy to remove barriers to access to behavioral health services for persons with brain injury

The findings of the 2016 needs assessment on people with brain injury in the state identified several barriers to individuals with brain injury receiving needed treatment, including behavioral health treatment. Stakeholders we spoke with noted that these barriers are particularly pronounced when it comes to accessing behavioral health services. Further, our analysis found that that current efforts to address brain injury issues may be insufficiently focused on behavioral health access. Therefore, we recommend that the DHS work with the ND Brain Injury Advisory Council to develop

⁵⁷ <http://www.peerrespite.net/>

specific strategies to address access to behavioral health services for persons with brain injury.

The incorporation of screenings for brain injury in HSCs is an important step in the right direction and will pave the way for identifying and addressing the access issues we identified in this study. The strategy should also include expand (or at a minimum, restoring funding to previous levels) the Community Options Return to Work program. There may also be opportunities to enhance behavioral health support capacity through the North Dakota Brain Injury Network and Centers for Independent Living throughout the state. The strategy should also incorporate widespread training and education related to brain injury, particularly for social service agencies, HSCs, and other behavioral health providers. The strategy should also include a review of current HSC policies and practices that may act as barriers to access.

3.5 Continue to invest in evidence-based harm-reduction approaches

The rising incidence of overdose deaths and other substance use-related problems in North Dakota was of great concern to stakeholders, and the state's recent investments in harm reduction approaches will hopefully reverse the recent upward trends. The development of syringe exchange programs is an important step in reducing the health problems associated with drug use in North Dakota's communities, and the Stop Overdose campaign and numerous local initiatives are important community assets. Continuing to support evidence-based harm reduction strategies should be part of future behavioral health system planning efforts.

4 – Expand outpatient and community-based service array

Stakeholders were emphatic that challenges across the continuum of child and family support services were rooted in the fact that there are inadequate community-based services to address the behavioral health needs of children, youth, and their families before they rise to the severity of needing residential or out-of-home placement. Similarly, many challenges in the adult system were seen as rooted in inadequate access to a full array of behavioral health services and supports, particularly those that address social determinants of health.

Community-based service needs include flexible supports such as peer support and community health workers. They also include in-home and school-based clinical services and, critically, substance use disorder treatment services, particularly for parents of children and youth with behavioral health needs. Ultimately, the state must work to shift the focus from congregate living to prevention efforts and community-based services. Over the long-term, these efforts will result in a system that relies less on out-of-home placements and facility-based care and supports the wellness of children, youth, and adults in their own communities.

The following recommendations are intended to support current and planned initiatives to expand the state's outpatient and community-based service array.

4.1 Ensure access to needed behavioral health coordination services

In our analysis of penetration rates across various service types, we observed a drop in case management utilization rates for adults and youth. This drop is not necessarily a concern, particularly if case management services are paired with enhancements to other community-based services. From available data, it is unclear whether this is currently the case. Our findings indicate a need to reevaluate and restructure case management services in the state, and to incorporate additional evidence-based and promising practices to behavioral health service coordination to meet the diverse needs of North Dakotans. It appears as though some of this work is already underway through the DHS Division of Field Services, and we offer additional considerations to support a continuation of these efforts.

This analysis has also found that the current system of case management needs to continue to be changed so that more individuals can access case management services in conjunction with other community supports. We recommend that the DHS continue to move toward a case management model that provides a continuum of case management services to a larger number of people. North Dakota's case management system should be carefully assessed to ensure intensity and duration are determined by individual need. If provided to individuals who are not high service users, intensive case management is likely to increase costs without substantial benefits to the individual.

Increased systemic flexibility in meeting behavioral health–related needs will allow for more adaptation to the needs of individuals. A 2016 study of flexible team-based full-service case management, which allowed for temporary increases in service intensity delivered by a core team of case managers and clinicians, resulted in significant improvements in quality of life and functioning and significant decreases in overall service utilization, including inpatient hospital days [121]. Shifting to more flexible models of case management and targeting those who truly need a higher level of support may be a more efficient use of case management for North Dakota.

Further, case management models should also become more rehabilitation-oriented, with a sustained focus on transitioning long-term service users out of intensive case management and into community-based and natural supports that support community inclusion and independence. Case management should focus on assessing need for and facilitating connections to services and supports for the social determinants of health, including housing, employment, and physical health concerns. The state might institute practices such as “recovery check-ins,” whereby service users can be moved out of case management to lower intensity service levels, while maintaining links to the system. This will allow for more persons to enter the case management system who need it, as well as for ongoing support as needed for individuals who experience greater stability in recovery.

For some individuals, peer support and community health workers may complement or replace case management services by promoting self-management practices. Peer wellness coaching and service navigation models are widely used throughout the country and have been associated with positive outcomes [122]. Peer-provided case

management holds promise for promoting improved care for individuals with behavioral health conditions [123]. Studies suggest the use of peer providers in case management can contribute to a stronger treatment relationship and greater participation in treatment [124, 125]. Options for financing these services are further discussed in Recommendation 12 – Diversify and Enhance Funding for Behavioral Health.

4.2 Continue to shift funding away from legacy services toward evidence-based and promising practices

A general theme across multiple areas was related to a need for more evidence-based and best practice approaches throughout the service continuum. We observed several initiatives to increase the use of evidence-based and promising practice that suggest that such changes are already underway; these included expansions of Assertive Community Treatment, Housing First approaches, and peer support. HSRI recommends continuing in this direction and methodically reviewing services across the system to determine whether more effective approaches are available. One example might be to explore ways to transition individuals receiving adult day treatment to other community-based services that address rehabilitation and recovery, such as supported employment and peer supports for community inclusion. Adult day treatment services are currently financed using general revenue funds; replacing day treatment services with Medicaid-reimbursable community supports would result in some cost savings for the state.

Many stakeholders emphasized that approaches that focus primarily or entirely on sobriety and substance use education are inadequate in addressing the root causes of addiction and supporting long-term recovery for all North Dakotans. We recommend that the DHS conduct a review of all publicly funded substance use disorder treatment services to determine which are incorporating evidence-based approaches to substance use disorder treatment. Using this information, the state should evaluate the proportion of substance use disorder treatment resources that are used on practices that do not have an evidence base and provide incentives to reinvest some of those resources into more evidence-based and best practice approaches, particularly those that are proven to meet the needs of people with co-occurring mental health and substance use problems, justice-involved individuals, and members of underserved groups including people with brain injury, LGBTQ populations, and racial and ethnic minority groups.

In general, approaches that require “readiness” and “motivation” as a precondition for treatment tend to be less effective in meeting the needs of individuals with the most complex needs and result in system inefficiencies and higher levels of behavioral health disparity. Stakeholders observed dynamics that suggest a need for reviewing behavioral health services across the continuum to identify such services and consider replacements that are more effective in engaging underserved and complex populations.

Historically, research into health and behavioral health interventions has done a poor job of acknowledging and investigating interventions that address culturally specific needs and programs tailored to specific cultural, racial, and ethnic groups. As a result, some cultural practices that may be effective with particular groups have yet to be established as “evidence-based” simply because of a lack of research and investigation. In its efforts to increase the use of evidence-based practice, DHS should be sensitive to these dynamics and should work with representatives from various cultural, racial, and ethnic groups to explore and determine which practices are a best fit for their communities’ unique needs. DHS should also explore the incorporation of evidence-based practices that have demonstrated effectiveness with specific groups as well as the development of cultural adaptations of existing evidence-based practice.⁵⁸

As new evidence-based practices are adopted, it is important to build in ongoing fidelity monitoring to ensure they are being implemented as designed. When resources are scarce, there is a tendency for fidelity monitoring to be one of the first activities to be cut; while this is understandable, a lack of investment in fidelity monitoring and other quality assurance activities can ultimately result in poorer system performance over the long term.

4.3 Expand the continuum of community substance use disorder treatment services for youth and adults

The expansion of medication-assisted treatment (MAT) in North Dakota is extremely promising. Stakeholders, however, indicated that more access to these services is needed and that low-income individuals face significant barriers to affording MAT services, many of which are self-pay.

We also documented a significant need for outpatient substance use disorder treatment for children and youth as penetration rates for these services are far below population prevalence estimates. In particular, we documented a need for enhanced school-based substance use disorder treatment services.

Further work is needed to remove barriers to access, particularly related to financing these services. For youth substance use disorder treatment in particular, removing financing barriers must be accompanied by large-scale efforts to enhance the workforce providing youth substance use disorder treatment (recommendations related to financing and workforce development are detailed elsewhere in this report).

4.4 Support and coordinate efforts to enhance availability of behavioral health outpatient services in primary care

By providing treatment earlier in the progression of behavioral health disorders, individuals may be less likely to require specialty behavioral health services like psychiatry and case management. In addition, some individuals may perceive behavioral health care received from their primary care provider as being less

⁵⁸ A partial listing of cultural adaptations to evidence-based practices can be found here: <http://www.healthalt.org/uploads/2/3/7/5/23750643/cultural-adaptations-to-evidence-based-practice-april-2013.pdf>

stigmatizing than specialty behavioral health care. This is particularly important for older adults and for certain racial and ethnic groups whose cultural beliefs and preferences may be inconsistent with the traditional Western/European approaches to behavioral health treatment. Successful expansion of behavioral health capacity in primary care requires surmounting many significant challenges, including reorienting professional cultures, implementing evidence-based practices and practice guidelines, and changing funding structures [126].

Ensuring that behavioral health is “at the table” at all initiatives to integrate behavioral and physical health care will be a first step in capitalizing on opportunities to expand behavioral health outpatient services in primary care. To strengthen and align integration efforts, we recommend the following:

- Explore emerging national models that build on integrated team-based approaches to care, such as health homes and Certified Community Behavioral Health Clinics [84]
- Build partnerships with medical providers (primary care physicians, clinics, and hospitals) to explore opportunities and create a cross-sector team care approach, improve care coordination and expand access to health services
- Prioritize and formalize essential care coordination functions across physical and behavioral health and determine roles and responsibilities across state, health plan, local and community agency partners
- Standardize navigation protocols, including referral pathways, cross-sector provider communication, and follow-up practices to ensure greater consistency of model implementation across sites
- Ensure that the primary care workforce receives basic and ongoing trainings to ensure basic clinical competencies in working with populations with behavioral health needs and confront misperceptions regarding this population

One of the primary benefits of expanding behavioral health service capacity in the Federally Qualified Health Centers (FQHCs) is the opportunity to integrate behavioral health care with comprehensive patient-centered medical homes for low-income individuals. FQHCs and similar health centers serve as medical homes, providing integrated medical, behavioral, dental, and vision care, as well as care coordination. In our study, we identified pockets of innovations in integrating physical and behavioral health services within FQHCs, and we recommend that those activities be explored and scaled up to promote more integration across the state.

An additional benefit of FQHCs is that North Dakota, like many other states, reimburses Medicaid outpatient procedures at FQHCs using a prospective payment system (PPS). Under this system, health centers receive a fixed, per-visit payment for any visit by a person with Medicaid, regardless of the length or intensity of the visit. Prospective payment reimbursement differs from Medicaid fee-for-service (FFS) reimbursement in two important ways. First, the per-visit rate for the Medicaid PPS is

specific to the individual health center location. Second, the per-visit rate is based on the previous year's rate, adjusted by the Medicare Economic Index (MEI) for primary care and *any change in the FQHC's scope of services*. These PPS rates can better allow FQHCs to cover their costs, which helps create a more sustainable workforce.

Under the Affordable Care Act, the FQHCs have received substantially increased funding to provide behavioral health services and to promote integrated care, with further increases to come. For example, effective January 1, 2018, FQHCs can receive payment for Behavioral Health Integration (BHI) services and psychiatric Collaborative Care Model (CoCM) services. Because this expansion of behavioral health capacity is relatively recent, and links between behavioral health systems and FQHCs have not been extensive in the past, many areas have yet to take advantage of this opportunity to increase the supply of innovative outpatient care. We recommend that the state work with all FQHCs in the state to ensure that services that could be provided by FQHCs are being fully utilized, and to provide regular outreach to FQHCs to coordinate system planning activities.

4.5 Address housing needs alongside behavioral health needs

Access to safe, adequate, and affordable housing is a critical element in supporting individuals with behavioral health needs to live independently in their communities. Unmet housing needs are obstacles to recovery and reduce the effectiveness of behavioral health treatment. There are numerous housing resources available to some North Dakotans with behavioral health needs, but stakeholders felt that more capacity is needed. In 2008, a 10-year statewide plan was developed by the North Dakota Intragency Council on Homelessness to implement holistic strategies to expand housing supports. These strategies were to (1) develop permanent supportive housing, (2) improve ability to pay rent, (3) expand supportive services to wrap around housing, (3) strengthen prevention and outreach programs, and (4) collect and disseminate data relating to long-term homelessness [127]. According to a 2016 Medicaid Supportive Housing Services Crosswalk, the most pressing recommendations for supportive housing services include (1) creating a supportive housing services benefit in the State Medicaid Plan, (2) covering/expanding supportive housing and targeted case management to include individuals with substance use disorders, (3) redirecting cost savings back to behavioral health and housing systems, and (4) weaving medically necessary housing services into regional HSC operations.

We highly recommend that the DHS partner with state and local housing agencies to build on the above work and explore ways to expand access to housing and related support services, in terms of their capacity and their reach, so that all individuals with behavioral health needs who are homeless are identified, engaged, and supported in finding and maintaining housing. Although Permanent Supportive Housing is the “gold standard” and an evidence-based practice, it is designed for those with complicated behavioral health needs. An ideal housing support service array would provide a range of services that can be tailored based on individual needs. To ensure that the housing support services are available, the state should work to expand

Medicaid funding for such services and ensure that such programs are delivered in adequate quantity and with high fidelity (this is discussed in a later recommendation).

Importantly, Medicaid funds housing support services but will not fund housing units. Ensuring the availability of housing units should involve partnerships with the state and local housing authorities to put new housing units into the development pipeline and explore other avenues to expand housing options to individuals with behavioral health needs. HSRI recommends the development of a broad, coordinated state-wide strategy for identifying and pursuing resources to address capital shortages, and a strategy for working with the state legislature to address these issues at the state level. This strategy could involve the following actions:

- Develop a centralized/coordinated housing registry
- Encourage collaboration of emergency departments, hospitals, HSCs and local Public Housing Authorities around their coordinated entry mechanisms, which can serve to identify existing housing stock that can be immediately used for individuals awaiting discharge from inpatient or residential treatment service
- Create a state level behavioral health housing coordinator

4.6 Promote employment and education among behavioral health service users

Expanding the availability of supported education and work support programs is one of the more cost-effective investments of services for persons who would otherwise be non-taxpayers enrolled in the Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) programs. Therefore, we recommend that the DHS ensure that a range of education and employment supports be established for people with behavioral health needs. These should include high-fidelity supported employment services such as Individualized Placement and Support (IPS), as well as other services such as supported education, job coaching, and training and placement assistance.

Community Options offers a range of employment and education support services to individuals with disabilities in several locations throughout the state and has a proven track record in delivering high-fidelity supported employment (IPS) to individuals with brain injury and individuals with serious mental health conditions and co-occurring substance use problems. Community Options is also providing supported education to a small number of individuals in the Prairie St. John's first episode psychosis program. Peer support, Recovery Centers, and other community-based organizations also provide important education and employment support services. Building on the existing capacity of these organizations will serve as a strong starting point for expanding supported education and employment services to more individuals throughout the state.

It will also be important to work with local providers and explore public and private partnerships to enhance access to employment supports for individuals who may not be eligible for Medicaid-funded employment support services. There may be additional opportunities for collaboration with the Division of Vocational

Rehabilitation to promote employment among behavioral health service users. For example, the Workforce Innovation and Opportunity Act (WIOA), effective July 1, 2015, requires state-run Vocational Rehabilitation agencies to work with employers to assess their labor needs and coordinate the development of work-based learning opportunities such as apprenticeships, with government funding available to fund half of the first six months of individuals' salaries along with other supports.⁵⁹ The WIOA may be an opportunity for coordination between the behavioral health system, the Division of Vocational Rehabilitation, and local businesses to establish employer-based programs for people with behavioral health conditions.

4.7 Restore and enhance funding for Recovery Centers

According to many stakeholders we interviewed, the state's eight Recovery Centers are highly valued community resources and one of the few places that support rehabilitation and recovery for individuals with serious mental health conditions. However, stakeholders also felt that Recovery Centers were not meeting their full potential to support recovery and wellness because of dwindling funding that has resulted in reduced staffing and programming and more limited hours. As one of the few organizations that currently employs peer specialists, Recovery Centers should figure prominently into current efforts to expand peer support services in the state.

We recommend that the DHS restore and/or enhance funding for Recovery Centers to demonstrate an investment in recovery-oriented and rehabilitative models. In addition, the DHS may consider transitioning Recovery Centers to become peer-run or peer-operated organizations, which would involve revisiting current licensure standards for these organizations. Alternatively, the DHS might consider transitioning the Recovery Centers to operate as Clubhouses, which are evidence-based programs that promote community integration and wellness. Clubhouses operate according to a well-established set of standards and benefit from a robust credentialing process supported by a strong international network of similar organizations.⁶⁰

4.8 Promote timely linkage to community-based services following crisis, inpatient, and residential treatment

Our analysis found a need for increased services to support transitions back to the community after completion of crisis and inpatient services. While expanding the community and outpatient service array more generally will result in greater likelihood of accessing community services, we also observed a need for targeted interventions designed specifically to support transitions back to the community and prevent return to more intensive service settings. Timely outpatient follow-up has been promoted as a key strategy to reduce emergency department and hospital readmissions. Because of data limitations, we were unable to calculate what proportion of individuals discharged from an inpatient stay receive a follow-up outpatient visit within 30 days. However, stakeholders described opportunities for

⁵⁹ For more information about the WIOA, see <https://www.doleta.gov/wioa>

⁶⁰ <http://clubhouse-intl.org/resources/overview>

improvement in this area and a need to ensure outpatient and community-based service connections in a timely manner.

The DHS should consider steps to develop guidance for emergency department, inpatient, and residential services to partner with community-based service providers to engage in follow-up for individuals who use those services. The DHS could offer guidance and require that institutional service providers have a process for identifying community treatment needs for individuals in institutions. Similarly, the DHS might consider establishing policies that providers are required to see referrals within a specified number of days of discharge from an inpatient or emergency department admission. The HSCs and other community providers should explore partnerships with hospitals to establish a process whereby hospitals and providers establish a "warm handoff" so that an individual is engaged by a provider at discharge.

Peer Bridger programs have been effective in reducing inpatient admissions and readmissions [72] and are one option that the state should consider to facilitate this process. Similarly, the HSCs might partner with inpatient settings to restore the practice of "inreach," whereby outpatient program staff meet with inpatient staff for case consultation and discharge planning. The partnership may also involve regular meetings with staff of emergency departments and hospitals to identify and problem-solve bottlenecks and communication and coordination issues and to develop and test telebehavioral health approaches that may facilitate these processes for rural communities.

We also observed a need for a broader continuum of services to support individuals transitioning back to the community after residential or inpatient substance use disorder treatment. According to stakeholder interviews, there is a need for more sober living environments and other recovery support services. In recent months, the DHS has explored options for supporting these transitions through the Money Follows the Person initiative and through the substance use disorder voucher, and we recommend that these efforts continue so that more comprehensive strategies can be employed. All services that are expanded through these efforts should be evaluated and monitored on an ongoing basis to ensure they are of high quality, ensure the health and safety of service users, and produce positive impacts on key person-centered outcomes.

4.9 Conduct a review of behavioral health services in long-term care facilities to explore options for community-based alternatives

In our analysis, we documented a high proportion—approximately one in four—of individuals under age 65 receiving behavioral health-related services in long-term care facilities. We recommend that DHS look into the service and support needs of younger populations currently receiving behavioral health services in long-term care facilities to explore options for better-meeting the needs of individuals in the community and reducing the use of these costly services.

5 – Enhance and streamline the system of care for children and youth with complex needs

In addition to enhancing access to community-based services and supports for all children, youth, and families, we observed particular challenges for families with complex behavioral health needs that result in multi-system involvement. The Family First Prevention Services Act,⁶¹ passed in February 2018, may result in increased federal support for the recommendations discussed in this section.

5.1 Improve coordination between education, early childhood, and service systems for children and youth

Past behavioral health system assessments have been clear in identifying a need for improved coordination for child and youth-serving systems in the state. These recommendations have resulted in the recent formation of the Children’s Behavioral Health Task Force. The formation of this group is an important first step in the process, but our assessment indicates that more and sustained coordination is needed. We also found a need for enhanced coordination with school districts, which will likely involve more localized coordination efforts. We therefore recommend that the state build from the Children’s Behavioral Health Leadership Group and develop mechanisms for extending that coordination to local communities and streamlining the work of the Children’s Behavioral Health Leadership Group with other systems change activities. For example, there are likely opportunities to explore areas of synergy and overlap between the Children’s Behavioral Health Leadership Group and the recently formed Juvenile Justice Dual Status Youth Initiative.

5.2 Expand targeted, proactive in-home supports for families with children and youth at risk of foster care placement and justice involvement

We documented a need for increased targeted supports for children and youth as well as for parents whose children are at risk of out-of-home placement and justice involvement. The state is home to a number of programs that are successfully supporting children, youth, and families in the community to reduce the overall demand for out-of-home services. For example, the Partnerships program was widely seen as an important community resource for Wraparound services, and the Department of Juvenile Services Community Day Treatment has documented success in preventing out-of-home placement for youth for several years. The current levels of need suggest these programs could be expanded.

In addition, stakeholders indicated that many out-of-home placements are related to parental behavioral health problems, particularly substance use disorders. Relatedly, stakeholders described parental behavioral health problems as a key barrier to family reunification. These challenges suggest a need for conducting targeted outreach and engagement and prioritizing access to substance use disorder treatment services for parents of children in foster care or at risk of out-of-home placement. Improvements

⁶¹ <https://www.congress.gov/bill/115th-congress/house-bill/253>

to the state's capacity for substance use treatment system in general will likely mitigate these issues as well.

5.3 Develop a coordinated system for enhancing treatment foster care capacity and increasing the cultural responsiveness of foster care placements

Our assessment documented a shortage of treatment foster care providers in the state. We recommend that DHS continue to partner with PATH ND to support one another in efforts to increase treatment foster care capacity, as well as to work toward a larger coordinated strategy to ensure appropriateness of treatment foster care, residential, and inpatient placements for children and youth.

Our assessment found that the system is inadequately meeting the needs of American Indian children and youth who would be best-served in American Indian foster care homes. Similarly, we found that LGBTQ youth need to be assured that they will not face judgment or negative treatment because of their sexual orientation or gender identity. We therefore recommend the development of a state-wide strategy in partnership with the tribal nations to:

- Increase the number of American Indian foster care providers through outreach and education, in partnership with representatives from tribal nations.
- Review current treatment foster care licensing requirements and explore opportunities to make adjustments to reflect and accommodate cultural differences, in partnership with representatives from tribal nations.
- Identify foster care providers who are accepting of and responsive to the needs of LGBTQ youth and prioritize their placement of those youth in those homes.
- Provide training for foster care and residential treatment providers on trauma-informed approaches and cultural competence, particularly related to American Indian and LGBTQ issues.
- Monitor the demographics and competencies of treatment foster care providers on an ongoing basis with a goal of having a foster care network that matches the racial and ethnic make-up of the population served, which is currently over 50% racial and ethnic minorities.

5.4 Prioritize residential treatment for children and youth with the most significant and complex needs

A range of stakeholders described challenges associated with treatment foster care and residential placements for children and youth, particularly related to right-sizing facilities and assessing bed counts. These challenges may be related to a limited number of treatment foster care and residential programs, but they also appeared to be impacted by the lack of a coordinated system to ensure that placements are informed by a regularly and consistently assessed level of need.

Stakeholders saw a need for system reforms that result in children and youth receiving the right level of care at the right time. We recommend that the DHS and its

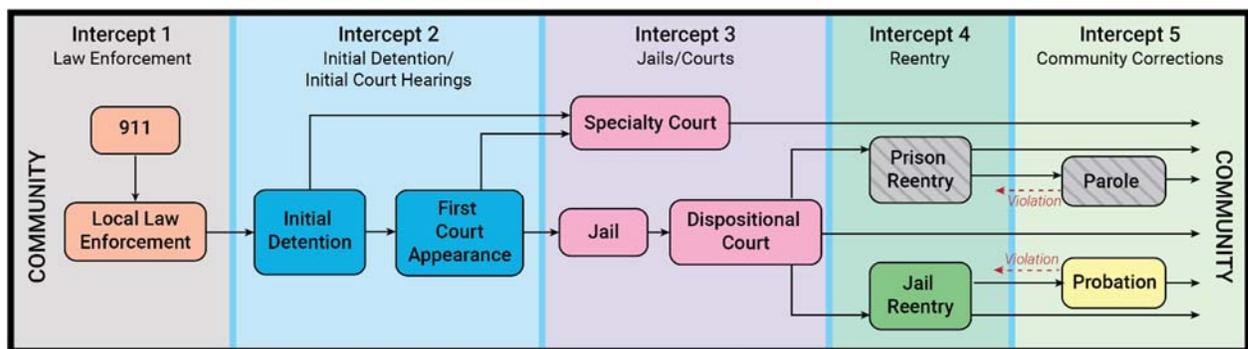
partner agencies incorporate a system for assessing need and capacity on an ongoing basis to inform treatment foster care and residential placements, support family reunification efforts, and prioritize the most intensive settings for children and youth with the most intensive needs. For children and youth with extreme behaviors, including those who exhibit violent or sexual behaviors (those with the highest level of need), the DHS should develop a system to ensure access to placements as soon as they become available. Stakeholders indicated that staff within even the most intensive residential treatment settings may need additional training and support to meet the complex needs of children and youth with extreme behaviors. Therefore, the prioritization process should be accompanied by a review of staffing and training practices in the most intensive settings to ensure these organizations have the capacity to serve these populations.

6 – Continue to implement and refine the current criminal justice system strategy

Nationwide, stakeholders have described the criminal justice system as the “de facto behavioral health system” for those with serious behavioral health conditions, referring to the overrepresentation of people with behavioral health issues in jails and prisons. This dynamic was observed in North Dakota as well, though we were impressed by the breadth and depth of current state and local initiatives to address issues at the intersection of behavioral health and criminal justice.

The Sequential Intercept Model is used by many communities as a conceptual framework to understand and address behavioral health issues and the criminal justice system [128]. The version of the model in Figure 26, developed by the SAMHSA GAINS Center, may be a tool for organizing and evaluating initiatives in North Dakota.

Figure 26
SAMHSA GAINS Center Central Intercept Model



SAMHSA's GAINS Center, (2013). Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

In a robust system, interventions are targeted at each point of intercept between the behavioral health and criminal justice systems to prevent individuals from entering (Intercept 1) or penetrating deeper into the criminal justice system. Ideally, most people are reached in the earlier stages, with decreasing numbers at each intercept.

Our recommendations are rooted in this framework, and we recommend that this framework be used as a tool in future efforts to coordinate and enhance these efforts.

6.1 Ensure continued collaboration and communication between criminal justice and behavioral health and other human service systems

The effectiveness of interventions designed to meet the behavioral health needs of those involved in the criminal justice system hinge on the quality of the collaboration between behavioral health and criminal justice system stakeholders. We observed significant efforts at collaboration that appear to be producing positive system change in North Dakota. These efforts should be sustained and coordinated with other systems change activities given the interrelated nature of criminal justice and behavioral health systems. A recent framework for behavioral health and criminal justice collaboration may serve as a useful resource for further understanding best practices in collaboration [129].⁶²

Individuals with behavioral health needs who are justice-involved typically have a complex set of interconnected needs that reach beyond the bounds of criminal justice and behavioral health systems. These include housing instability, poverty, and brain injury, among other issues. Further, we found that many youth who are justice-involved also have a parent or close relative with justice-involvement, indicating a strong need for coordination between adult-and child-serving systems around criminal justice and behavioral health issues. Therefore, the current initiatives should, to the extent possible, be aligned across systems so that other agencies can share in the responsibilities and benefits of systems improvement work.

6.2 Promote behavioral health training among first responders and other criminal justice system staff

Corresponding with Intercept 1 in the Central Intercept Framework, the practice of diverting individuals from the criminal justice system to treatment is the first opportunity to prevent criminal justice system involvement. Training police officers using Crisis Intervention Team (CIT) training is a first step in equipping the police force to better manage crisis situations encountered with individuals with behavioral health needs and can help to assist individuals in accessing the treatment system [130]. By ensuring that these trainings are available on an ongoing basis, all first responders should be better-equipped at identifying and responding to behavioral health-related issues and engaging individuals in a voluntary decision to treatment or a safe alternative. Expanding CIT trainings for first responders in rural areas will likely require creative solutions to accommodate the fact that personnel in some areas cannot leave their posts to participate in weeklong trainings. The state might explore distance training options, breaking up longer trainings into smaller components, or other strategies to allow for more widespread participation.

HSRI also recommends trainings for corrections officers so that they have a better understanding of behavioral health issues and can respond to these issues in trauma-

⁶² <http://www.ncbi.nlm.nih.gov/pubmed/27417893>

informed ways in correctional settings. Several states have adapted CIT training for corrections officers.⁶³ In addition, the SAMHSA GAINS Center has developed a free Trauma-Informed Response Training for criminal justice professionals to raise awareness about trauma and its effects.⁶⁴

6.3 Review behavioral health treatment capacity in jails and explore options to fill gaps

Several stakeholders we interviewed noted that in contrast the services that were available in the prison system, there were very few services offered in local jails throughout the state. In particular, services to support people experiencing drug and alcohol withdrawal symptoms were seen as lacking. HSRI recommends that existing criminal justice behavioral health initiatives include a more detailed review of jail-based services to systematically identify and address service gaps. Providers can enter jails and provide services through the substance use disorder voucher program, which could be one avenue to expand needed services.

6.4 Ensure Medicaid enrollment for individuals returning to the community

As noted throughout this report, individuals face numerous barriers to obtaining health insurance, even after the Medicaid expansion. A lack of Medicaid coverage is a significant barrier to access and results in higher system costs if unmet behavioral health treatment needs contribute to the “revolving door” phenomenon—with an individual cycling through inpatient, emergency, and justice involvement repeatedly. Terminating Medicaid benefits for incarcerated individuals exacerbates this dynamic. This approach is consistent with the one supported by CMS in a recent guidance letter to states.⁶⁵ Currently, the DHS is making changes to its Medicaid Eligibility and Enrollment system, and once the second phase of this work is completed, DHS will suspend rather than terminate enrollment for individuals who are incarcerated.

7– Engage in targeted efforts to recruit and retain a qualified and competent behavioral health workforce

Staffing shortages appear to be a core challenge in expanding the availability of culturally responsive and high-quality behavioral health services in North Dakota. The consistent endorsement of proposed workforce enhancement strategies documented in the Center for Rural Health’s recent survey of behavioral health stakeholders (Appendix G) affirms that these actions represent positive next steps for

⁶³ <http://www.pacenterofexcellence.pitt.edu/documents/Maine%20NAMI%20CIT-3.pdf>, <https://www.merage-equitas.org/wp-content/uploads/2014/06/Training-US-Correctional-Officers-in-Mental-Health-Response.pdf>, <https://www.correctionsone.com/jail-management/articles/4206236-Crisis-intervention-in-a-correctional-setting/>

⁶⁴ <https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals>

⁶⁵ The letter can be found at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>

future efforts. The strategies and findings from the Center for Rural Health's survey have been incorporated into our recommendations related to workforce development.

7.1 Establish a single entity responsible for supporting behavioral health workforce implementation

Because workforce issues in North Dakota are highly complex and interrelated, we recommend that the DHS establish a single coordinating entity to oversee concerted action in this area. This coordinating entity should be tasked with providing resources and support regarding all workforce-related issues in the state, including incentive programs, training, certification and licensure. The entity should conduct workforce-related research and evaluation, including gathering and monitoring workforce-related data. It should also foster partnerships among public and private providers and assist them to identify needed human resources and implement creative solutions to fill gaps in provider recruitment and retention. The entity should also work closely with universities, community colleges, and public and private high schools throughout the state—including those in the tribal nations—to coordinate and align education efforts with workforce strategies.

7.2 Develop a single electronic database of available statewide vacancies for behavioral health professionals

A single database, separate from the licensing authorities, for all behavioral health vacancies in the state would not only act as a community resource, it would also serve as a tracking mechanism for the DHS to understand workforce capacity dynamics and to identify shortages (in particular, workforce shortage areas).

The database should include information about statewide vacancies for all provider types, including mental health and substance use disorder treatment professionals and paraprofessionals for adults, children, and youth. The database should also include a statewide list of available student placements. To the extent possible, it should incorporate population demographic data to support aligning the provider population with the service user population in terms of racial, cultural, and other characteristics (related to Recommendation 9.4: Identify cultural, language, and service needs). It may also incorporate information on need for specific competencies and specialties, including training and experience supporting people with co-occurring mental health and substance use disorders, individuals with brain injury, justice-involved populations, early childhood mental health, etc.

7.3 Provide assistance for behavioral health students working in areas of need in the state

Stakeholders were clear in the need to provide tuition assistance and other supports for behavioral health students who are receiving training in identified areas of need in the state. These areas of need could be informed by the electronic database described in Recommendation 7.2 and will likely include providers who come from underrepresented population groups, providers with an interest and commitment to working in rural areas, and specific professional disciplines such as licensed

addictions counselors and child psychiatrists. Assistance may take the form of internship stipends or other financial assistance such as student scholarships and loan repayments with required service components after graduation. Support could also include mentorship and leadership development activities.

7.4 Ensure providers and students are aware of student internships and rotations

The Center for Rural Health survey identified a need to educate behavioral health providers on the benefits of student internships and rotations to promote buy-in and increase the number of available student placements for all behavioral health service types. Providers will need to understand the concrete benefits of supporting student placements, including cost benefits and potential for alleviating workforce strain.

7.5 Conduct a comprehensive review of state licensure requirements and establish licensure reciprocity with bordering states

Although there has been some progress in addressing issues with inconsistencies in state licensure requirements, stakeholders noted that more efforts are needed, including a comprehensive review of state licensure requirements across disciplines. This review should examine whether there are adequate training and education opportunities to meet the set requirements. Current requirements should then be revised to better align with available training and education resources. This would mean that there are accessible training and education opportunities available within the state to meet all requirements.

The review should also include a consideration of the extent to which North Dakota's licensing boards align with one another, with similar boards in other states, and with federal entities. Multiple stakeholders, and the respondents to the Center for Rural Health survey, indicated that establishing greater reciprocity between states will remove a key barrier to growing the behavioral health workforce in North Dakota by facilitating the process by which individuals with out-of-state licensure can practice in the state.

7.6 Continue to establish a training and credentialing program for peer services

Efforts are already underway to develop a statewide training and credentialing program for peer specialists in North Dakota. While the program is primarily focused on training and certifying the adult lived experience workforce, we recommend the state build on the current momentum to develop a similar effort for family peer support. Although they all involve the provision of support by people with lived experience, each of these three disciplines—mental health peer support, substance use disorder peer support (recovery coaching), and family peer support—are distinct practices that have evolved separately. They share common values and principles but may have unique orientations and practices, which should be respected and accommodated in training and credentialing efforts.

7.7 Expand credentialing programs to prevention and rehabilitation practices

We recommend that the DHS work with relevant stakeholders to review and consider incorporating additional certification programs related to prevention such as certified prevention specialist and infant and early childhood certifications to further promote and elevate prevention activities in the state. Likewise, adding the Certified Psychiatric Rehabilitation Practitioner (CPRP) certification into the state's system of community-based services will foster growth of a diverse community-based workforce that practices according to a code of ethics rooted in principles of recovery. Similarly, the DHS should partner with existing efforts already underway in tribal nations to support training and credentialing of community health workers.

7.8 Support a robust peer workforce through training, professional development, and competitive wages

As North Dakota engages in efforts to expand peer support services, there are several things to consider beyond peer training and certification—including supervision, ongoing or continuing education, and creating a career ladder for peer specialists. Critically, peer services must be delivered according to national practice standards in a manner that maintains the integrity of peer support [131]. This will require significant support for the peer workforce as well as education for providers to promote culture change and challenge misperceptions about the role of peers in clinical treatment settings. Clinical supervision of peer specialists is typically required for Medicaid billing; however, experience in clinical supervision does not always directly translate to working with peer specialists. Supervisors should have training in both basic supervision skills and specific skills related to peer specialist supervision—and training in how the role differs from traditional clinical roles. Peer specialist supervisors have a responsibility to advocate for equal compensation and benefits for this workforce and are responsible for promoting professional and job related personal growth. In addition to its training and certification efforts, HSRI recommends that the DHS ensure that peer services are supported through these national practice standards to ensure fidelity to peer support values and develop career opportunities and skills for peers working in behavioral health.

8 – Continue to expand the use of telebehavioral health interventions

We documented significant enhancements in the use of telebehavioral health interventions throughout the state, which stakeholders and Center for Rural Health survey respondents endorsed as key resources that alleviate workforce shortages and behavioral health access issues, particularly for rural populations.

8.1 Support providers to secure equipment and staff necessary for telebehavioral health services

As with the work conducted by the Center for Rural Health, our review found that providers lack financial and personnel resources to establish capacity to provide and receive telebehavioral health services. Financial and other resources are likely needed

to build capacity, including hardware and software, connectivity, and staff training. Initial investments in staff time and equipment are likely needed to set up these services, but these one-time investments to develop capacity may set in motion self-sustaining telebehavioral health efforts.

8.2 Expand the reach of telebehavioral health services for substance use disorders, children and youth, and American Indian populations

Our review and the Center for Rural Health's survey found that although a range of providers offer telebehavioral health services, the majority of those services are mental health-related, not substance use-related. We also observed that children and youth and American Indian populations are less likely to receive telebehavioral health services. Therefore, efforts to expand telebehavioral health should target these three areas, and any other areas of need identified in future assessments and ongoing data tracking activities.

8.3 Increase the types of services available through telebehavioral health

Stakeholders expressed interest in expanding the telebehavioral health capacity for a range of services that are not currently capitalizing on this technology. We recommend that the state work with providers to explore the suitability and capacity for offering new telebehavioral health services, particularly peer support and psychiatric rehabilitation services and crisis response services.

8.4 Develop clear, standardized regulatory guidelines for telebehavioral health

Stakeholders we interviewed were unclear about state regulations and resources for telebehavioral health, and the Center for Rural Health identified a lack of clear regulatory guidelines as a barrier to telebehavioral health. By providing more information, providers will be better able to weigh the risks and benefits of investing in telebehavioral health.

9 – Ensure the system reflects its values of person-centeredness, cultural competency, and trauma-informed approaches

In our interviews, we learned that the DHS and organizations in North Dakota have a strong commitment to values of person-centeredness, cultural competency, and trauma-informed approaches. We applaud this commitment to these important principles, which should be at the heart of any effort to coordinate and improve behavioral health services. However, we documented that individuals who receive services in the behavioral health system do not necessarily experience these services as person-centered, culturally responsive, and trauma-informed. Our findings point to opportunities for better engaging service users and their family members as active participants in their care. We also documented significant disparities, particularly for American Indian populations, LGBTQ individuals, and New Americans. Therefore, we recommend that all systems change activities include strategies to ensure person-centeredness, cultural competence, and trauma-informed care.

9.1 Promote shared decision-making

As noted previously, shared decision-making is a process through which service users and providers work with one another to understand a person's needs and preferences and ensure service users are active participants in their care. The SAMHSA-HRSA Center for Integrated Health Solutions maintains a website with links to resources to support shared decision-making, including freely available workshops and instructional videos and practical tools.⁶⁶ Shared decision-making could be promoted through connecting providers with free trainings and toolkits and measuring uptake of these shared decision-making practices throughout the behavioral health system. A number of web-based applications support shared decision-making in behavioral health care. CommonGround, developed by Dr. Pat Deegan, generates a one-page health report prior to an appointment to facilitate shared decision-making during the 15-minute treatment encounter.⁶⁷

9.2 Encourage establishment and use of mental health advance directives

Another strategy for ensuring that service users are active and engaged in their care involves promoting Mental Health Advance Directives (also known as Psychiatric Advance Directives). Mental Health Advance Directives are legal instruments an individual can use to specify instructions or preferences regarding future mental health treatment, including circumstances in which individuals lose capacity for informed consent during a mental health crisis.⁶⁸ Mental Health Advance Directives have been shown to reduce the need for costly involuntary treatment; a recent review synthesizing evidence from multiple interventions designed to reduce compulsory treatment found that advance directives were associated with the greatest reduction at 23% [132]. Although many states have such legislation, Mental Health Advance Directives are largely underutilized nationwide [133]. The state of Virginia has been lauded as pioneering policy innovations in this area, and a recent article in the journal *Psychiatric Services* describes these efforts [133].⁶⁹ The National Resource Center on Psychiatric Advance Directives⁷⁰ is also a useful resource for individuals, family members, and providers.

9.3 Develop a statewide plan to enhance overall commitment to cultural competence

In 2011, the U.S. DHHS developed an *Action Plan to Reduce Racial and Ethnic Health Disparities* that includes action steps related to behavioral health.⁷¹ A first step in a commitment to cultural competency involves developing a written cultural competency plan that outlines clear goals and objectives, strategies, and implementation timetables; and developing policies on cultural and linguistic

⁶⁶ <http://www.integration.samhsa.gov/clinical-practice/shared-decision-making>

⁶⁷ <https://www.patdeegan.com/commonground>

⁶⁸ <http://www.nrc-pad.org/>

⁶⁹ <http://www.ncbi.nlm.nih.gov/pubmed/25554231>

⁷⁰ <http://www.nrc-pad.org/>

⁷¹ http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

competency for the entire system or as they relate to specific services (crisis, inpatient, community-based services). The plan should be developed in partnership with communities that represent the racial, ethnic, linguistic, and cultural diversity of North Dakota, including American Indians, New Americans, and LGBTQ individuals.

The National Standards for Culturally and Linguistically Appropriate Standards in Health and Health Care (The National CLAS Standards), developed by the DHHS Office on Minority Health, can provide a framework for developing a cultural competence plan. The CLAS website⁷² includes numerous resources for systems and providers, including a “Tracking CLAS” page that offers a state-by-state compendium of National CLAS Standards Implementation activities.

The plan should include targeted efforts to recruit, develop, and retain a diverse workforce aligned with the workforce development strategies described in Recommendation 3. Stakeholders we spoke with emphasized a need for more workforce diversity, particularly in terms of racially and ethnically diverse providers and providers who come from the LGBTQ communities. They described barriers for members of racial, ethnic, sexual, and gender minority groups on multiple levels, including related to obtaining education and training, job placements, and licensure.

9.4 Identify cultural, language, and service needs of behavioral health service users

In addition to collecting accurate data on race and ethnicity, we recommend that the state routinely collect data on preferred spoken and written languages, country of birth, sexual orientation, and gender identity for all individuals who enter the behavioral health system. Ideally, this information would be collected from private as well as public providers. This information should be entered into electronic health records and aggregated to identify the cultures and language needs of individuals served by the behavioral health system. State administrators should use the data to maintain a current demographic, cultural, and epidemiological profile of each region and, if possible, conduct targeted needs assessments to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the state. These data can be used to identify and respond to disparities in the location of services, workforce availability, service quality, and population health outcomes.

9.5 Ensure effective communication with individuals with limited English proficiency

All behavioral health providers in the state should ensure there is sufficient staff to meet the language needs of its service users. If there is not sufficient staff, there should be a commitment to recruit, hire, and retain staff that are from or have experience working with the most prevalent cultural groups and that meet the language needs of individuals in the system.

When using interpreter services, leadership should ensure that the interpreters have been formally trained and certified or have received cultural competency trainings.

⁷² <https://www.thinkculturalhealth.hhs.gov/>

Access to bilingual staff and interpreter services as well as American Sign Language (ASL) services should be available at all points of contact and in a timely manner.

The state should also ensure that all key or essential documents and forms have been translated into the most prevalent languages of its service users. Some key documents and forms include those related to consent to treat, release of information, medication information (specifically instructions and dangerous side effects), and rights and grievance procedures. Service descriptions and educational materials should also be translated for individuals with limited English proficiency and should be provided in formats that can be understood by individuals with limited reading skills.

9.6 Implement training in cultural issues, culturally and linguistically appropriate service delivery, disparities, and trauma-informed care

Public and private system administrators should directly provide or make available to staff at all levels of the system (administrative, direct care, and non-direct care, etc.) educational activities or training in cultural issues and culturally and linguistically appropriate service delivery. Ideally, trainings should be available yearly and there should be requirements regarding the amounts of trainings specific staff (administrative, direct care, non-direct care, etc.) should receive. These trainings should include, at a minimum:

- American Indian history, disparities, and cultural contexts, including historical trauma
- Culturally and linguistically appropriate service delivery
- Principles of trauma-informed care
- Trainings related to providing a safe and welcoming environment for LGBTQ individuals such NDSU's Safe Zone Ally program⁷³ and Dakota OutRight's Creating Safe Spaces⁷⁴

Trainings should be delivered across the behavioral health system and within related systems, including the juvenile justice and child welfare systems.

9.7 Develop and promote safe spaces for LGBTQ individuals within the behavioral health system

In addition to promoting and requiring trainings that turn behavioral health treatment settings into safe spaces for LGBTQ populations (and identifying such settings that are already culturally responsive), it will be important to promote these services to the community to combat the current perception that behavioral health services lack cultural responsiveness. North Dakota State University maintains a list of "Allies" who have received training and have committed to being an ally to LGBTQ individuals [134], and this process could inform future efforts. Similarly, NDSU's directory of LGBTQ-affirmative therapists [135] could serve as a starting point that

⁷³ https://www.ndsu.edu/fileadmin/safezone/2016_SZ_Packet.pdf

⁷⁴ <http://dakotaoutright.org/css/>

could be expanded to include providers across the state. Similarly, the state's Suicide Prevention Plan includes specific strategies to enhance the cultural sensitivity of suicide response programs that could be expanded upon to include behavioral health services more generally.

9.8 Ensure a trauma-informed system

The recently initiated trauma screening initiative is an excellent first step in ensuring a trauma-informed system, and HSRI recommends that the state use the important data gathered through this initiative to ensure a trauma-informed system across the state. The SAMHSA National Center for Trauma-Informed Care (NCTIC)⁷⁵ outlines a framework that is focused on healing and recovery, under which the premise for organizing services shifts from looking at “what is wrong with you?” to “what happened to you?” A trauma-informed approach rests on the following key assumptions: “A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.”

NCTIC offers a variety of resources, including training and technical assistance, to assist behavioral health systems in ensuring a trauma-informed approach. The project team recommends that leadership in North Dakota follow the actions that NCTIC identified in its *Guidance for a Trauma-Informed Approach*⁷⁶ to ensure a system-wide orientation to trauma-informed care.

9.9 Conduct initial and ongoing organizational self-assessments of person-centeredness, cultural competence, and trauma-informed care, and include them in quality improvement initiatives

We recommend that key behavioral health organizations in the state perform organizational self-assessments related to person-centeredness, cultural competence, and trauma-informed care. The self-assessments should be conducted at multiple levels (central office, HSCs, and within provider organizations). Ideally, the self-assessments should include analysis of populations served, state and county demographics, race/ethnicity/gender of staff, and language capacities. The self-assessments should be used to understand how the system promotes its values both formally and informally. The data obtained from the self-assessments can be used to identify areas to be improved and to monitor changes over time. It is important that these data be included in any organizational quality improvement and accountability frameworks so that person-centeredness, cultural competence, and trauma-informed care is an integral component of management and services.

⁷⁵ <http://www.samhsa.gov/nctic/trauma-interventions>

⁷⁶ <http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>

10 – Encourage and support communities to share responsibility with the state for promoting high-quality behavioral health services

Increasingly, behavioral health is being recognized as having a community-based public health dimension. The Centers for Disease Control (CDC) describes this multi-faceted issue as a need to identify risk factors, increase awareness about behavioral health disorders and the effectiveness of treatment, remove the stigma associated with receiving treatment, eliminate health disparities, and improve access to behavioral health services for all persons, particularly among populations that are disproportionately affected.⁷⁷ Addressing many of these needs involves activities at the community level, which has the additional potential to educate the public about the community-level benefits of increased funding of behavioral health. It also involves espousal of the “nothing about us without us” mantra of the disability rights movement, which holds that behavioral health systems should be continuously and significantly informed by people who use those services.

10.1 Establish a state-level leadership position that represents the perspective of persons with lived experience

State and county behavioral health departments throughout the country have offices designed to represent the perspective of people with lived experience of the system. These departments—which vary in size and scope—have a variety of functions, including supporting strategic planning efforts, collaborating with service user and advocacy groups to bring lived experience perspectives to the table at leadership meetings, and working with system stakeholders to ensure that all system activities support recovery and wellbeing and are informed by service users and their families.⁷⁸

While it is unlikely the DHS has the capacity to immediately set up a new, fully staffed Office of Consumer Affairs or the like, we recommend that DHS begin by establishing a full- or part-time leadership position within the Department to begin to develop more capacity in this area. It is important that the position is filled by a person who self-identifies as having lived experience of receiving behavioral health services and has established relationships with a range of communities of service users and family members. Ideally the person has a background and training in peer support, rehabilitation and recovery, trauma-informed approaches, and other areas that reflect the values of DHS and of good and modern behavioral health systems. Establishing a state-level leadership position within DHS demonstrates a fundamental belief in the power of personal experience in effecting change.

⁷⁷ <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a1.htm>

⁷⁸ The National Association of State Mental Health Program Directors website includes resources to support the development of Offices of Consumer Affairs: <https://www.nasmhpd.org/content/nacsmha>. The organization also produced a brief on the topic: <https://www.nasmhpd.org/content/offices-consumer-affairs-pathway-effective-public-mental-health-services-executive-summary>

10.2 Strengthen advocacy throughout the state, particularly among individuals with lived experience and their families

A strong and diverse advocacy community composed of individuals with personal lived experience of behavioral health systems and their family members is an asset to behavioral health systems. Advocacy communities can partner with government and provider organizations to collaborate on systems change initiatives, and they hold organizations accountable to ideals of recovery and person-centeredness. North Dakota is home to some skilled advocates who have effectively called attention to mental health and substance use issues within the state. However, stakeholders we spoke with noted that advocacy in the state has largely been driven by a small number of longtime activists who represent multiple organizations at once; though no one found fault with these individuals, many wished that the community would expand to include new and more diverse voices representing a range of lived experience throughout the state.

Numerous stakeholders described a culture in North Dakota in which individuals are reticent to “rock the boat” for fear of standing out. Nonetheless, we observed a great amount of energy and enthusiasm for expanding peer advocacy in the state. We recommend the following strategies to strengthen advocacy:

- Create and promote opportunities for people with lived experience to sit on local boards and committees. To avoid tokenism and ensure that people with lived experience are comfortable and supported, having more than one person with lived experience is vital. Creating a welcoming environment that fosters involvement of people with lived experience requires concerted effort; this may include holding meetings in the evenings and in locations that are easily accessible by public transit, or by providing stipends to cover the costs of time and transportation to meetings.
- Offer training and mentorship opportunities for emerging advocates. Support for individuals to learn how to communicate effectively and have the courage to “speak out” about issues they care about.
- Identify and create opportunities to bring advocates together within the state—for example, scholarships for advocates with lived experience to attend the State Behavioral Health Conference, dedicated sessions and trainings related to advocacy skills and partnerships between advocates and other behavioral health stakeholders.
- Foster connections to national advocacy movements by supporting travel and attendance at national conferences such as the Alternatives conference,⁷⁹ and virtual advocacy networks.

⁷⁹ <https://www.ncmhr.org/alternatives.htm>

- Foster public-private partnerships such as the Face It Together initiative, which is a grant-funded coalition of business owners and community leaders working collaboratively to reduce the impacts of addiction on their communities.

10.3 Support the development of and partnerships with peer-run organizations

Peer-run organizations are programs in which a majority of people who oversee the organization's operations are individuals with lived experience of mental health or substance use services [136]. These organizations serve as valuable community resources, providing a range of supports, education, and advocacy aimed at improving quality of life for people with lived experience of behavioral health challenges. These organizations are key partners in systems change activities, providing important linkages between and across systems and holding leadership accountable to recovery principles.

HSRI recommends the state consider ways in which it might support the development of additional peer-run organizations. Through SAMHSA, technical assistance is available to support the operations and sustainability of peer-run organizations. The Family Café TA Center,⁸⁰ the organization assigned to North Dakota, provides technical assistance and support in several topics, including organizational development, working with emerging adults, and cross-disability collaboration.

10.4 Sustain community education efforts that promote better understanding and reduce stigma, discrimination, and marginalization

Some state and local community education and outreach initiatives are currently underway in North Dakota; however, most are predominantly focused on raising awareness of substance use issues. Community stakeholders voiced a need for more broad-based and multifaceted community education, particularly campaigns aimed at promoting greater community acceptance and integration of people with behavioral health conditions. For example, efforts focusing on outreach and education to potential employers regarding the provision of reasonable accommodations for people with psychiatric disabilities may help to reduce barriers to employment for this population. Several stakeholders noted that local, community-driven initiatives are more likely to be well-received than state-driven initiatives.

NAMI offers a number of educational programs that are free to attend and taught by NAMI-trained volunteers. Although these are not costly interventions, they do require an ongoing investment of time for organization and building a pool of volunteers, and most have modest costs for materials and meeting space.

10.5 Offer and require coordinated behavioral health training among related service systems

Our assessment identified a need for consistent and coordinated behavioral health training across the full range of public systems that touch the lives of people with behavioral health conditions. Training should inform these stakeholders on social

⁸⁰ <http://cafetacenter.net/>

determinants of health, trauma and trauma-responsive approaches, cultural competence, and rehabilitation and recovery. Trainees should include physical health care providers, teachers and daycare providers, law enforcement and other first responders, criminal justice professionals including corrections staff, social service agencies, public health workers, child welfare coordinators, vocational rehabilitation providers, housing authorities and developers, and others. By promoting a unified understanding of behavioral health issues, stakeholders will share a common language and vision. This shared vision will support cross-system collaboration and coordination and combat harmful misperceptions about behavioral health that were identified in this study.

11 – Partner with tribal nations to increase health equity for American Indian populations

The following recommendations were developed through a process of engagement with members of the Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians, and Mandan Hidatsa Arikara Nation during a Talking Circle that took place in July 2017 (described further in Appendix C). These recommendations may be addressed in partnership with the tribal nations and should include a process for revision and review.

1. Form a tribal nation behavioral health collaborative to develop an inter-tribal behavioral health strategic plan; meet regularly to communicate progress toward the objectives in the strategic plan.
2. Redouble efforts to establish partnerships between tribal nations and the state. Create opportunities for state leadership to visit tribal communities and meet regularly with tribal leadership. Reestablish an office of health equity at the state level.
3. Develop services and program directories for each tribal nation so all community members know what services are available.
4. Educate tribal leaders about what services they can bill and be reimbursed for and provide training specific to each tribal nation.
5. Invest the monies recouped from the 100% FMAP back into the tribal communities.
6. Include regular and ongoing American Indian cultural competency training as part of all state, county and provider employee orientations.
7. Integrate traditional medicine as part of the behavioral health care continuum and explore options for sustainable financing of traditional approaches.
8. Explore additional sustainable options for delivering care and strengthening the workforce – telemedicine, tribal colleges for workforce development, expanded use of community health workers.

In the months since the Talking Circle, some collaborative efforts have already been initiated. HSRI applauds these efforts and strongly encourages their continuation and expansion. Incorporating clear and actionable goals and objectives related to partnership and collaboration with tribal leadership will be critical to the success of future systems planning efforts.

12 – Diversify and enhance funding for behavioral health

Throughout this analysis, we noted many areas in which the system could improve its cost-efficiency, such as shifting investments in costly inpatient and residential services to lower-cost outpatient and community-based services and employing prevention and early intervention strategies with a high return on investment. Over the long-term, these broad system changes will likely result in some measure of cost savings. Over the short-term, however, upfront investments are likely needed to spur change. HSRI recognizes that resources are scarce and that systems change efforts will be constrained by resource availability. No single strategy or funding source will change this picture, but consistent and coordinated efforts to diversify and enhance behavioral health funding are the best option for the DHS.

North Dakota relies on state and local funds to finance a large proportion of many of its most costly services, including residential treatment, case management, evaluation and assessment, and substance use disorder treatment services. Without drawing down additional funding from federal and other sources, expanding these and other services will be unlikely in the future.

12.1 Develop an organized system for identifying and responding to funding opportunities

This is a period of tremendous change for health and behavioral health systems, for North Dakota and the country. Having a designated person to keep a finger on the pulse of system changes and opportunities will be critical for ensuring that North Dakota receives an adequate and ongoing supply of funding for system improvement efforts. Behavioral health initiatives are funded by an array of sources, including private and public grants and local, state, and federal programs. While we discuss some potential financing opportunities, they are by no means a comprehensive account of all possible funding streams. By establishing an entity charged with monitoring possible funding sources and identifying and responding to opportunities, the state may capitalize on diverse funding streams and ensure a more sustainable system.

12.2 Pursue 1915(i) Medicaid state plan amendments to expand community-based services for key populations

The 1915(i) state plan amendment (SPA) has been the most common avenue for states to pursue funding for community-based services via the Centers for Medicare and Medicaid Services (CMS). The 1915(i) is not a waiver like 1915(c)—it is an optional set of benefits that states can choose to add to their Medicaid state plan. The 1915(i) offers states the option to include a wide range of home and community-based services as a state plan option, including services that address the social determinants of health. Through a 1915(i), North Dakota can institute services identified as lacking in our data sources: peer-provided services, supported employment, and supported housing, among others. Adding these services could significantly reduce demand for emergency, inpatient, and long-term care services that are not reimbursed by Medicaid, which could reduce overall system costs in the long run.

In 2010, the Affordable Care Act (ACA) amended the 1915(i) in key ways, presenting new opportunities for using the state plan option to fund behavioral health services and supports: the range of covered services and supports was further expanded, eligibility was extended to include individuals with incomes up to 300% of the SSI Federal Benefit Rate, and states were permitted to have more than one 1915(i) benefit targeted to specific populations. If interested, the state can request free technical assistance from experts in using CMS authorities to expand behavioral health services.⁸¹

12.3 Pursue additional options for financing peer support and community health workers to address social determinants of health and provide preventive and rehabilitative services

Ensuring Medicaid reimbursement for services that support recovery and wellness and linkages to social services will help the state to better-address the social determinants of health for North Dakotans. These services should include assessment for social support needs, identifying and tracking community-based resources, developing plans to connect individuals to those resources, and supporting individuals to take full advantage of these resources [84]. These services could also include “preventive” or “rehabilitative” services, which are broadly defined as those that support “the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level” [137]. Such services may include support navigating the medical system, sustaining mental health or substance use recovery, identifying and pursuing personal goals, supporting behavioral changes to support wellness, and connecting with social support services [84].

At the State’s discretion, these individuals may be non-licensed community health workers, or they may be peer specialists—provided they receive appropriate training and oversight. Further, these services can be provided in an array of settings, including in the community or the person’s home. Services may be targeted to groups of individuals, such as persons with serious mental health conditions or persons with co-occurring chronic medical conditions and behavioral health conditions. There are also specific provisions that allow for expansion of these services through the Indian Health Service that the state and tribal nations are currently exploring. There are multiple options for financing expanded coordination services. These include a 1905(a)(19) optional case management, 1915(g)(1) targeted case management, and additional case management service options through the 1915(i) state plan option. HSRI recommends that the state pursue technical assistance to explore and pursue these and other related options.

⁸¹ To apply for free technical assistance, fill out an application at <http://www.hcbs-ta.org/>. CMS has a website with the regulations and all published guidance to date found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

12.4 Sustain and explore expanding voucher-based and other flexible funding for recovery supports.

The substance use disorder voucher program, funded through state general revenue, is an important community resource that provides funding for key services not otherwise covered by other public sources, including medication-assisted treatment and peer support. Stakeholders saw this funding stream as a key resource that can be flexibly employed to meet unique community needs. We recommend that the state sustain (and perhaps expand) the substance use disorder voucher program to continue to support access to recovery support services and fill other gaps in the substance use disorder service continuum.

Related approaches in mental health, including mental health self-direction,⁸² are employed in several states to connect individuals with serious mental health conditions to non-traditional services and supports and enhance self-determination and choice in the delivery of mental health services more generally. In self-direction—also known as self-directed care—a service user or “participant” controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. Participants receive planning and budgeting assistance from a specially trained staff person, often a peer support specialist. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual’s traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. Mental health self-direction is associated with improved social and functional outcomes and, depending on how it is structured, can be implemented at a similar cost to traditional arrangements [138, 139]. The 1915(i) state plan option allows for the inclusion of self-direction in state Medicaid plans.

12.5 Engage in targeted efforts to enroll eligible service users in Medicaid to maximize federal contribution to publicly funded behavioral health services

We observed that a large proportion of services that are typically reimbursed by Medicaid appeared to be funded through state and local general revenue dollars. These include outpatient mental health services, outpatient substance use disorder treatment, evaluation and assessment services, crisis intervention services, and as mentioned above, case management and other community-based services. Given that North Dakota is a Medicaid expansion state and many low-income adults are eligible for insurance, these figures suggest that there may be opportunities to work with current and potential HSC service users to ensure they are receiving all the public benefits they are entitled to, particularly Medicaid. Investing in personnel and programs that support entitlements, including support with initial applications and ensuring continuous coverage, could result in enhanced federal revenue for a range of behavioral health services system-wide.

⁸² www.mentalhealthselfdirection.org

12.6 Join in federal efforts to ensure behavioral and physical health parity

An important contribution to the availability of behavioral services in primary care and substance use disorder treatment services system-wide is the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (“Parity Act”). However, many barriers have prevented the legislation from fulfilling its promise. These barriers include insufficient state and federal enforcement, health plan noncompliance, including lack of disclosure of medical management information, and other implementation barriers to accessing mental health and substance use services on par with physical health services. The Helping Families in Mental Health Crisis Act (H.R. 2646), passed by the House of Representatives on a near unanimous vote (422-2), and the Mental Health Reform Act (S. 2680), unanimously approved by the Senate Health, Education, Labor and Pensions Committee (HELP), both include provisions for better enforcement of the Parity Act. These bicameral, bipartisan bills promote mental health and substance use parity by requiring better federal agency collaboration to enhance compliance through issuance of clarifying guidance, the reporting to Congress on federal parity investigations, and the development of an action plan to improve federal and state enforcement. If this legislation is coupled with state and federal implementation and oversight, including the randomized auditing process detailed in the Behavioral Health Transparency Act (H.R. 4276), the letter and spirit of the 2008 law will be realized and non-discriminatory access to treatment and recovery will ultimately become available. We recommend that the DHS work with state legislators and others to advocate for increased attention to parity enforcement. The DHS may consider undertaking a systematic review of compliance with parity laws across the state to guide its efforts in ensuring parity.

13 – Conduct ongoing, system-wide, data-driven monitoring of need and access

The analyses in this report, based on utilization data and stakeholder interviews, provide a picture of existing and needed services. However, continued monitoring of outpatient need and capacity will be essential to ensuring a high-quality behavioral health system in the long term.

The recommendations in this section are designed to support an infrastructure in which resource allocation is informed by demonstrated improvements in outcomes. The Free Through Recovery initiative is founded on a performance payment system linking payment to outcomes and could serve as a blueprint for future efforts. The outcomes that are measured in that effort are stable housing, stable employment, recovery, and involvement with the criminal system.

13.1 Work to enhance and integrate provider data systems

In today’s health care environment, comprehensive, integrated data systems are considered essential to effective planning, service coordination, and delivery. The use of electronic health records has been vastly accelerated since the passage of

the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, which authorized incentive payments to increase physician adoption [140].

In the behavioral health field, although progress varies widely, a number of state behavioral health agencies have initiated efforts to link person-level data with other agencies such as criminal justice, health, employment, child welfare, juvenile justice, and education [141]. We recommend that the DHS work with other state agencies to develop data sharing standards and common understandings of privacy laws, and advocate to the federal government to amend privacy laws as appropriate to reflect today's integrated health care environment. This effort should include working with other state agencies to align data monitoring systems and encourage them to adopt shared data conventions, including shared measures, data elements, and data dictionaries. This enhanced system should also allow for monitoring of racial and ethnic disparities to track whether the state is meeting the needs of all residents and enable a quick response to correct disparities in access, quality, and outcomes.

The state, health plans, and counties play an important role in facilitating a shift from data reporting for “compliance” to “accountability” for population health management and outcome and value-based care. The following should accompany the rollout of any new data system:

- Training for behavioral health providers to routinely collect and use data to inform clinical decision-making and demonstrate improved individual-level outcomes.
- Sufficient capacity across all providers to collect data in formats that allow for assessment of the core functions that are essential to integrated or coordinated care (e.g., referral tracking, follow-up, care planning, and cross provider or system communication).
- Efforts to ensure that the goal of required data collection and reporting moves beyond documenting the number and type of services delivered to tracking whether the services are making a difference in the lives of individuals and improving overall population health (i.e., moving from volume-based care to value-based care).

13.2 Develop system metrics to track progress on key goals

Data system efforts may also include selecting a set of performance and outcome indicators based on specific system goals. Service users, families, providers, advocates, and other key stakeholders should be involved in the identification and selection of the performance and outcome indicators for the system. It is important that both process and short-term and long-term outcome measures are included. Process measures capture how services and treatments are provided and allow system stakeholders to compare the quality of services across the state and to identify trends and exceptions to trends.

Some examples of metrics other communities have used as part of routine reporting and dashboard systems include the following:

- Provider collaboration measures around referrals and data sharing
- Number of inpatient and residential bed days utilized by payer source and demographics
- Number of behavioral health emergency room encounters
- Number of new persons entering the system (could be defined as those completely new to the system or those who have not received a service for a specified amount of time)
- Number of persons entering the system via police or other criminal justice entry point
- When new services are added, tracking the number of people utilizing the service by month
- Number receiving employment support services
- Number receiving housing support services
- Number of service users in competitive employment
- Number of service users who attain and maintain stable, integrated housing
- Number receiving housing vouchers
- Number of peer specialists employed
- Service user and health and mental health-related functioning
- Substance use disorder treatment, retention and engagement
- Utilization of and fidelity to evidence-based practices
- Rates of screening and other preventive activities
- Rates of early intervention for individuals experiencing a first-episode of psychosis
- Rates of attending a behavioral health appointment upon returning to the community from residential or inpatient treatment (numbers attending and length of time between discharge and date of service)
- Engagement in services/treatment after initial appointment
- Other short and long-term outcomes for individuals returning to the community, including re-admission, overdose fatalities, and emergency room or crisis service use

13.3 Identify and target services to those with highest service costs

The capacity of the system to identify individuals with high service costs depends on the compatibility of its data systems, or at the very least the ability of entities to work together to identify and respond to those with the most intensive service needs. In the North Dakota context, a starting point might be focused on linking data on services provided through the HSC (and ideally its contracted providers), the state Medicaid program, and the state hospital. Individuals with frequent emergency room visits and those who come into contact with first responders on a regular basis could be a focus, as could individuals with frequent readmissions to the state hospital and younger populations residing in long-term care facilities.

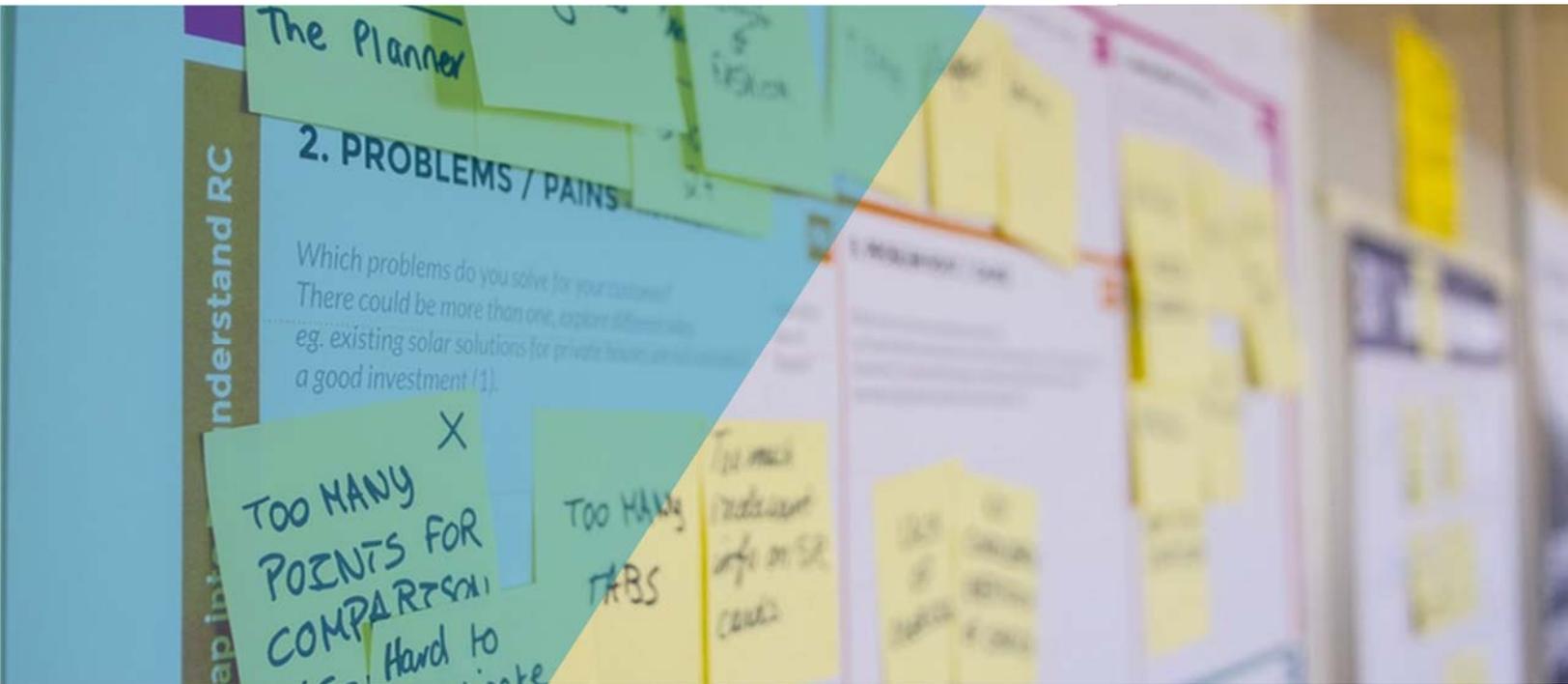
Contacts with law enforcement and criminal justice may also factor into the identification of high-need individuals. Identifying and responding to the needs of individuals with behavioral health–related needs who are justice-involved requires establishing relationships and data sharing agreements with law enforcement and justice systems, and there are numerous models for such collaboration.⁸³

Using data to target those with the highest service costs would enable the state to [142]:

- Cement partnerships between the Behavioral Health Division and other relevant agencies, including housing, criminal justice, first responders, and physical health systems.
- Leverage partnerships and generate momentum for increased funding.
- Target underserved populations and work toward health equity. Focusing on high utilizers using data-driven methods will allow the DHS to target resources to those who may not proactively seek services but would benefit the most from those services.
- Develop baselines and track ongoing progress by describing the scope of the challenges to those with the most complex behavioral health-related needs in North Dakota. Ongoing monitoring of the needs and characteristics of the high utilizer population will help stakeholders identify whether and how targeted strategies are making an impact.
- Provide appropriate services, including services targeted to the needs of particular population groups. Examining the demographics of the high utilizer population will guide efforts to ensure services are culturally responsive, person-centered, and trauma-informed.

⁸³ <http://www.csh.org/wp-content/uploads/2015/10/Frequent-User-Initiative-Profile-Booklet-10th-Decile-Project-Final.pdf>

Background and Approach



Examining behavioral health needs

The Human Services Research Institute (HSRI) was commissioned by the North Dakota Department of Human Services to conduct a study to better understand the particular challenges for the behavioral health system in North Dakota and to identify areas where the State can focus its improvement efforts in the future. The main aims and questions to be addressed by the study were:

Aim 1: Conduct an in-depth review of North Dakota's behavioral health system

- 1.1 What are the behavioral health-related needs of North Dakotans?
- 1.2 What behavioral health services are currently available to meet the needs of North Dakotans?
- 1.3 How do needs and access to behavioral health services differ by population group, including members of tribal communities, early childhood, youth and young adults in transition, justice-involved populations, persons with other disabilities, individuals who are homeless, nursing facility residents, military service members and their families, persons with traumatic brain injury, and the uninsured?
- 1.4 How does North Dakota's behavioral health system compare with national guidelines for comprehensive systems of care, including the use of evidence-based practices?

Aim 2: Analyze current utilization and expenditure patterns by payer source

- 2.1 What are the current utilization and expenditure patterns for behavioral health services in North Dakota, including mental health promotion, prevention and early intervention, evidence-based practices, community-based services, emergency room and inpatient, corrections-based care, and unreimbursed care?
- 2.2 How do utilization and expenditure patterns differ by payer source, including Medicaid, Medicare, and state and local funds?

Aim 3: Provide actionable recommendations for enhancing the comprehensiveness, integration, cost-effectiveness and recovery orientation of the behavioral health system to effectively meet the needs of the community

- 3.1 What behavioral health services should be adjusted, reduced, or added?
- 3.2 How can the State target behavioral health services to ensure they are meeting the needs of all population groups?
- 3.3 How can the State leverage multiple financing streams and target resources to meet the behavioral health needs of the community in as cost-effective a manner as possible?

Aim 4: Establish strategies for implementing the recommendations produced in Aim 3.

- 4.1 What management structures and processes will be required for implementing recommendations?
- 4.2 What financing options will fill the identified gaps in a sustainable way?
- 4.3 How should the State prioritize the recommended system changes?

Approach

HSRI is a 501(c) (3) nonprofit corporation, formed in 1976. We help public agencies develop effective, sustainable systems to deliver high-quality health and human services and supports in local communities. We help create positive change by taking a person-centric approach. We believe that systems are more effective—and less costly—when service users have a direct say in the services they receive and help define their desired outcomes.

Across our focus areas, we work to:

- Help design data systems and analytics solutions that produce actionable insights
- Partner with leaders and change agents to identify best practices, add value, and solve problems
- Help design robust, sustainable systems based on qualitative and quantitative data, engaging service users, self-advocates, and other stakeholders early and often
- Assist organizations in building the capabilities they need to sustain systems change

In the behavioral health space, our goal is to deliver actionable, viable, and culturally relevant strategies that promote wellness and recovery. We examine the entire interplay of community factors and supports that influence behavioral health—not just the formal systems. By taking such a broad view, we're able to identify and highlight a range of existing strengths, assets, and successful practices. On the flip side, this approach enables us to pinpoint barriers related to access, discontinuity of care, system fragmentation, and more.

The Western Institutional Review Board (WIRB) reviewed all study protocols to ensure all activities were conducted in accordance with federal, institutional, and ethical guidelines. Key informants and survey participants were given descriptions of the study activities, including a detailed discussion of potential benefits and risks of participation, and each provided informed consent before participating in study activities.

As part of its data-gathering activities, the HSRI team collaborated with a colleague from the Department of Public Health at North Dakota State University to convene representatives from the four tribal nations for a talking circle to understand their perspectives of the behavioral health system in North Dakota and its relationship to the health systems within the tribal nations. The talking circle was convened in July 2017 at the United Tribes Technical College and included members of the Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians, and Mandan Hidatsa Arikara Nation. Before meeting, the group was offered the following potential discussion topics:

- What do you see as the most pressing behavioral health-related needs and challenges in your communities? What would need to change for these needs to be adequately met?
- What are some examples of practices, programs, or initiatives that do a good job of meeting behavioral health-related needs in your community?
- How would you describe the relationship between Tribal Nation leadership and the state, and with county health and social service systems?
- What other information unique to the Tribal Nations needs to be understood to effectively meet the behavioral health needs of tribal members?

During the talking circle, members of the HSRI/NDSU team took notes. After the talking circle, the team presented the group with two documents: the notes (the *Notes on Challenges, Strengths, and Takeaways* are included in Appendix C) and another document with key themes and recommendations arising from the discussion. These documents were sent back to all talking circle participants for review and were revised based on additional feedback. The themes discussed in several sections of this report and multiple study recommendations, including Recommendation 11, are a direct result of this process.

Data Sources and Methods

The behavioral health study involved three types of data: existing reports and publicly available data on prevalence, service utilization, and community need; key informant interviews with stakeholders; and service utilization and claims data obtained from the state Medicaid program and the Behavioral Health Division. Data were analyzed using a mix of qualitative and quantitative research methods.

Existing Reports and Publicly Available Data

A team at HSRI located, compiled, and synthesized existing quantitative and qualitative data from a wide variety of sources for this report. These included publicly available data as well as reports and information provided by key informant interviews. Data sources, referenced throughout the report, included reports and articles from a variety of published and unpublished sources. To place the local North Dakota issues in the context of the national health and behavioral healthcare environment, peer-reviewed research articles and national literature have also been drawn on as part of this project and are referenced throughout the report.

Data sources most commonly used for this report include:

- **America’s Health Rankings, 2017 Annual Report.**⁸⁴ America’s Health Ranking provides state-level health rankings. Their model includes four categories of determinates of health which impact health outcomes: behaviors, community and environment, policy, and clinical care. Measures from national and state level data sources are used to calculate rankings and are presented as aggregates at the state level.
- **Centers for Disease Control and Prevention, Drug Overdose Death Data.**⁸⁵ The number and age-adjusted rates of drug overdose deaths for each state are derived from mortality data from the CDC’s National Center for Health Statistics (NCHS), National Vital Statistic System (NVSS). NVSS contains demographic, geographic and cause-of-death information for persons across the nation. The CDC classifies deaths using the International Classification of Diseases, Tenth Revision (ICD-10).
- **National Survey on Drug Use and Health (NSDUH).**⁸⁶ NSDUH is a federally conducted questionnaire administered through face-to-face interviews to noninstitutionalized U.S. civilians, 12 and older. Data are collected on mental disorders, the use of illicit drugs, alcohol and tobacco, co-occurring substance use and mental disorders, and treatment for substance use and mental health issues. Persons who are homeless who do not use shelters, military personnel on active duty, and residents of institutional groups including jails, prisons and long-term hospitals are excluded from the questionnaire.

⁸⁴ <https://assets.americashealthrankings.org/app/uploads/2017annualreport.pdf>

⁸⁵ <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

⁸⁶ <https://nsduhweb.rti.org/respweb/homepage.cfm>

- **Robert Wood Johnson Foundation, County Health Rankings.**⁸⁷ The County Health Rankings program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. This county-level ranking system follows a model of population health which highlights “health factors” and “health outcomes” that influence the overall well-being of communities across the nation. County-level measures from an array of national and state data sources (e.g., BRFSS) were standardized then combined using rigorous, scientifically informed procedures. Counties within states are ranked on overall health outcomes based on these measures.
- **United States Census Bureau.**⁸⁸ The U.S. Census Bureau’s Population Estimates program produces estimates of the population for the nation, states, counties, cities and towns, and Puerto Rico. New resident population estimates are released annually using measures of population change from the last decennial census (i.e. 2010). State and county data are available by age, sex, race, and ethnicity.

Stakeholder Interviews

HSRI conducted 66 in-depth interviews with 120 stakeholders over the course of this study. Stakeholders were chosen as having a particular perspective about behavioral health issues in North Dakota and included service users, family members, and representatives from mental health and substance use disorder service providers, state and local agencies. Some interviews were conducted by telephone and others in-person during two site visits in the spring and summer of 2017. A preliminary list of stakeholder interviewees was identified by DHS staff, and additional stakeholders were identified through a “snowball sampling” process in which the preliminary stakeholder interviewees recommended other stakeholders with particular knowledge of behavioral health issues. The HSRI team also identified stakeholders through the background document review process. Interviews were conducted individually and in small groups. Represented service and support organizations are listed in Appendix B. Stakeholder interviewees also included service users and their families, who were identified and recruited by local community stakeholders.

Interviews were conducted using a semi-structured style using a set of interview questions that were developed by the study team and reviewed by DHS. With interviewee consent, interviews were audiotaped and then summarized. All stakeholder interviewees were informed about the purpose of the study and processes in place to ensure research ethics. Special precautions were put in place to ensure informed consent and anonymity of service user and family member interviewees. The interview guide, interview protocol, recruitment materials, and informed consent forms were reviewed and approved by the WIRB.

⁸⁷ <http://www.countyhealthrankings.org/>

⁸⁸ <https://www.census.gov/>

Interviews were typically conducted by two HSRI researchers, with one researching leading the discussion and a second researcher taking notes. Using notes and audio recordings, the HSRI researchers created detailed summaries of each interview. Interview content was categorized into the following themes: Brief biography of key informant; background/overview of key informant's organization and/or relationship to the North Dakota behavioral health system; identified challenges, barriers, and problems within the current behavioral health system; identified beneficial resources, services, and supports within the current system; and recommendations for improving the North Dakota behavioral health system in the future.

In addition to these interviews, several stakeholders provided direct email feedback, and this information was also incorporated into the report as appropriate.

Medicaid Claims and HSC Service Utilization Data

Data obtained from the state Medicaid program and the Behavioral Health Division were analyzed to provide service utilization penetration rates. Data from the Behavioral Health Division consisted of services administered by the eight Human Service Centers (HSC). HSRI performed the following actions to prepare the datasets for analysis: clarified the date range, removed non-behavioral health related claims and events, removed developmental disability-specific claims and events, removed administrative and missing services, and grouped services into broad categories that correspond with the sections of the final report.

Claims and HSC data were contained to state fiscal years (SFY) 2013 to 2017. Additionally, only behavioral health claims and events were used in the analysis. To isolate behavioral health claims in the Medicaid data, the analysis team selected claims where the primary diagnosis was a mental health or substance use disorder. This categorization was done using a simple HSRI-developed cross-walk of ICD-9 and ICD-10 codes associated with behavioral health conditions. Claims were categorized broadly as either mental health or substance use. A subsequent selection of behavioral health events in the HSC data was not necessary since the extract only consisted of behavioral health events.

In both data sources, claims and events related to developmental disabilities (DD) services were removed. In the Medicaid data, the developmental disability specific service location, "Intermediate Care Facility/MR" was removed. In the HSC data, persons who *only* received DD services were removed from the analysis. Overall, this eliminated 4,837 people from the HSC data. Data were also removed to optimize the quality of the datasets. This included removal of: cost adjustments, corrections to the data, administrative notes, services with missing descriptions.

To run the analysis on specific groupings of services, HSRI created service categories in both data sources based on the Medicaid procedure and the HSC service descriptions. In Medicaid, if the procedure was accessed by only 10 or less people, or if it was related to a medical service, then it was categorized as “other”.

To reduce the duplication of claims/events when showing a service in both data sources, we removed events in the HSC data when the funding source was Medicaid. Although this procedure reduced the chance of duplication, the funding source in the HSC data is missing for 39% of the events. Therefore, it is possible that utilization counts, and penetration rates duplicate an individual across the two data sources. For each service category where Medicaid and HSC data are shown together, the proportion of events where HSC funding source is unknown is reported.

Service location was taken into consideration for the analysis of each service category. Service locations corresponding to the service category were included in analysis. All locations not pertaining to the service category were excluded. For some service categories in the Medicaid data, the primary diagnosis (mental health or substance use) was utilized to define the category. For example, the outpatient mental health selection in the Medicaid data included only persons with a primary diagnosis of mental health.

Penetration rates were calculated using the state and county U.S. Census “annual estimates of resident population, April 1, 2010 to July 1, 2016” for North Dakota. The HSC regional estimates were calculated using the census county-level annual estimates. For the state and regional fiscal year penetration rates, the denominator referred to the census year range closest to the SFY.

HSC Contract Data

Some programs, such as the Recovery Centers and many inpatient and residential providers, receive HSC contract funding and do not bill services based on individual service users. Counts of individuals receiving crisis intervention, inpatient, and residential services in SFY 2017 were obtained from the HSCs for seven of the eight HSC regions. These unduplicated counts were factored into the penetration rates for HSC services.

Data Limitations

As noted above, we derived the state’s service utilization data from services and supports billed to Medicaid or delivered through HSCs, which means it was impossible to capture a complete service summary. Some programs, such as the Recovery Centers and many residential and inpatient providers, receive separate funding and do not bill services based on individual service users. Thus, these programs were not captured in the service utilization data, although many service users may be using them as part of their service packages. Additionally, our data do not capture services and supports that were delivered outside of the behavioral health authority through other state and local agencies or social service organizations that do

not bill Medicaid or contract with the HSCs. Also, any analysis of claims data is subject to administrative errors associated with that data.

Another limitation is that a fairly substantial proportion of demographic data were missing from the HSC data (for example, 10% of individuals who received HSC services during FY2017 had missing race information). Because of a high level of missing values related to funding source in the HSC data, we were unable to link the two primary datasets, Medicaid claims and HSC service utilization data.

Approximately 39% of service events in the HSC data were missing information about the funding source, and 95% of the individuals in the HSC sample had at least one service with a missing funding source. Just over half of the sample did not have a Medicaid identification number listed in the data; however, 4% of individuals with a missing Medicaid identification number had at least one Medicaid-funded service during the study period. As a result, we analyzed the two datasets separately and presented data in an aggregated format when we were reasonably sure there was not significant overlap. We were also unable to link Medicaid or HSC data with information from the state hospital because Medicaid enrollment data were unavailable. Finally, there were limited quantitative data available on the rates of screenings and prevention activities in the state as well as on services provided in criminal justice settings.

We were also unable to link Medicaid or HSC data with information from the state hospital because Medicaid enrollment data were unavailable. Because HSCs contracted out many services, and because there are no data on numbers served within each contract, we are unable to provide accurate estimates of penetration rates and per-person costs for those services. Finally, there were limited quantitative data available on the rates of screenings and prevention activities in the state as well as on services provided in criminal justice settings.

Additional Data Sources

In addition to HSC and Medicaid claims data, we also received data from the North Dakota State Hospital and from the State's largest foster care provider, PATH ND. The state hospital data was derived from the Advanced Institutional Management Software (AIMS) an application that gathers information on demographics, intakes, and discharges. The DHS provided HSRI with AIMS data from FY 2013 to 2017. Using these data, we calculated length of stay information and examined available demographic characteristics of state hospital patients during the study period.

A PATH ND staff person met with the HSRI study lead to discuss available data that might be relevant for the study. Based on those discussion, PATH ND supplied HSRI with aggregated data on characteristics of foster care recipients and length of stay. HSRI and PATH ND then remained in ongoing communication to clarify particular data elements and ensure accuracy in presenting the data.

Strengths and Limitations

As with any effort of this kind, our approach carries unique strengths and limitations. To our knowledge, this systems analysis is the most comprehensive and data-driven of its kind. It builds off previous work that has already been produced, incorporates stakeholder feedback using a variety of means, and includes detailed analysis of existing data, including Medicaid claims and Human Service Center service utilization data. While the data sources are extensive, they are not without limitations.

For this report, we attempted to engage stakeholders who represent a range of perspectives on behavioral health and the behavioral health system in the state. While we make concerted efforts to reach out to as diverse as possible a group of stakeholders, some viewpoints, perspectives, and parts of the state are represented more than others. This is the nature of qualitative research when there are finite resources (research staff time and funding). For example, while we did conduct telephone interviews with individuals throughout the state, we did not visit all regions in North Dakota, nor did we visit any of the tribal nations in North Dakota. Through the course of this study, we met with over 20 individuals with lived experience of the behavioral health system and their family members (many stakeholder interviewees had direct lived experience and also had family members with lived experience). The critical importance of understanding the lived experience of the behavioral health system can't be overstated, and we hope that our efforts are furthered as these recommendations are implemented.

As noted above, there are also limitations associated with the quantitative data we sourced for this study. Some of these limitations are common to all types of administrative data in any systems analysis effort, while others are specific to North Dakota's current data management systems. Despite some significant limitations, the information presented here begins to provide a picture of the current utilization and expenditure patterns by service type. Further, the data limitations we encountered were instructive for understanding how the state may improve its use of these datasets to inform future systems planning efforts, and we've incorporated a discussion of these issues into our data-related recommendations.

Definitions

The data sources for this report use standard classifications for behavioral health disorders based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV):

- **Mental illness** is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID).

- **Serious mental illness (SMI)** is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID). SMI includes individuals with diagnosis resulting in serious functional impairment.

Appendices

Appendix A: Stakeholder Interviewee Organizations

During the course of this study, we interviewed stakeholders representing the following organizations and groups:

- Beyond Shelter, Inc
- Bismarck Police Department
- Bismarck-Burleigh Public Health Department
- Burleigh County Social Services
- Community Medical Services
- Community Options
- Dakota Boys and Girls Ranch
- Dakota Center for Independent Living
- Dakotah Recovery Center
- Fargo VA Health Care System
- Grand Forks Public Health Department
- Grand Forks Housing Authority
- Heartview Foundation
- Indian Health Service
- Lakes Social Service District
- Lutheran Social Services of North Dakota
- MHA North Dakota
- Minot Housing Authority
- Minot State University, North Dakota Center for Persons with Disabilities
- Native American Development Center
- North Dakota Brain Injury Network
- North Dakota Association of Counties
- North Dakota Behavioral Health Planning Council
- North Dakota Department of Corrections and Rehabilitation
 - Clinical Services
 - Division of Juvenile Services
 - Parole and Probation Services
 - Transitional Planning Services
- North Dakota Department of Human Services
 - Adults and Aging Services
 - Behavioral Health Services
 - Children and Family Services
 - Division of Vocational Rehabilitation
 - Health Tracks
 - Life Skills and Transition Center
 - Medicaid Analytics and Projects
 - North Dakota State Hospital
 - Southeast Human Service Center
- North Dakota Department of Public Instruction
- North Dakota Housing Finance Agency
- North Dakota Prevention Resource and Media Center
- North Dakota Protection and Advocacy Project
- North Dakota State Council on Developmental Disabilities

- North Dakota Suicide Prevention Program
- North Dakota Long Term Care Association
- North Dakota State University, Department of Public Health
- PATH North Dakota
- Prairie Harvest Mental Health
- Prairie St John's Hospital
- ShareHouse
- Sheyenne Care Center
- Traill County Social Services
- Valley Community Health Centers

In addition, we spoke with 21 people with lived experience receiving behavioral health services in North Dakota and/or lived experience as a family member of North Dakota behavioral health service users. We also spoke with five unaffiliated behavioral health service providers and community advocates.

Appendix B: Service User Characteristics by Service Type

Table 10 – Race of service users (Medicaid and HSC), SFY 2017

Service Type	American Indian		Black or African American		White	
	N	%	N	%	N	%
Information & Referral (n=3,492)	765	26.2%	57	2.0%	2,009	68.8%
SUD Evaluation & Assessment (n=3,927)	934	25.1%	123	3.3%	2,560	68.7%
MH Evaluation & Assessment (n=9,549)	1,672	18.4%	450	5.0%	6,677	73.5%
Adult MH Outpatient (n=17,662)	2,088	12.1%	508	3.0%	14,275	82.9%
Youth MH Outpatient (n=8,017)	1,800	22.7%	402	5.1%	5,459	68.9%
Adult Day Treatment (n=392)	36	10.7%	12	3.6%	280	83.6%
Adult SUD Outpatient (n=3,626)	825	23.3%	108	3.1%	2,519	71.2%
Youth SUD Outpatient (n=288)	96	34.2%	19	6.8%	159	56.6%
Adult Case Management (n=6,921)	871	12.9%	229	3.4%	5,486	81.3%
Youth Case Management (n=2,034)	342	17.2%	71	3.6%	1,467	73.9%
PATH Case Management (n=367)	57	19.0%	22	7.3%	209	69.7%
Family Support Services (n=453)	82	19.4%	11	2.6%	316	74.7%
TIP (n=176)	23	13.6%	4	2.4%	137	81.1%
Home Health Aide (n=672)	71	10.9%	24	3.7%	536	82.1%
Other Community-Based Services (n=953)	91	9.7%	43	4.6%	780	82.7%
Adult MH Residential (n=733)	85	11.9%	22	3.1%	598	83.4%
SUD Residential (n=1,132)	294	26.4%	15	1.3%	782	70.1%
Long-Term Care Facility (n=1,262)	12	1.0%	13	1.1%	1,195	96.6%
Foster Care Case Management (n=894)	109	12.5%	38	4.4%	668	76.8%
Youth MH Residential (n=164)	42	26.4%	11	6.9%	96	60.4%
Ambulance (n=323)	72	23.2%	23	7.4%	204	65.8%
Crisis Intervention (n=3,297)	363	12.7%	87	3.0%	2,343	82.0%
Emergency Rooms (n=1,427)	348	25.1%	75	5.4%	921	66.5%
MH Inpatient (n=1,979)	328	17.7%	81	4.4%	1,400	75.4%
SUD Inpatient (n=358)	98	31.4%	8	2.6%	199	63.8%
Telehealth (n=3,122)	267	8.5%	79	2.5%	2,613	83.3%

Source: Medicaid and HSC data; U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Characteristics for Home Health Aide services were not available in SFY 2017. This table presents characteristics in SFY 2016. Characteristics for persons who received only an HSC contracted service were unknown; therefore, they are not included in the unduplicated counts and percentages. Please refer to Table 13 for the number of persons with missing race.

Table 11 – Gender of service users (Medicaid and HSC), SFY 2017

Service Type	Female	
	N	%
Information & Referral (n=3,492)	1,596	46.2%
SUD Evaluation & Assessment (n=3,927)	1,653	42.3%
MH Evaluation & Assessment (n=9,549)	5,128	53.9%
Adult MH Outpatient (n=17,662)	10,431	59.1%
Youth MH Outpatient (n=8,017)	3,468	43.3%
Adult Day Treatment (n=392)	154	45.0%
Adult SUD Outpatient (n=3,626)	1,742	48.1%
Youth SUD Outpatient (n=288)	134	46.5%
Adult Case Management (n=6,921)	3,285	47.6%
Youth Case Management (n=2,034)	866	42.7%
PATH Case Management (n=367)	138	38.0%
Family Support Services (n=453)	216	50.3%
TIP (n=176)	85	48.3%
Home Health Aide (n=672)	288	42.9%
Other Community-Based Services (n=953)	406	42.7%
Adult MH Residential (n=733)	285	39.0%
SUD Residential (n=1,132)	507	45.0%
Long-Term Care Facility (n=1,262)	729	63.8%
Foster Care Case Management (n=894)	330	37.2%
Youth MH Residential (n=225)	98	43.6%
Ambulance (n=323)	176	54.5%
Crisis Intervention (n=3,297)	1,493	45.7%
Emergency Rooms (n=1,427)	882	61.8%
MH Inpatient (n=1,979)	1,121	56.8%
SUD Inpatient (n=358)	187	52.5%
Telehealth (n=3,122)	1,674	53.7%

Source: Medicaid and HSC data; U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Characteristics for Home Health Aide services were not available in SFY 2017. This table presents characteristics in SFY 2016. Characteristics for persons who received only an HSC-contracted service were unknown; therefore, they are not included in the unduplicated counts and percentages. Please refer to Table 13 for the number of persons with missing gender.

Table 12 – Age of Service Users (Medicaid and HSC), SFY 2017

	0 to 17		18 to 24		25 to 44		45 to 64		65 and Older	
North Dakota Census Population Estimate	176,311	23.3%	91,112	12.0%	199,967	26.4%	180,563	23.8%	109,999	14.5%
Service Type	N	%	N	%	N	%	N	%	N	%
Information & Referral (n=3,492)	989	28.4%	487	14.0%	1,389	39.9%	520	15.0%	93	2.7%
SUD Evaluation and Assessment (n=3,927)	269	6.9%	733	18.7%	2,323	59.2%	579	14.7%	23	0.6%
MH Evaluation & Assessment (n=9,549)	3,645	38.2%	1,149	12.0%	3,319	34.8%	1,235	12.9%	200	2.1%
Adult MH Outpatient(n=17,662)	0	0.0%	2,546	14.4%	7,848	44.4%	5,753	32.6%	1,515	8.6%
Youth MH Outpatient (n=8,017)	8,017	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Adult Day Treatment (n=392)	0	0.0%	18	5.3%	142	41.5%	171	50.0%	11	3.2%
Adult SUD Outpatient (n=3,626)	0	0.0%	611	16.9%	2,095	57.8%	840	23.2%	80	2.2%
Youth SUD Outpatient (n=288)	288	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Adult Case Management (n=6,921)	0	0.0%	970	14.0%	3,487	50.4%	2,140	30.9%	324	4.7%
Youth Case Management (n=2,034)	1,889	92.9%	140	6.9%	5	0.2%	0	0.0%	0	0.0%
PATH Case Management (n=367)	0	0.0%	30	8.3%	163	45.3%	155	43.1%	12	3.3%
Family Support Services (n=453)	92	21.4%	62	14.5%	192	44.8%	79	18.4%	4	0.9%
TIP (n=176)	23	13.1%	136	77.3%	15	8.5%	2	1.1%	0	0.0%
Home Health Aide (n=672)	135	20.1%	35	5.2%	159	23.7%	293	43.6%	50	7.4%
Other Community-Based Services (n=953)	555	58.4%	50	5.3%	116	12.2%	188	19.8%	42	4.4%
Adult MH Residential (n=733)	0	0.0%	87	11.9%	353	48.2%	261	35.6%	32	4.4%
SUD Residential (n=1,132)	40	3.5%	164	14.5%	679	60.1%	234	20.7%	13	1.2%
Long-Term Care Facility (n=1,142)	8	0.7%	6	0.5%	19	1.7%	242	21.2%	867	75.9%
Foster Care Case Management (n=894)	765	85.9%	126	14.1%	0	0.0%	0	0.0%	0	0.0%
Youth MH Residential (n=225)	219	97.3%	6	2.7%	0	0.0%	0	0.0%	0	0.0%
Ambulance (n=323)	55	17.0%	37	11.5%	108	33.4%	104	32.2%	19	5.9%
Crisis Intervention (n=3,297)	380	11.6%	391	11.9%	1,447	44.2%	892	27.2%	166	5.1%
Emergency Rooms (n=1,427)	387	27.1%	192	13.5%	495	34.7%	288	20.2%	65	4.6%
MH Inpatient (n=1,979)	599	30.3%	227	11.5%	622	31.5%	416	21.1%	112	5.7%
SUD Inpatient (n=358)	35	9.8%	40	11.2%	150	42.0%	111	31.1%	21	5.9%
Telehealth (n=3,122)	578	18.5%	331	10.6%	1,020	32.7%	850	27.3%	339	10.9%

Source: Medicaid and HSC data; U.S. Census Bureau, Population Estimates Program (PEP) for North Dakota as of July 1, 2016.

Note: Characteristics for Home Health Aide services were not available in SFY 2017. This table presents characteristics in SFY 2016. Characteristics for persons who received only an HSC contracted service were unknown; therefore, they are not included in the unduplicated counts and percentages. Please refer to Table 13 for the number of persons with missing age.

Table 13 – Total number of unduplicated service users and number of missing characteristics per service category, SFY 2017

	Total Unduplicated Number of People	Missing		
		Race	Gender	Age
Information & Referral	3,492	573	39	14
SUD Evaluation and Assessment	3,927	200	16	0
MH Evaluation & Assessment	9,549	463	31	1
Adult MH Outpatient	17,662	451	21	0
Youth MH Outpatient	8,017	92	4	0
Adult Day Treatment	392	57	50	50
Adult SUD Outpatient	3,626	88	5	0
Youth SUD Outpatient	288	7	0	0
Adult Case Management	6,921	171	15	0
Youth Case Management	2,034	50	6	0
PATH Case Management	367	67	4	7
Family Support Services	453	30	24	24
TIP	176	7	0	0
Home Health Aide	672	19	0	0
Other Community-Based Services	953	10	3	2
Adult MH Residential	733	16	3	0
SUD Residential	1,132	17	6	2
Long-Term Care Facility	1,142	23	0	0
Foster Care Case Management	894	21	6	3
Youth MH Residential	225	6	0	0
Ambulance	323	13	0	0
Crisis Intervention	3,297	440	32	21
Emergency Rooms	1,427	43	1	0
MH Inpatient	1,979	122	5	3
SUD Inpatient	358	46	2	1
Telehealth	3,122	89	4	4

Source: Medicaid and HSC data.

Note: Characteristics for Home Health Aide services were not available in SFY 2017. This table presents characteristics in SFY 2016. Characteristics for persons who received only an HSC contracted service were unknown; therefore, they are not included in the unduplicated counts.

Appendix C: Behavioral Health Talking Circle Notes

On July 11, 2017, representatives from four tribal nations gathered at United Tribes Technical College to discuss behavioral health-related needs and challenges in tribal communities. The group included members of the Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians, and Mandan Hidatsa Arikara Nation.

The Talking Circle was part of an assessment of the behavioral health system in North Dakota being conducted by the Human Services Research Institute for the state's Department of Human Services. Before meeting, the group was offered the following potential discussion topics:

- What do you see as the most pressing behavioral health-related needs and challenges in your communities? What would need to change for these needs to be adequately met?
- What are some examples of practices, programs, or initiatives that do a good job of meeting behavioral health-related needs in your community?
- How would you describe the relationship between Tribal Nation leadership and the state, and with county health and social service systems?
- What other information unique to the Tribal Nations needs to be understood to effectively meet the behavioral health needs of tribal members?

The notes below depict the challenges, opportunities, and strengths that were identified by the group during the Talking Circle. These notes also include a list of “key takeaways” identified by participants at the close of the meeting.

Challenges

- Lack of funding. The Indian Health Service's budget has been cut significantly in recent years and has never been funded at the level of need. For providers operating outside of IHS 638 settings, Medicaid reimbursement rates have dropped, and now only 75% of some expenditures are reimbursed. There is a shortage of treatment facilities and no residential care.
- There is limited Medicaid reimbursement under clinic services. Currently, only providers with LICSW, LCSW, LPC, and LAC licensures can bill under rehab services. This limits the ability for tribal 638 facilities to obtain Medicaid reimbursement for specialty behavioral health services that are not substance use disorder-related. This scenario further limits the workforce and ability to increase self-sufficient tribally-run services.
- More reimbursement is needed for care coordinators and system navigators. Other than “targeted case management” contracts, there is currently no opportunity for case management reimbursement under Medicaid.
- There are limited incentives and reimbursement for behavioral health services provided in the primary care setting. Integrated physical and behavioral health services would facilitate

improved screening and assessments (e.g. AUDIT-C, PHQ-9, SBIRT, PTSD screening) and initiatives like Zero Suicide. Integrated services would also increase the likelihood that individuals can receive both behavioral and physical health services during the same visit.

- Tribal communities are very rural and require hours of travel to access services. There is a lack of home health services, and a lack of discharge planning and coordination. When possible, services should be provided when a person is at the clinic to reduce the need for follow-up services, thereby reducing the likelihood that individuals will be lost to follow-up.
- Lack of services. People present to providers wanting to quit drugs and alcohol, but there is no place to send them. It is the same situation with other services for children and the elderly – oftentimes there are no services or programs available.
- In areas where there has been a lot of oil development, there has also been an increase in drug use. The communities don't have the resources to deal with these increased drug use issues.
- Hepatitis C is on the rise on the reservations, and babies are born addicted to methamphetamines. There is a shortage of foster care homes. Kids are sent out of state for treatment or adopted by non-tribal members. There is limited personnel/workforce available to help youth. There is also trafficking of young women. On reservation, people don't want to talk about it - the problem is too big, they don't have solutions, so they don't talk about it.
- MHA Nation needs to know which county offices are supposed to provide services to their tribal members so they can get the right people around the table to provide training on what services are available.
- Standing Rock's straddling of state borders also has an impact. North and South Dakota have different services which makes it challenging for tribal members who live and work across the borders.
- Communities are not connected with each other and are not aware of what others are doing. We also have to think about how to deliver services and who delivers the services; consider using telemedicine
- In 2016 there was a balanced budget requirement in North Dakota. Medicaid is 68% of the ND Department of Human Services budget, so cuts were made, effective 7/1/16. The 2017 legislature restored most of those cuts with the exception of professional fee schedules.
- Workforce challenges: Spirit Lake has one Licensed Addiction Counselor. The funding is not there to pay high wages, and it's very rural. It's tough to attract people.
- There is an overall shortage of options, especially for individuals co-occurring mental health and substance use issues - you need to find a place that can address all. You can find those services (e.g., Prairie St. John's), but then patients must pay for it out of pocket, and most can't afford it. People end up taking a piecemeal approach to treatment (for example, address alcohol problems but not mental health issues, because that is what you can do).

- If people do get services, they have nowhere to go once they get home. They just fall back into old environments and old habits. Spirit Lake Nation has asked five times for funds for a treatment center. The politicians say they support it but haven't yet made funding available.
- Tribal nations are always enhancing research, but the returns/benefits of that research are never seen by the communities. The results leave with the researchers.
- It is difficult to coordinate around or get discharge information; individuals are left to essentially do their own discharge transitioning.
- There are issues with continuity of care, and communities/providers/departments are siloed; it's tough keeping on top of what resources are available; there needs to be a better job of communicating that.
- Communities are not healthy, and prevention is not on the radar much; but there are opportunities for us to take advantage of what is out there.
- Need a Native American advocate in services when people come in, at the point of admission.
- Tribal member participation in statewide stakeholders groups seems to be limited. Members who have participated in initiatives felt like "a raisin in a rice bowl", the only one.
- We need a group home for the safety of the children, so parents can get detox and other services.
- Non-native providers are not trained to be culturally sensitive; they need to understand who we are and where we came from.
- There needs to be training in cultural competency across the board in social/human service systems in the state. Training needs to be ongoing and robust, not one-offs that reach a lot of people and then fall off with attrition/turnover. For cultural competency, it is important to know the principles, values, and customs, as well as the history of Native Americans. The training needs to be developed by American Indian people.
- There are no support systems in the community after residential treatment for substance use disorders.
- There are very few services for men other than jail. There are lots of services and supports for women, but very little to address men's health
- Malnutrition exists across the age spectrum – people who are using sell food for money to support their habit, often leaving no food for the elders and children living in the same home.

Opportunities and Strengths

- Everybody needs to work together, we all have the same purpose/goals in mind.
- Spirit Lake: tries to do a lot of prevention

- ND Medicaid has allowed tribal nations to bill for targeted case management, we are the only state that has done that; they should try to grandfather cultural brokers into behavioral health services. You need to address the cultural/traditional/tribal aspect of mental health as well
- Standing Rock does use telehealth; IHS regulations and constraints can have an impact on its reach
- Marilyn Youngbird has developed a program – a halfway house for young kids. Can that be replicated?
- CMS rule changes allow 638 facilities and IHS facilities to bill for services “received through IHS.” to tribal members with 100% federal funding
- The group agreed that a resource containing tribal services available throughout the state would be a useful thing. The directors of behavioral health for Great Plains IHS all meet together, share info across programs, so at the level of directors, people are connected. Front line staff need to contact their directors to get this info; but this is at the IHS level, not tribal directors
- There are community health representatives (CHRs; also referred to as community health workers) in Spirit Lake, Standing Rock, Turtle Mountain, and Fort Berthold. CHRs started 49 years ago, primarily act as health educators now; the training used to be in person, and now it is all online. It has 69 modules, and you print your own certificate, which won't get you anywhere.
- The state has recently put Medicaid applications online, so they aren't required in person. Before it could take five days or more to get the application signed and actually submitted. It's made fewer hoops to jump through, by putting it online.
- Third party reimbursement can help with raising of wages on the reservations
- All the entities need to work together, identify a common community goal and work towards it. We need to let go of old feuds and work for the people; develop a task force/talking circles and support groups among others attempting tribal systems change.
- Also need a halfway house, and something to do besides drinking and drugging. People need to learn to have sober fun, recapture their lost cultural and spiritual pride.
- Need to find additional options for funding traditional medicine
- Patient navigators can help; if someone doesn't show up, this is a person who knows who to reach out in the community to see what is going on.

Key Takeaways

- There are a lot of challenges facing our people. Talking circles like this are great for sharing ideas.

- Resources are lacking.
- A health disparities person/health equity office at the state level would help with health and human service issues on the reservations.
- Partnerships between the state and tribes should be promoted. There used to be quarterly meetings pulling together tribes, state leadership, and other state people. State leadership would go to the reservations. We used to have that, maybe we could restart it.
- We need guidance about what can be billed, what we can get reimbursed for. Help us better to get the funds that are already out there.
- We should partner to build facilities and share the costs.
- There needs to be more communication amongst everybody. Directors may meet, but it doesn't necessarily trickle down to front line staff.
- Partnerships are needed to continue communications. Our needs are great, and there's too much for one entity to do - we need to partner with each other to address the issues.
- The shortage of providers - for those of us in tribal colleges, how can we develop curriculums to produce tribal providers and bill for those services? We need to help ourselves. Need to engage tribal colleges in this dialogue to be part of the solution.
- Training of the general public is needed to know what to look for with people when they are in their houses, on the signs of drug use.
- You need to go to the reservations to understand; restart the strategic planning process and those rotating quarterly meetings so tribal leadership can attend.
- Need the 100% FMAP monies recouped from the CMS "services received through IHS" invested into tribal nation public health infrastructure.
- We are all unique tribes. The culture of each is specific, but we are all tribes; we need help to help us help our people. Community is key for us.
- The Lakota lesson - to listen, and hear what you listen to, have a positive reaction to what you hear, leads to loyalty.
- There are issues of accessibility and funding.
- There is a lack of aftercare for adolescents and youth, and suicide prevention services for youth
- Talking about keeping a behavioral health group for tribal nations together and going; we want to unify behavioral health leaders.
- There is a need for better communication all around - between tribes, within tribes, and with government.
- There is a lack of funding. North Dakota can fund jails, but why not treatment services?

- We need an inter-tribal directory of resources and services.
- We need funding.
- We need consistency in communication and teamwork, more regular, more solid.

Appendix D: Behavioral Health–Related Initiatives

Created by the Behavioral Health Stakeholders Steering Committee, July 2017

DISCLAIMER: This document is not inclusive of all initiatives but only those that have been identified to the Behavioral Health Stakeholders Steering committee. The information in this document was secured from various websites and other documents.

STATEWIDE GROUPS

Behavioral Health Stakeholders (Informal)

The purpose of the North Dakota Behavioral Health Stakeholders group is to build stronger behavior health services in North Dakota. This group consists of over 400 members representing many different groups. The group convened in the fall of 2013 with the purpose of discussing emerging behavioral health challenges. This network has brought together numerous organizations and individuals to develop a collaborative response to the Schulte Report, advocate for legislation and to encourage administrative changes to address unmet needs. A summary of all various actions and recommendations are available at the Center for Rural Health website.

Web Link: <https://ruralhealth.und.edu/projects/nd-behavioral-health>

Contact: John Vastag jvastag@ndassistive.org

Behavioral Health Planning Council (Legal Governmental)

- A mental health planning and advisory council exists in every State and U.S. Territory as a result of federal law first enacted in 1986.
- The law requires States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds.
- Stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership on the council.
- The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) is encouraging states to move toward a behavioral health planning and advisory structure that integrates mental health and substance abuse services.
- The council consists of 30 members who are appointed by the Governor. A diverse membership brings vast strengths and varying perspectives to the council. Points of view are presented from consumers of mental health and substance abuse services, family members, advocates, referral sources, schools, institutional and peer mentoring, service delivery, children's issues, community-based service providers, the general disability community, and the criminal justice system.

Web link <http://www.nd.gov/dhs/services/mentalhealth/ndmhpc/>

Contact: Julie Huwe dhsbhd@nd.gov

Building a Culture of Health in ND Think Tank (Education)

The ND Center for Nursing/ND Action Coalition has partnered with the Robert Wood Johnson Foundation and Center to Champion Nursing in America to introduce the Culture of Health Initiatives as a possible framework to address these existing behavioral health issues for ND.

Contact: Patricia Moulton patricia.moulton@und.edu

Children's Behavioral Health Task Force (Legal Governmental)

Task force on children's behavioral health - Membership - Duties - Reports to Governor and Legislative Management.

1. The task force on children's behavioral health is created for the purpose of assessing and guiding efforts within the children's behavioral health system to ensure a full continuum of care is available in the state.
2. The task force consists of the following members:
 - a. The Superintendent of Public Instruction, or the superintendent's designee.
 - b. The executive director of the Department of Human Services, or the executive director's designee.
 - c. The State Health Officer, or the state health officer's designee.
 - d. The director of the Department of Corrections and Rehabilitation, or the director's designee.
 - e. The executive director of the Indian Affairs Commission, or the executive director's designee.
 - f. The director of the Committee on Protection and Advocacy, or the director's designee.
3. The executive director of the Department of Human Services, or the executive director's designee, shall serve as the chairman of the task force. The task force shall meet at least quarterly. Additional meetings may be held at the discretion of the chairman.
4. The task force may request appropriate staff services from the Department of Human Services.
5. The task force shall:
 - a. Assess and guide efforts within the children's behavioral health system to ensure a full behavioral health continuum of care is available in the state.
 - b. Make recommendations to ensure the children's behavioral health services are seamless, effective, and not duplicative.
 - c. Identify recommendations and strategies to address gaps or needs in the children's behavioral health system.
 - d. Engage stakeholders from across the continuum to assess and develop strategies to address gaps or needs in areas including:
 - (1) Education
 - (2) Juvenile Justice
 - (3) Child Welfare

- (4) Community
- (5) Healthcare
- e. Provide a report to the Governor and the Legislative Management every six months regarding the status of the task force's effort.

Contact: Julie Huwe dhsbhd@nd.gov

Face it Together (Private Group)

A state-wide initiative to solve substance abuse. With the support of a Community Innovation Grant from the Bush Foundation, we're engaging with communities and stakeholders across the state to address North Dakota's addiction crisis. A statewide task force of business, community and public-sector leaders is being formed to identify ways to coordinate statewide services, remove barriers and fill gaps in current care models.

The goal is to design a public/private partnership plan that ensures far greater access to high quality, effective addiction care, and support across North Dakota. The task force will issue a report with recommendations by the end of the year.

Contact: faceit@wefacetogether.org

ND Health Information Network (Government)

At the North Dakota Health Information Network (NDHIN), we are dedicated to improving healthcare by creating a secure medical record sharing network for providers and consumers. We aim to empower patients by ensuring their medical data remains safe and private. Our Health Information Technology Office is responsible for implementing this information network, and developing efficient health record systems, which in turn will benefit patients with higher quality care. We promote proper handling of patient data by training health personnel and improving the record sharing process.

The NDHIN creates a safe connection for life's critical moments.

Contact: Sheldon Wolf shwolf@nd.gov

ND Rural Health Learning Collaborative Team (Government)

The vision is to increase access to behavioral health care services in rural areas by expanding delivery settings and improving regulatory barriers. This is a seventeen-member group appointed by the ND Health Department. Goals and objectives are being developed.

Contact: KMinnes@NGA.ORG

Reducing Pharmaceutical Narcotics Task Force (Informal)

The Reducing Pharmaceutical Narcotics in Our Communities Task Force is a group of over 40 public and private organizations including the medical community, law enforcement, treatment services, educators, policy-makers and others gathered to address the state-wide public health concern of the opioid crisis. The five pillars of the task force are: Education, Prescription Drug Take-Back Program, Law Enforcement, ND Prescription Drug Monitoring Program (PDMP),

and Effective Treatment. The task force has been meeting since 2008 and has worked to improve the PDMP, pass Good Samaritan laws, providing naloxone prescription authority to pharmacists, etc.

Contact: Mike Schwab mschwab@nodakpharmacy.net

John Vastag jvastag@ndassistive.org

ThinkND – Behavioral Health Group (Not for Profit)

Behavioral health was a top concern among those polled and was even more of a prominent issue when we conducted our focus groups a few months later.

The current mental health and substance abuse treatment systems in our state have clear and identified gaps which are impacting nearly every population in the state - from children to seniors in our cities and small towns, in our schools and in our neighborhoods. The ND legislature has been studying these issues closely during the interim session and has approved a significant set of measures for consideration during the 2017 session which would address a number of the core concerns. But there is more work to be done, and ThinkND's Blue Ribbon Panel will assess the ongoing crisis and contribute expert, non-partisan, third party analysis of and recommendations for how to curb it.

Contact: Tasha Carvell tasha@thinknd.org

LOCAL INITIATIVES

Local Commissions on Substance Abuse

Bismarck *The Mayor's Gold Star Community Task Force*, includes communities of Bismarck/Mandan/Lincoln)

Established in June 2017, the mission of the Mayors' Gold Star Community Task Force is to provide strategic leadership and guidance to develop a continuum of care model, which incorporates prevention, treatment, and recovery efforts using a collective, adaptive approach to effectively reduce substance misuse, overdose, death and the disease of addiction.

Contact: Renae Moch rmoch@bismarcknd.gov

Dickinson

Their vision is to have a strong and healthy community free from the burden of addiction along with an informed community investing in a culture of addiction prevention.

Contact: karen.buresh@dickinsongov.com

Fargo *The Mayors Blue Ribbon Commission on Addiction* includes Dilworth, Fargo, Horace, Moorhead, and West Fargo.

Established in September 2016, the core purpose of the commission is to mobilize the community to take back what addiction is stealing. The five-year vision is a strong and healthy

community, free from the burden of addiction. The commission released emerging strategic recommendations in December. This included six overarching themes that apply to all three expert panels' priorities:

- Framing the problem through data, clear messaging and community readiness.
- Reprioritizing funding & reimbursement to grow and sustain programming with proven outcomes.
- Fully integrate with healthcare providers.
- Build the capacity of organizations to innovate and produce results.
- Leverage technology to improve collaboration, awareness, education and access to care.
- Improve social capital by moving away from a punitive focus and helping people develop networks of connectedness.

Contact: Ann Malmberg Ann.Malmberg@essentiahealth.org

Grand Forks Grand Forks *Call to Action* on Addiction and Substance Abuse

Led by Mayor Brown and the Grand Forks City Council, the CTA has begun to mobilize the community around addressing addiction and substance abuse. 300 community members attended the initial public Call to Action and the resulting four committees (Prevention & Education, Intervention & Treatment, Recovery & Support, and Data & Communication) are developing strategic recommendations that will be compiled into a long-term Community Action Plan. The CTA is founded in a spirit of compassion and dedicated to de-stigmatizing addiction, coordinating existing resources, and mobilizing the community for effective, long term culture change about all phases of addiction including prevention, intervention, treatment and recovery. This effort is led by a steering committee of community members across diverse sectors and background. Recommendations and an adopted community plan are expected in Fall 2017.

Contact: Peter Haga phaga@grandforksgov.com

Minot

Their vision is to have a strong and healthy community free from the burden of addiction along with an informed community investing in a culture of addiction prevention.

Contact: Tami Stroklund tami.stroklund@minotnd.gov

Moorhead, MN reGroup

At regroup, our mission is to strengthen the recovery community through peer-to-peer support, public education, and advocacy. We serve the 25 counties of northwest Minnesota and surrounding areas. We are people living in long-term recovery from addiction.

Children's Consultation Network in Cass and Clay County

In 2006, a Children's Mental Health Initiative funded by Dakota Medical Foundation recognized that gaps existed in diagnosing children and getting help to families. From a summit of all Cass and Clay County providers and referral sources, came an advisory council of more than 20 area children's mental health experts. We pioneered new widespread screening systems and Children's Consultation Network (CCN) in 2010 to provide helpful, expert resources to parents and caregivers of young children. CCN therapy provides assessment, education and short-term, therapeutic consultation for children through age 8 with difficult behaviors or emotions, and their caregivers. Services are provided in-office, in-home or in the community, including at school and childcare facilities.

Contact: rvcmh@rvcscc.org

Re-Think (Cass/Clay Counties)

The ReThink Mental Health Initiative focuses on improving behavioral health systems and promoting mental health and well-being in the Cass/Clay community. Over 40 individuals are involved. A major initiative has been the community wide implementation of the Columbia Suicide Screening protocols across key partnerships including education, first responders, healthcare providers, and information and referral organizations through both training and use of common forms.

Contact: Rory Beil Rory.Beil@co.clay.mn.us

Appendix E: Summary of 2017 Behavioral Health Legislative Actions

Created by the Behavioral Health Stakeholders Steering Committee, July 2017

GENERAL ISSUES

Funding for expanded services (HB 1040)

Originally the bill addressed key funding issues to fund for the full continue of care with a total cost of over \$28 million. The bill came out of the House with only funding of \$350,000: \$150,000 for an early intervention school pilot project, \$100,000 for peer to peer support and \$100,000 for family to family support. Authority for Department of Human Services to develop administrative rules for minor in possession (early intervention) programs.

Policy issues that could be addressed without funding (SB 2038)

- Broadens behavioral health teacher training requirement options for schools to include trauma, social and emotional learning, suicide prevention and bullying.
- Modified timeframes on commitment procedures.
- Established a task force on children's behavioral health.

Clarify roles/responsibilities of DHS, HSC/NDSH (SB 2039)

- Major rewrite of the structure and duties of Department of Human Services updating behavioral health language.
- Separates licensing/policy/regulatory functions from direct services.
- Modifies role/function/structure of Advisory Council at regional Human Service Centers.
- Requires external accreditation.
- Expands Medical Assistance reimbursement beyond Human Service Centers.
- Redefines core services for children/adults with serious and persistent mental health issues and adds housing, peer/recovery and crisis services.

Oversight of multi-Behavioral Health drugs in children (HB 1120)

- Requires Department of Human Service authorize/consult for >4 psychotropic meds.
- Pediatric psychiatric consultation plan that is to be determined.

Good Samaritan clarifications (HB 1269)

- Clarifies current Good Samaritan laws to allow friends or family to access medical help in overdose situation.

HARM REDUCTION STRATEGIES

Development of Syringe Exchange Programs (SSPs) (SB 2320)

Known as a needle exchange program

- This structure will reduce long term health problems such as HIV and Hepatitis C for individuals who may be users.

Infant exposure to drugs and direct needed services (SB 2251)

- Allows Department of Human Service to respond to reports of drug exposure without a finding of child abuse through “alternative response assessments”.

Required drug screening for TANF recipients (SB 2279 failed)

WORKFORCE RELATED BILLS

Expands scope of practice for addiction counselors (SB 2088 passed/signed)

- Expands scope of work for addiction counselors to include nicotine and gambling disorder.
- Creates flexibility for supervision of Licensed Addiction Counselors (to include other behavioral health professionals).
- Develops masters level addiction counselor.

Clarified definition of Mental Health Professional (SB 2042 passed/signed)

- A bill to establish a four-tiered system of classifying various types of the mental health professionals based on their training and scope of practice.
- ND century code related to duties of mental health professional was modified to reflect new tiered system, i.e. commitment laws, criminal code.

Expands Expert Examiners for guardianship (HB 1095)

- Allows Advanced Practice Registered Nurses and Physician Assistants to serve as expert examiners for guardianships

Licensing and training changes (HB 2033 and 2141)

- Improves training and licensing process for social workers, professional counselors, Marriage/Family therapists and psychologists.

Nursing practices changes for multi-state licenses (HB 1096 and HB 1097)

- Updates Nursing Board practices, and permits granting of multi-state licenses.

ALTERNATIVES TO INCARCERATION BILLS

Department of Corrections budget bill SB 2015

- \$7,000,000 to Department of Corrections to partner with Department of Human Services to develop a community-based pilot behavioral health service program to divert individuals from incarceration.

Corrections/sentencing changes (HB 1041 and 1269)

- Prioritizes prison space for serious offenders.
- Provides sentencing flexibility.
- Reduces drug use charges.
- Funds \$500,000 to develop and implement a behavioral health provider network and process for offenders.

DEPARTMENT OF HUMAN SERVICE BUDGET

Department of Human Services Budget (HB 1012)

- Reductions in the human service centers and North Dakota State Hospital have not yet been finalized.
- Reduced Parent's LEAD program to \$100,000 from \$360,000. Evidence based and effective program (evaluated by NDSU). These are the only state funds currently supporting behavioral health prevention.
- Gambling Treatment was decreased by \$237,573.
- Substance Use Disorder Vouchers for next biennium will be increased from \$700,000 to \$2,779,000 with a focus on increasing Medication Assisted treatment for Medicaid eligible individuals.
- 4 million dollars in federal funding to expand Opioid treatment and infrastructure particularly Medication Assisted treatment.
- Medicaid expansion was maintained at commercial rates to cover over 22,000 low income adults. Particularly helps coverage in rural areas.

INTERIM STUDY RESOLUTIONS

Alternatives to Incarceration issues including juvenile justice issues (SCR 4003)

- Assigned to Alternatives to Incarceration Committee.
First meeting not yet scheduled.

Overall structure/duties of the ND Department of Human Services (HB 1012)

- Assigned to Interim Human Service Committee.
First meeting August 1, 2017

State's legal requirements for provision of least restrictive services (HB 1012)

- Assigned to Interim Health Services Committee.
First meeting August 2, 2017 .

Options for Management Care in Medical Assistance

- Assigned to Interim Health Care Reform Committee.
First meeting August 3, 2017.

OTHER ISSUES

Medical Marijuana (SB 2344)

- Set rules for growing, distributing and decriminalizing use.
Will be available in approximately one year.
Will be reviewed in 2019.

Appendix F: Center for Rural Health Report – Telebehavioral Health in North Dakota



Center *for* Rural Health

Telebehavioral Health in North Dakota: 2017

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The Center for Rural Health

The Center for Rural Health (CRH), established in 1980, is one of the nation's most experienced organizations committed to providing leadership in rural health. The CRH mission is to connect resources and knowledge to increase the health status of people in rural communities. The CRH serves as a resource to healthcare providers, health organizations, citizens, researchers, educators, and policymakers across North Dakota and the nation. Activities are targeted toward identifying and researching rural health issues, analyzing health policy, strengthening local capabilities, developing community-based alternatives, and advocating for rural concerns. Although many specific activities constitute the agenda of the Center, four core areas serve as the focus: (1) education and information dissemination; (2) program development and community assistance; (3) research and evaluation; and (4) policy analysis.

Executive Summary

In July 2017, research staff at the CRH were contacted by the Behavioral Health Division of the North Dakota Department of Human Services (NDDHS) to determine the status of behavioral health services provided in North Dakota using telehealth. As part of the CRH study, healthcare facilities (i.e., rural and urban hospitals, long-term care, and community health centers), public health departments, and mental health and substance-use-related programs across the state were surveyed regarding telebehavioral health services they provided or received, as well as about demographic information and payer sources. In this report, providers refer to organizations that offer the clinical intervention of telebehavioral health services; receivers are the facilities that host the clinical telebehavioral health intervention. Facilities that indicated they did not offer or receive telebehavioral health services were asked to indicate potential barriers. This report provides an overview of the telebehavioral health services that exist within the state.

Key Findings

- At least nine facilities provide telebehavioral health services to North Dakota facilities, and at least 44 facilities receive telebehavioral health services in the state.
- Providers were about equally likely to offer mental health, substance abuse, or both types of telebehavioral health services. Receivers primarily reported delivering mental health telebehavioral services to their clients.
- Only 55.6% of facilities reported providing telebehavioral health services to children and adolescents 17 years of age and younger. Only 36.6% of receivers reported delivering services to this same age group.
- When asked if their facility had enough provider time to meet the need for telebehavioral health services, 88.9% of respondent providers said they did not.
- Receiver types of telebehavioral health services were primarily nursing homes and outpatient settings, delivering services to seniors and adults.
- Among respondents who did not utilize telebehavioral health services, most indicated they did not plan to do so in the future.

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Introduction

Mental health and substance abuse issues are becoming progressively significant aspects of healthcare in today's society. In fact, at their current trajectory, it is expected they will exceed physical diseases as a primary cause of disability by the year 2020 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017c). These disorders can impact the well-being of and have significant implications not only for affected individuals, but also their loved ones and even their communities. As a result, increasing efforts have been made to connect these individuals with behavioral healthcare providers so they are able to obtain the needed services.

SAMHSA's 2016 National Survey on Drug Use and Health provides a glimpse into the current prevalence rates across the country. For example, it is estimated that 44.7 million American adults ages 18 and older (18.3%) had experienced some form of mental illness in the last year (SAMHSA, 2017a). Additionally, 20.1 million individuals ages 12 and older had a substance use disorder connected to alcohol or illicit drug use.

Mental health and substance use issues are likewise present in North Dakota, with 2013-2014 SAMHSA estimates indicating that approximately 89,000 individuals over the age of 18 (16.1%) experienced some form of mental illness (SAMHSA, 2015). Additionally, an estimated 50,000 individuals over the age of 18 (9.1%) were reported as being dependent upon or having abused illicit drugs or alcohol in the last year.

Despite the influence and difficulties associated with these issues, such disorders are often treatable, with many individuals subsequently experiencing recovery (SAMHSA, 2017b). As a result, efforts toward providing individuals with the resources they need are an important step in reducing mental health and substance use issues.

Working to connect individuals with qualified behavioral healthcare professionals can be difficult if there are few professionals or programs nearby to provide such services. This is the case in North Dakota, where it is estimated that approximately 386,352 residents (slightly more than 50.0% of the population) live in health professional shortage areas (HPSAs) in which mental health provider shortages exist (Bureau of Health Workforce, 2017). This translates into 47 out of 53 North Dakota counties being designated as mental health professional shortage areas (Center for Rural Health [CRH], 2017). As a result, it can be difficult to obtain the mental health and substance use services needed in such areas.

One potential approach to addressing this shortage, as well as increasing the availability of behavioral healthcare professionals, is through the use of telebehavioral health services. Also known as telemental health, telepsychology, or telepsychiatry, this service utilizes technology to provide mental health services across various locations (National Center for Telehealth & Technology, 2011). This approach is similar to the concept of telehealth (or telemedicine), which allows physicians or other healthcare providers to practice medicine with patients who are in different locations. Although the North Dakota Board of Medical Examiners has developed a definition for telehealth (2014), no description of telebehavioral health services currently exists (Epstein Becker Green, 2016). As a result, for the purposes of this report, telebehavioral health was subsequently defined as:

The use of electronic communication and information technologies to provide or support real-time psychiatric, psychological, mental health, marriage and family, social work services, and/or addiction counseling at a distance. This includes the use of video conferencing (i.e., the internet, smartphone, tablet, PC desktop system, etc.) or other interactive communication technology to provide behavioral health assessment, diagnosis, intervention, consultation, supervision, education, and information to a client/patient across a distance.

Telebehavioral health services has the potential to increase connections between individuals and the mental healthcare and substance abuse treatment they require, particularly in underserved areas. Because of this, the purpose of the current study was to examine what telebehavioral health services are offered across the state of North Dakota, and look at the demographic and payer factors of such programs. Throughout this report, a few distinctions with regard to the provision of telebehavioral health services are included. For example, providers are defined as the facility that offers the clinical intervention of telebehavioral health services. In contrast, receivers refers to facilities that host the client/patient who receives the clinical telebehavioral health intervention.

The findings in this report are based on data collected during a two-week period in 2017. The findings illustrate various demographic factors regarding the provision and receiving or utilization of telebehavioral health services in North Dakota.

The results included in this report are accurate summaries of facilities who received and responded to the survey. As a result, it may not be representative of all telebehavioral health services existing in the state. However, the current report does provide a starting point to better understand what telebehavioral health services are available in the state.

Methods

Survey Development

CRH staff and researchers developed a questionnaire addressing telebehavioral programs and related demographic factors in North Dakota. This tool was developed in partnership with the medical director and director of the Behavioral Health Division from the NDDHS, and the state health officer of the North Dakota Department of Health. Because information was only collected regarding facilities as a whole, and not specific individuals, Institutional Review Board approval was not required for the current study.

The survey, which was created in Qualtrics,¹ was divided into three main branches: facilities that provided mental health and/or substance abuse telebehavioral health services; facilities that received mental health and/or substance abuse telebehavioral health services; and those who did not offer or receive telebehavioral health services. Respondents were asked to indicate what telebehavioral services they provided and/or received, if any. Based on their responses, they were then directed to a specific set of questions tailored to their designated involvement with telebehavioral health services (i.e., provider, receiver, and/or no telebehavioral health question sets).

In the provider and receiver sections of the survey, multiple demographic factors regarding telebehavioral health programs in North Dakota were assessed. These included populations served by telebehavioral health services, how long the services had been offered or received, the types of facilities that provided or hosted the services, payment and insurance options, and the types of technology used. If respondents indicated that they did not currently provide or receive telebehavioral health services, future intentions of doing so were addressed, as well as potential barriers. The final survey consisted of 39 questions: 4 introductory questions, 17 provider questions, 16 receiver questions, and 2 questions for facilities not currently providing services. A full copy of the survey can be found in Appendix A.

Survey Dissemination

Staff at CRH and the NDDHS disseminated the survey electronically to North Dakota healthcare facilities, public health units, human service centers, social services, and other behavioral health providers. The North Dakota Long Term Care Association also disseminated it to their members. Respondents were asked to provide their program information in order to assess the level of behavioral health services currently being provided or received using telebehavioral health in the state. Survey respondents had approximately two weeks in which to complete the survey. One hundred and one responses were collected. The respondent data was subsequently cleaned and prepared for further analysis.

In addition, although a large number of facilities completed the survey, there were still some individual survey questions that were not completed. As a result, unless otherwise noted, the percentages calculated for each respective question were based upon the total number of responses received for the question within each particular group (e.g., providers, receivers, or no telebehavioral health services). Additionally, some survey questions allowed for multiple responses, which may result in totals greater than 100.0%

¹ The Qualtrics Research Suite is a powerful online tool available to all faculty, staff, and students at the University of North Dakota for academic purposes. The Research Suite allows researchers the capacity to build complex surveys that fulfill a variety of research needs. This tool can build surveys incorporating features such as branching, skip logic, response timing, video and audio integration, direct export to SPSS and Excel, and many more.

Results

Respondent Facility Type

One hundred and one North Dakota facilities participated in the assessment of telebehavioral health services in North Dakota. These included 38 long-term care facilities (34.9%), 29 critical access hospitals (CAHS) (26.6%), and 15 public health units/departments (13.8%), among others. A full listing of facility type is shown in Table 1. In some cases, facilities completed the survey for multiple sites or locations; as a result, the totals for Table 1 will be greater than 100%.

Table 1. Facility Type Listing of North Dakota Telebehavioral Health Survey Respondents (n = 109)

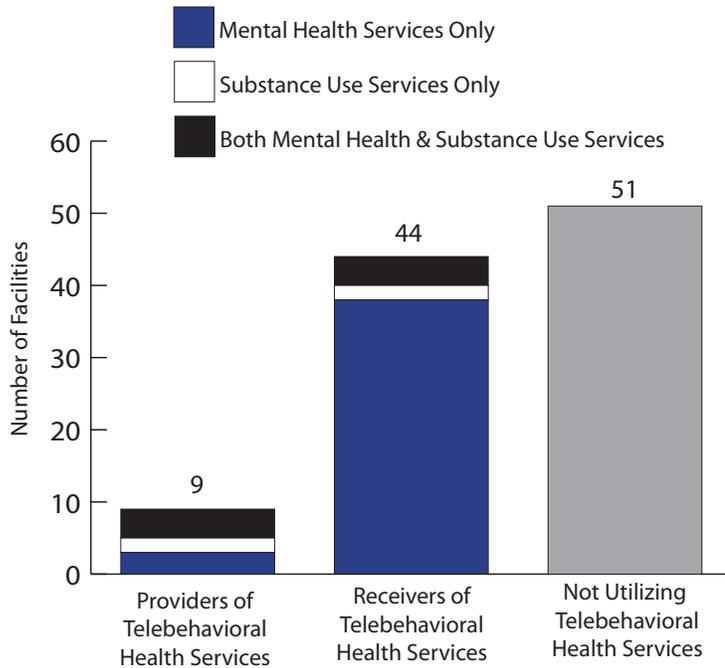
Facility Type	N	Percent
Long-Term Care	38	34.9%
Critical Access Hospital	29	26.6%
Public Health Unit/Department	15	13.8%
Human Service Center	8	7.3%
Tertiary Health System	3	2.8%
Community Health Center/Federally Qualified Health Center	3	2.8%
Hospital – Inpatient Setting	2	1.8%
Outpatient Setting	2	1.8%
Substance Use Disorder Treatment Facility	2	1.8%
Psychiatric Hospital	2	1.8%
Residential Treatment Setting	1	0.9%
Partial Hospitalization/Day Treatment	1	0.9%
Telemedicine Company	1	0.9%
SUD/Facility/Treatment Provider	1	0.9%
Private-for-Profit Behavioral Health Agency	1	0.9%

Telebehavioral Health Services in North Dakota

Overall, nine respondents reported providing telebehavioral health services, 44 reported receiving telebehavioral health services, and 51 neither provided nor received telebehavioral health services (Figure 1). These numbers include three facilities that reported both providing and receiving telebehavioral health services; their results were included in each corresponding section. Additionally, some respondents completed the survey for multiple locations.

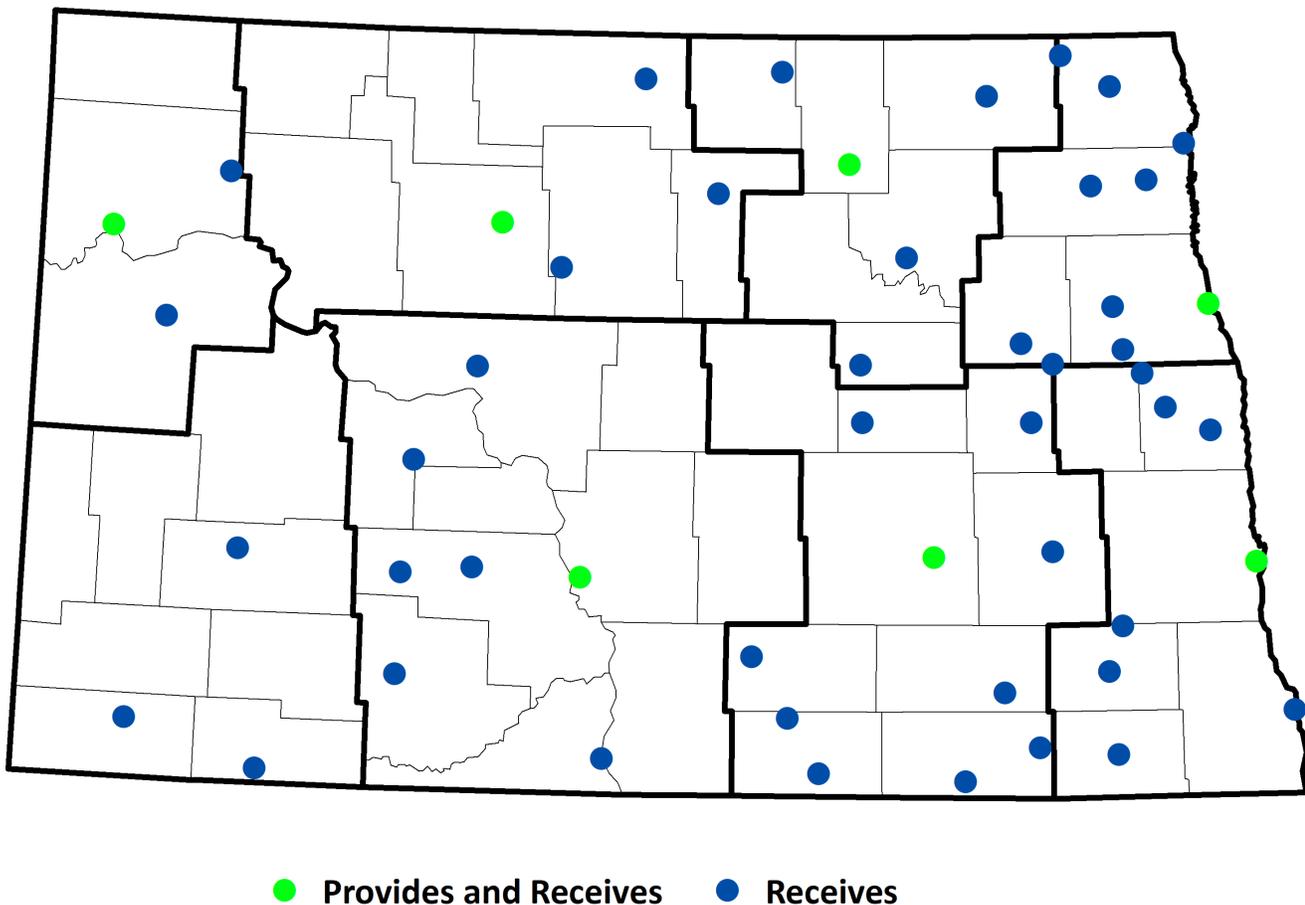
As will be discussed in more detail in subsequent sections, facilities utilizing telebehavioral health services could provide/receive mental health and/or substance abuse services. Among facilities providing telebehavioral health services, four provided both mental health and substance use telebehavioral health programs, three provided only mental health services, and two provided only substance use. Among telebehavioral health receivers, there were four facilities that received both mental health and substance use telebehavioral health programs. Thirty-eight received only mental health services, and two received services for substance abuse.

Figure 1. Number of Facilities Providing, Receiving, or Not Currently Utilizing Telebehavioral Health Services in North Dakota (n = 101)



A map of provider and receiver locations of telebehavioral health services locations is shown in Figure 2. The map contains all current provider and receiver locations that could be extrapolated from survey responses. In some cases, more than one provider and/or receiver existed within the same city. Additionally, one respondent was not included on the map due to providing telebehavioral health services to North Dakota facilities from outside of the state.

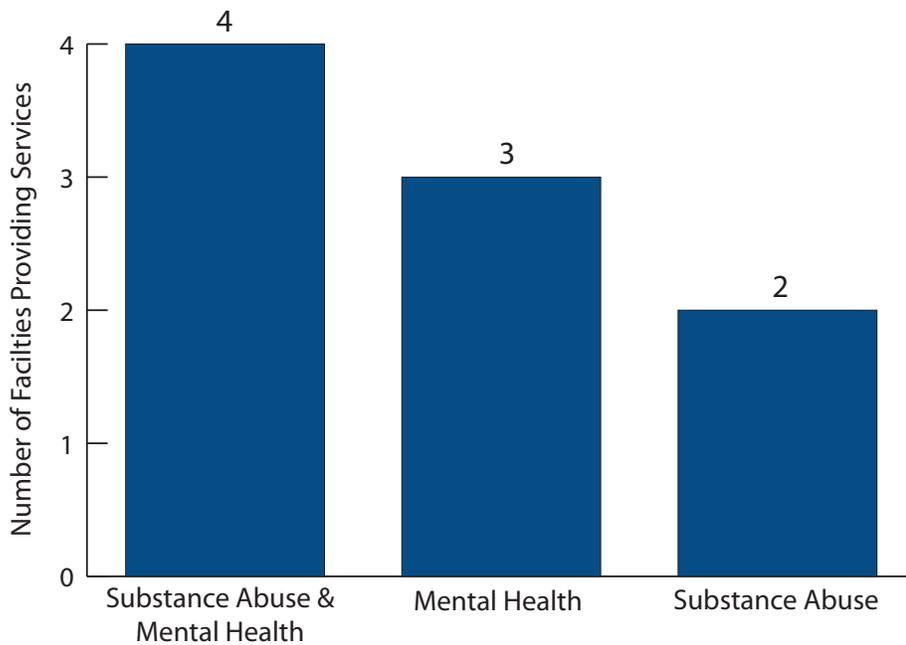
Figure 2. Map of Telebehavioral Health Provider and Receiver Locations in North Dakota



Providers of Telebehavioral Health Services

Among the respondents surveyed, nine facilities (8.9%) reported providing telebehavioral health services. These refer to facilities that offer the clinical intervention of telebehavioral health services. Among the nine provider respondents, four (44.4%) indicated they provided both substance use and mental health telebehavioral health services to clients. Additionally, three (33.3%) solely provided mental health telebehavioral health services; two (22.2%) reported they provided only substance abuse telebehavioral health services (Figure 3).

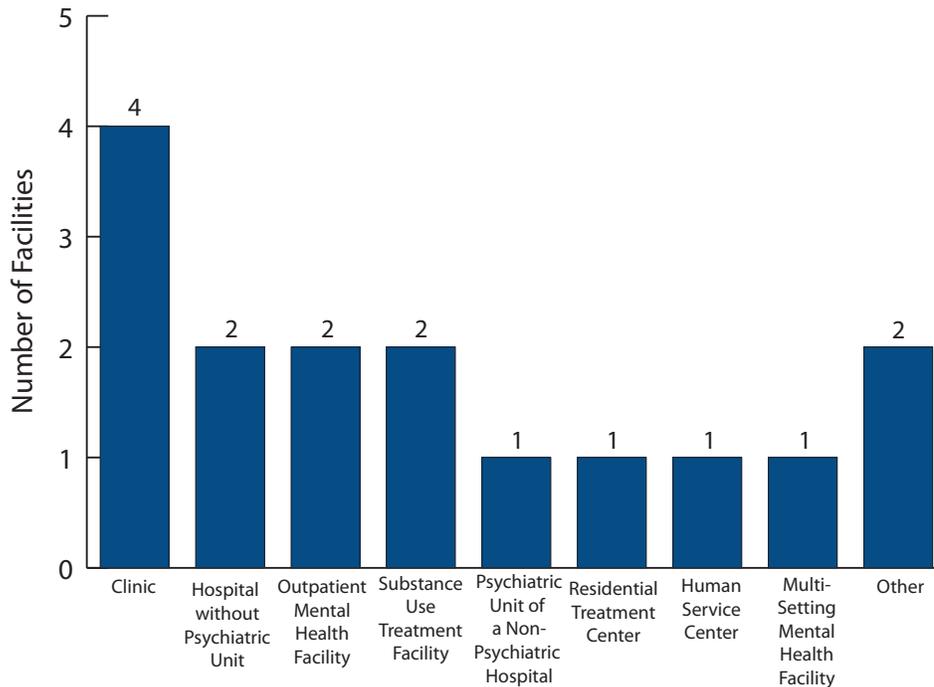
Figure 3. Telebehavioral Health Services Offered by Providers (n = 9)



Provider Facility Type

Respondents were asked to list the type of facility from which they provided telebehavioral health services. Four providers (44.4%) indicated that their facility was a clinic, although locations such as hospitals without a psychiatric unit (n = 2, 22.2%), outpatient mental health facilities (n = 2, 22.2%), or substance use treatment facilities (n = 2, 22.2%) were also common. Responses in the “Other” category included an eCare Hub, as well as a tertiary health system. A visual representation of the various facility and program types is shown in Figure 4.

Figure 4. Type of Facility that Provides Telebehavioral Health Services (n = 9)*

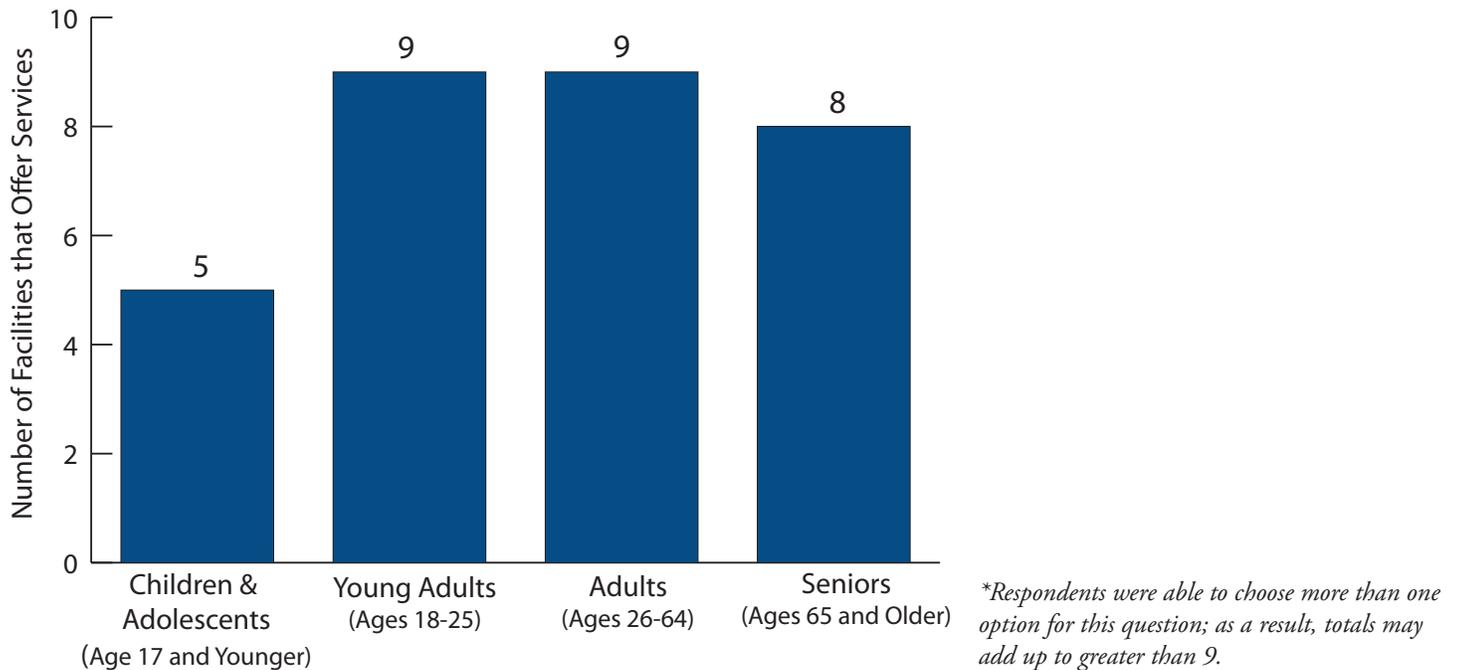


**Respondents had the option of choosing more than one response; as a result, totals for the question may add up to greater than 9.*

Population and Age Groups Served

Respondents were asked to specify what age groups they provided telebehavioral health services to; the results are shown in Figure 5. Only five facilities (55.6%) reported providing telebehavioral health services to children and adolescents ages 17 and younger. In contrast, 100.0% (n = 9) of provider locations reported offering services to young adults (ages 18-25) and adults (ages 26-64). Eight (88.9%) reported providing services to seniors ages 65 and older. In addition to age groups, provider respondents were also asked if they offered services to special populations. Eight (88.9%) reported providing services to veterans, and 100.0% reported providing services to American Indians.

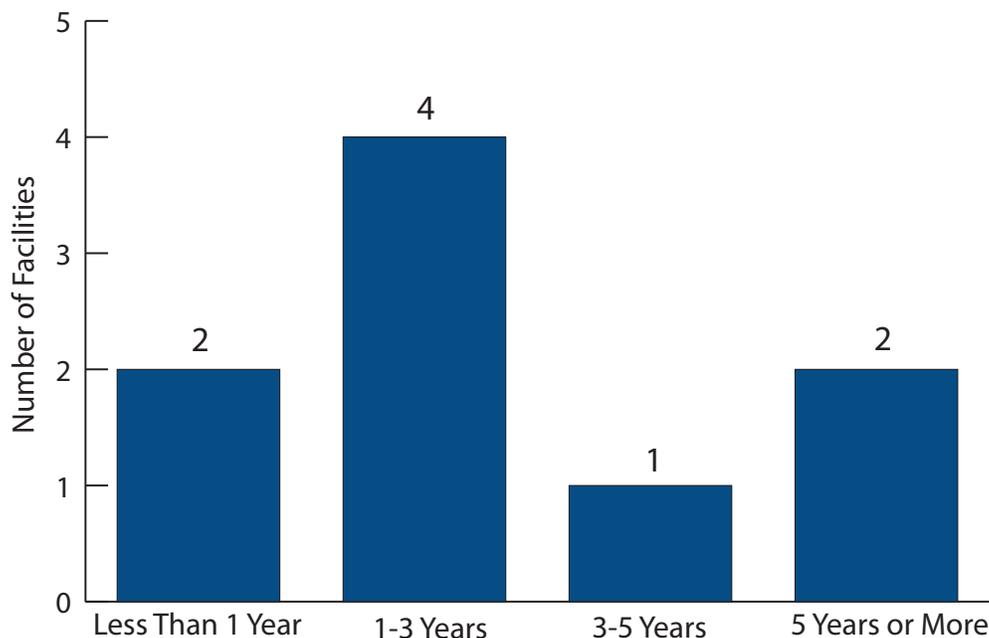
Figure 5. Age Groups to Whom Telebehavioral Health Service Providers Offer Services (n = 9)*



Length of Telebehavioral Health Service Coverage

The number of years that the facility provided telebehavioral health services to clients was also assessed (Figure 6). The majority of telebehavioral health providers reported offering services for 1-3 years (n = 4, 44.4%). Two (22.2%) provided services for less than one year, as well as for five years or more. Only one provider (11.1%) had been offering services for 3-5 years.

Figure 6. Number of Years Facility Provided Telebehavioral Health Services (n = 9)



Emergency Telebehavioral Health Services

In addition to the number of years the facilities had been providing services, respondents were also asked if their facilities provided emergency telebehavioral health services. In this context, emergency telebehavioral health services were defined as:

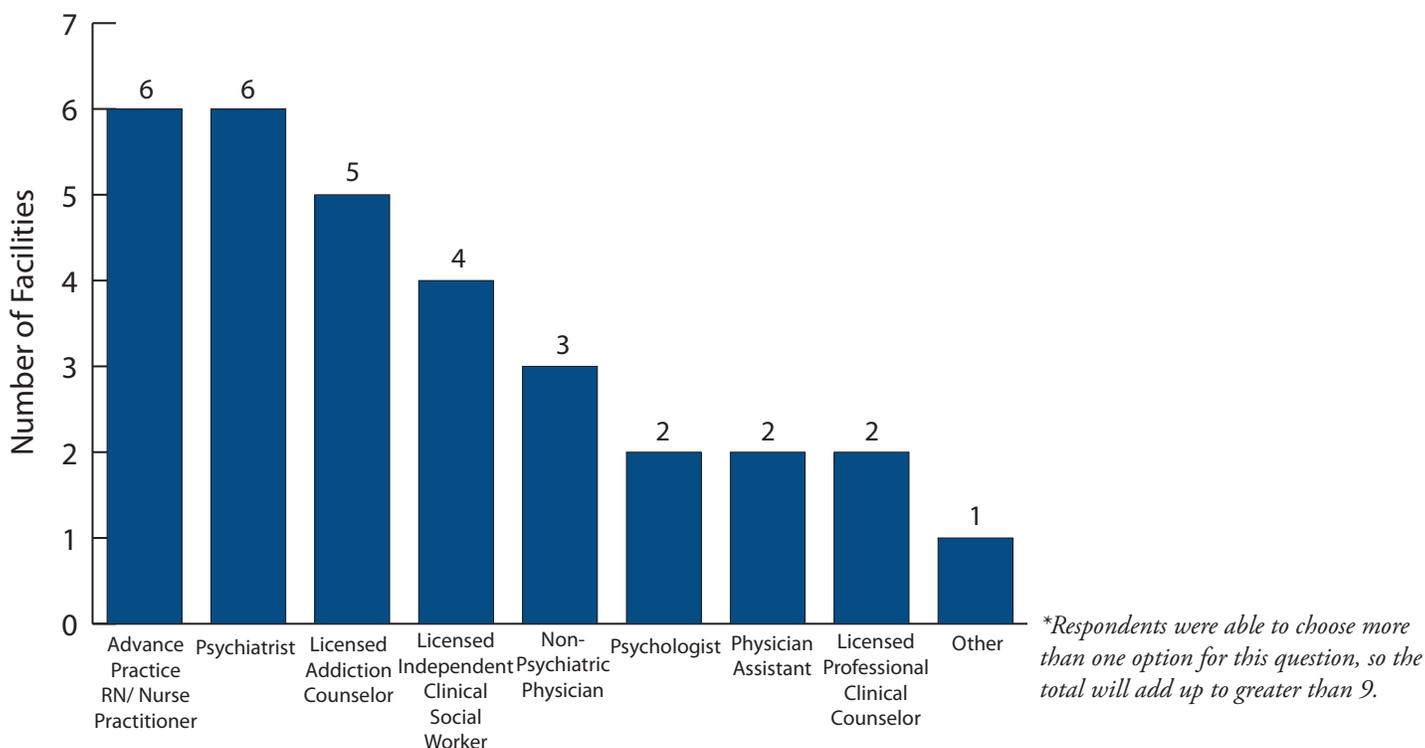
The provision of behavioral health services using electronic communication, video conferencing (i.e., telephone, the internet, smartphone, tablet, a PC desktop system, etc.), or other secure interactive communication technology for clients/patients who present to an emergency department or urgent care and are identified as having a behavioral health crisis that may present a danger to themselves or others and are in need of immediate assistance.

Among the nine provider respondents, three (33.3%) indicated they provided emergency telebehavioral health services. The facility type of respondents who provided emergency services included a tertiary health system, hospital – inpatient setting, and telemedicine company. The remaining six (66.7%) did not provide emergency telebehavioral health services.

Provider Practitioner Types

Respondents were also asked to indicate the types of practitioners who provided telebehavioral health services to clients. As can be seen in Figure 7, advance practice registered nurse/nurse practitioners (n = 6, 66.7%) and psychiatrists (n = 6, 66.7%) were the most commonly reported practitioners to provide telebehavioral health services. This was followed by licensed addiction counselors (n = 5, 55.6%), licensed independent clinical social workers (n = 4, 44.4%), and non-psychiatric physicians (n = 3, 33.3%). The “Other” category included one respondent (11.1%) who indicated that registered nurses provided services at their facility.

Figure 7. Telebehavioral Health Services Provider Practitioner Types (n = 9)*



Providers were asked if their facility had enough provider time to meet the need for telebehavioral health services (i.e., whether they had enough behavioral health providers to offer services based on their existing telebehavioral health service demand). Providers overwhelmingly indicated that they did not have sufficient provider time to meet their needs (n = 8, 88.9%). Among these, one respondent reported that all of their sites wanted to add additional days or hours; another needed a provider for assessment; and one indicated that there was a shortage of licensed addiction counselors. Only one facility (11.1%) reported they had enough provider time to meet their need for telebehavioral health services.

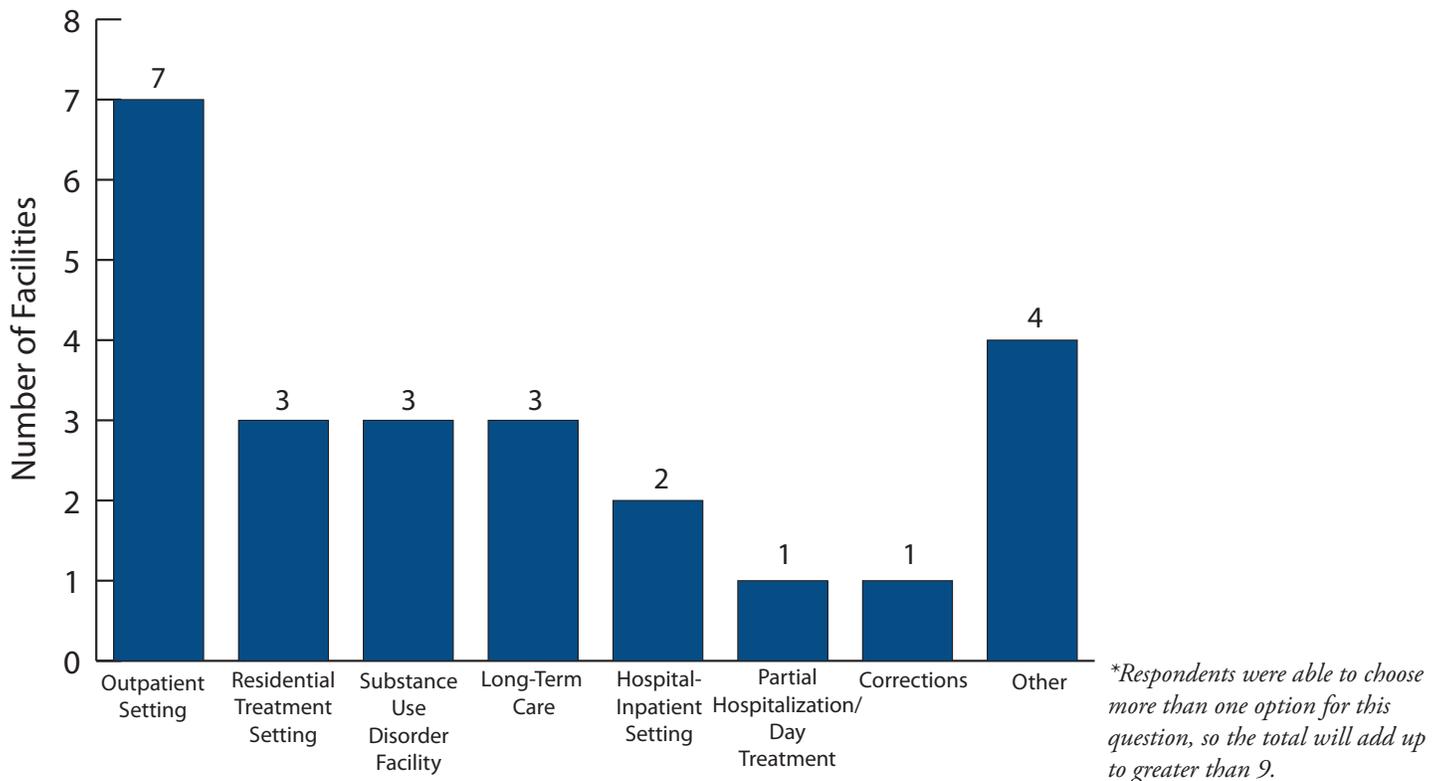
Receiver Site Demographics

Provider respondents (n = 8) indicated that their facility offered telebehavioral health services to approximately 11 receiver facilities on average. This number varied, however, with some facilities providing services to only one or two locations, whereas other facilities provided services for up to 34 facilities. Specifically, six facilities (75.0%) provided services to fewer than 10 facilities, one (12.5%) provided services to 18 facilities, and the remaining facility (12.5%) provided services to 34 locations.

There was wide variation in the number of clients to whom providers reported offering services through receiver sites (n = 8). The average number of clients was 496 (median = 92), although this number is influenced by some facilities that provided services to large numbers of clients. Across facilities, the number of clients receiving services ranged from a minimum of 35 to approximately 2,900 per month. Specifically, four respondents (50.0%) reported they provided services for 100 or fewer individuals; two (25.0%) provided services for between 100 and 200 clients, and two (25.0%) provided services for 200 clients or more.

The type of receiver facility location was also assessed; this refers to the facility type where clients receive telebehavioral health services (Figure 8). According to provider respondents, clients were most likely to be seen for telebehavioral health services in outpatient settings (n = 7, 77.8%). Locations such as residential treatment settings (n = 3, 33.3%), substance use disorder facilities (n = 3, 33.3%), and long-term care (n = 3, 33.3%) were also common responses. “Other” category responses consisted of services that were received in an emergency room (n = 2, 22.2%); one (11.1%) reported providing services to clinics and a psychiatric hospital; and one (11.1%) wrote they were in the process of developing jail coverage.

Figure 8. Receiver Facility Type (n = 9)*



Telebehavioral Health Services Availability

Respondents were asked open-ended questions about the number of days per week and hours per day their facility provided telebehavioral health services to clients in receiver facilities (n = 9). Regarding days per week, one facility (11.1%) indicated they provided services around the clock throughout the year. Another (11.1%) reported that constant on-call coverage was also available for their emergency room and in-patient coverage, but they provided services for two days each week in their clinic. In addition, two providers (22.2%) indicated they offered services three days a week, and four (44.4%) reported providing services five days a week. One (11.1%) indicated they provided services five days a week but were available seven days a week for emergencies. As a whole, most provider facilities appeared to offer telebehavioral health services two to five days a week, with some locations offering additional hours for emergency services.

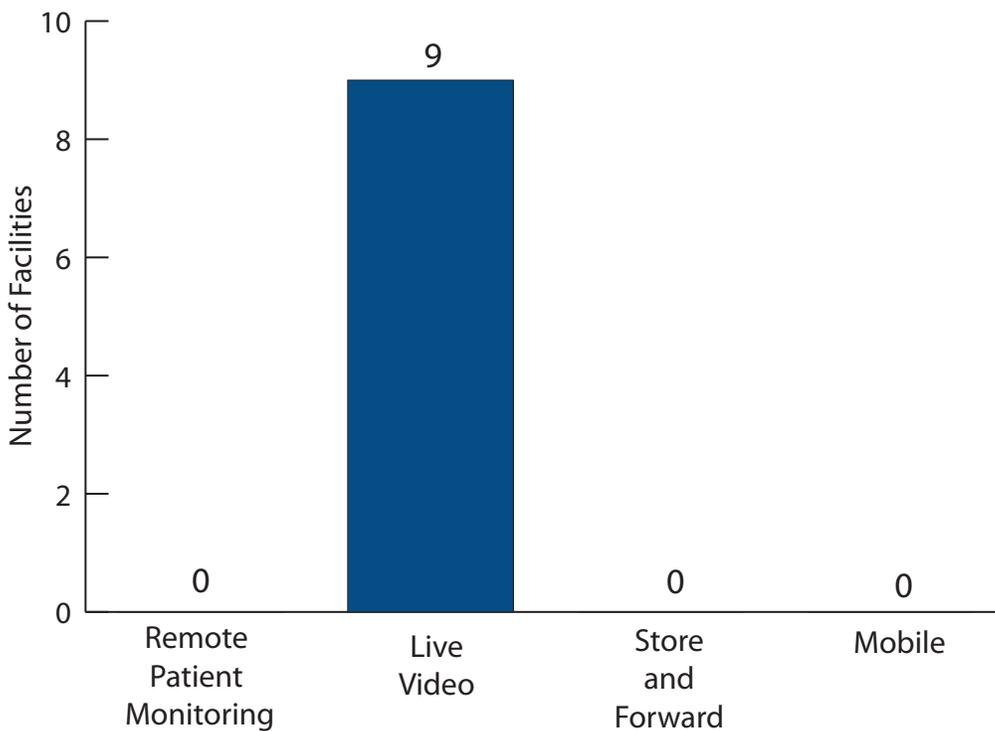
The number of hours per day that provider facilities offered telebehavioral health services also varied (n = 9). Six providers (67.7%) indicated that they provided telebehavioral services between 2-9 hours per day; one (11.1%) reported they provided services for 12-16 hours per week. On the higher end were facilities that reported providing services for up to 20 or 24 hours a day (n = 2, 22.2%). Among the facilities listed above, one third provided 24 hour a day coverage for emergency situations.

Respondents were also asked the average amount of time it takes for patients to get appointments (n = 8). One facility (12.5%) reported they provided on-demand behavioral health assessment services through their emergency room. Two respondents (25.0%) indicated that it would take about one day to get an appointment, whereas another two (25.0%) reported that it would be within one to two weeks. Other facilities had longer waiting times, such as one to two months (n = 2, 25.0%); one respondent (12.5%) said the wait time was unknown. Approximately 25.0% of the provider facilities listed above specifically indicated that if an emergency appointment was necessary, the client could be accommodated much earlier as needed.

Technology

Provider respondents were also asked what technology equipment was necessary in order to provide telebehavioral health services. Results are shown in Figure 9. Live video was overwhelmingly the most popular choice, with all respondents indicating this as their method of telebehavioral health services delivery; no other technology was reported. One respondent indicated that mobile services also would be developed within six months.

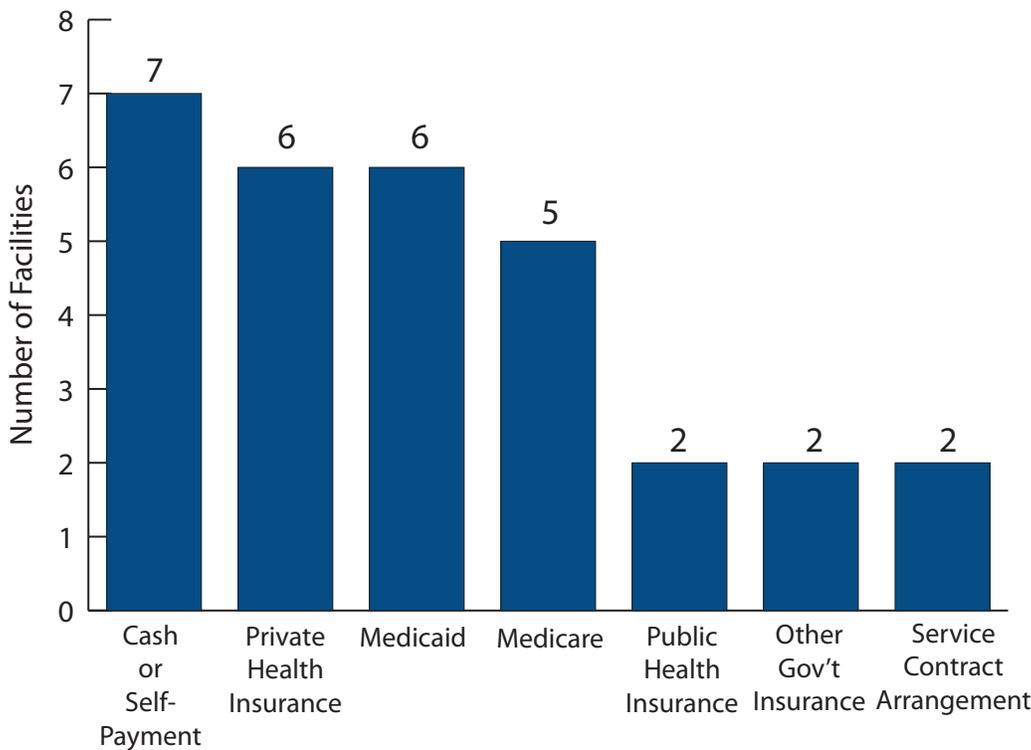
Figure 9. Type of Technology Used to Deliver Telebehavioral Health Services (n = 9)



Payment Information

Providers were asked to indicate what payment and insurance options were accepted for telebehavioral health services provided by their facilities. As seen in Figure 10, most facilities accepted a wide variety of payments, with cash or self-payment being the most common (n = 7, 77.8%). Private health insurance (n = 6, 66.7%), Medicaid (n = 6, 66.7%), and Medicare (n = 5, 55.6%) were also frequently used. Five respondents (55.6%) did not offer payment assistance. Among the four (44.4%) that did, common forms included a substance use disorder (SUD) voucher, sliding scale, or working with the client to come up with an attainable payment option.

Figure 10. Provider Payment and Insurance Options for Telebehavioral Health Services (n = 9)*



**Respondents were able to choose more than one option for this question, so the total will add up to greater than 9.*

Other Analyses

Electronic Health Record

Provider respondents were asked if they utilized an electronic health record, and if so, what type (n = 9). Seven respondents (77.8%) indicated they used an electronic health record, with common types including Bradoc, Celerity LLC, EPIC, Meditech, Allscripts, Methasoft, and Netsmart Technologies. The remaining two (22.2%) did not report using electronic health records.

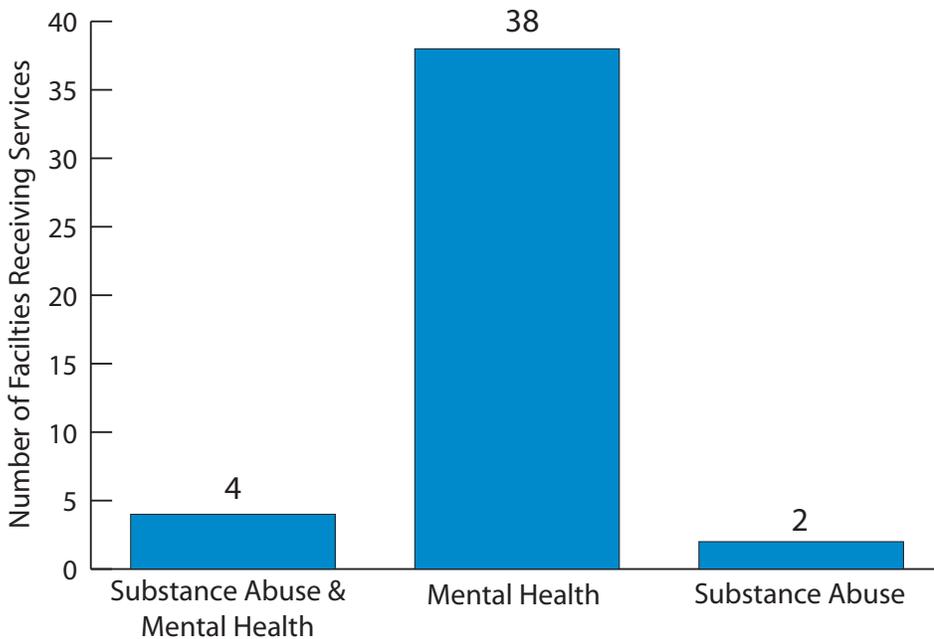
North Dakota Health Information Network

Respondents were also asked if they utilized the North Dakota Health Information Network to access patient information, and if they did not, their reasons for not doing so (n = 9). While four (44.4%) did utilize this service, five (55.6%) reported not using it. Reasons mentioned for not using the program included 42 CFR Part II restrictions, needing more education on it, or that the program was too cumbersome.

Receivers of Telebehavioral Health Services

Among the respondents surveyed, 44 facilities (43.6%) reported they received telebehavioral health services. These refer to the facilities that host the client who receives the clinical telebehavioral health intervention. Among the 44 receiver respondents, 38 (86.4%) indicated they received only mental health telebehavioral health services. Additionally, two (4.5%) solely provided substance abuse telebehavioral health services. The remaining four (9.1%) provided both substance abuse and mental health telebehavioral health services (Figure 11).

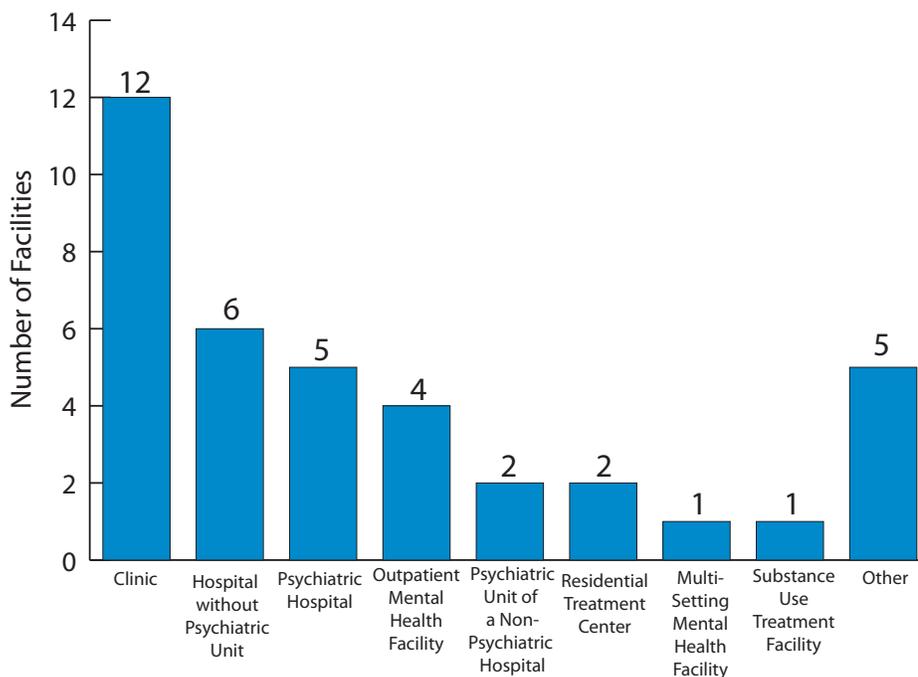
Figure 11. Telebehavioral Health Services Delivered by Receivers (n = 44)



Provider Site Demographics

Respondents were asked what type of facility they received telebehavioral health services from (i.e., the type of facility that provided the telebehavioral health services to their facility; Figure 12). Most receivers indicated the facility they received services from was a clinic (n = 12, 35.3%), hospital without a psychiatric unit (n = 6, 17.7%), or a psychiatric hospital (n = 5, 14.7%). Outpatient mental health facilities were also frequently utilized (n = 4, 11.8%). Those in the “Other” category included independent physician/physician practices and private groups.

Figure 12. Type of Facility Providing Telebehavioral Health Services (n = 34)*



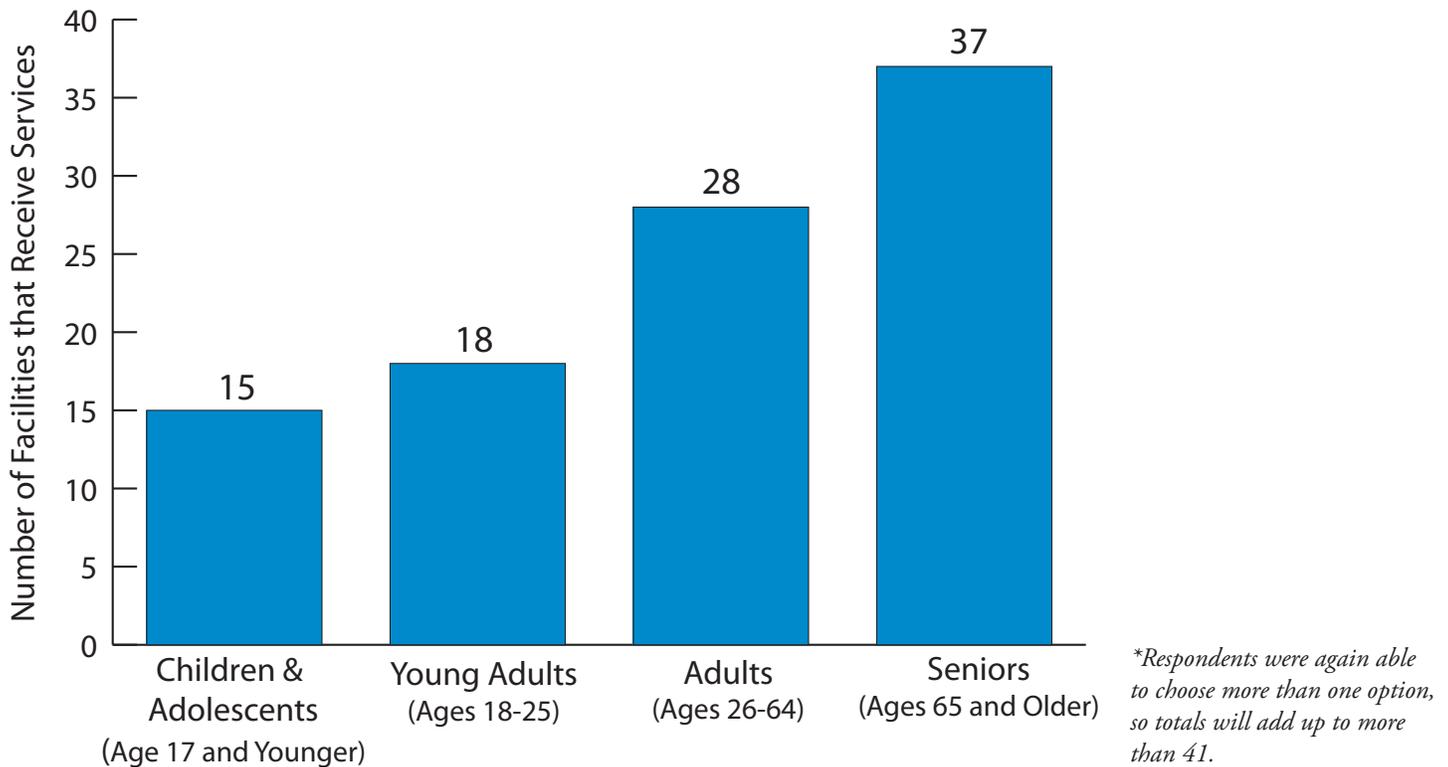
**Respondents were able to choose more than one option for this question; as a result, totals add up to greater than 34.*

Respondents were asked to name the locations currently providing telebehavioral health services to their facilities (n = 37). The majority of receivers indicated they only received telebehavioral services from one provider facility (n = 34, 91.9%). Only one facility (2.7%) received services from two providers; two (5.4%) received services from three providers.

Population and Age Groups Served

Respondents were asked to choose what age groups they received telebehavioral health services for; the results are shown in Figure 13. The majority of facilities received telebehavioral health services for seniors ages 65 and older (n = 37, 90.2%). This was followed by adults (ages 26-64; n = 28, 68.3%) and young adults (ages 18-25; n = 18, 43.9%). Only 15 facilities (36.6%) reported receiving telebehavioral health services for children and adolescents ages 17 and younger. In addition to age groups, receiver respondents were also asked if they delivered services to special populations. Here, 17 (41.5%) reported receiving services for veterans, and 13 (31.7%) reported receiving services for American Indians.

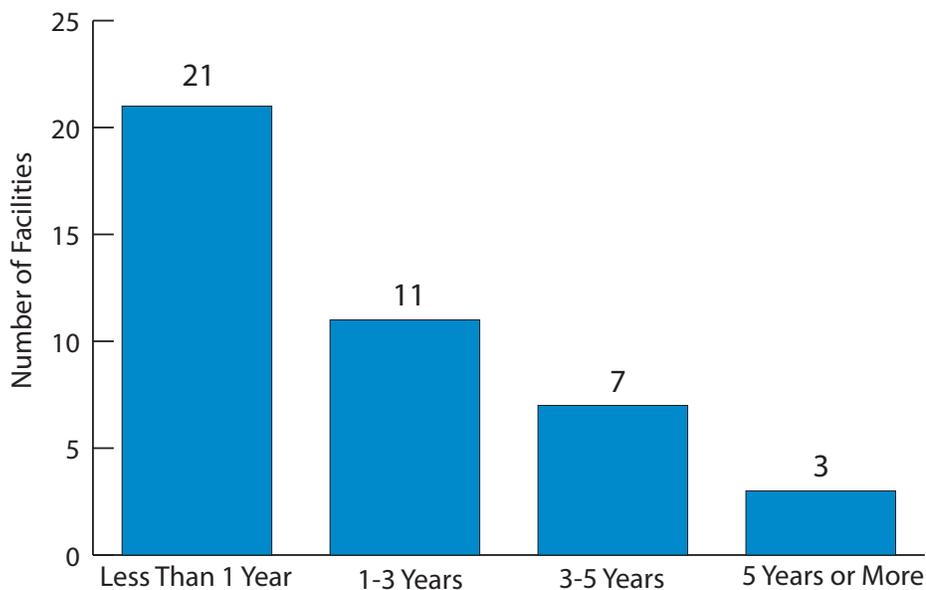
Figure 13. Age Groups Receiving Telebehavioral Health by Receiving Facility (n = 41)*



Length of Telebehavioral Health Service Coverage

The number of years the facility received telebehavioral health services for clients was also assessed (Figure 14). The majority of telebehavioral health receivers had only been receiving services for clients for less than one year (n = 21, 50.0%). Eleven respondents (26.2%) had been receiving services for 1-3 years, and seven (16.7%) had been receiving telebehavioral health services for 3-5 years. Only three (7.1%) had been delivering services for five years or more.

Figure 14. Number of Years Facility Received Telebehavioral Health Services (n = 42)



Emergency Telebehavioral Health Services

In addition to the number of years the facilities had been receiving services, respondents were also asked if their facilities received emergency telebehavioral health services. In this context, emergency telebehavioral health services were defined as:

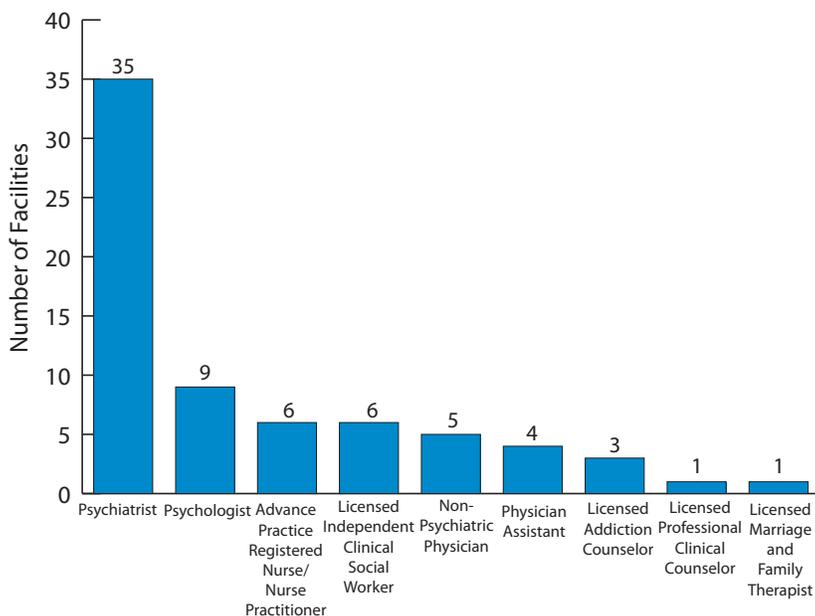
The provision of behavioral health services using electronic communication, video conferencing (i.e., telephone, the internet, smartphone, tablet, a PC desktop system, etc.), or other secure interactive communication technology for clients/patients who present to an emergency department or urgent care and are identified as having a behavioral health crisis that may present a danger to themselves or others and are in need of immediate assistance.

Among the 44 respondents, 21 (47.8%) responded they received emergency telebehavioral health services. Facility types of respondents who received emergency services included 11 CAHs, 8 long-term care facilities, 1 tertiary health system, and 1 hospital-inpatient setting. The remaining 23 (52.3%) did not receive emergency telebehavioral health services.

Provider Practitioner Types

Respondents were also asked to indicate the types of practitioners who provided telebehavioral health services to clients in their receiving facilities. As can be seen in Figure 15, psychiatrists (n = 35, 85.4%) were the most commonly reported type of practitioner. This was followed by psychologists (n = 9, 22.0%), advance practice registered nurse/nurse practitioners (n = 6, 14.6%), and licensed independent clinical social workers (n = 6, 14.6%), among others.

Figure 15. Telebehavioral Health Services Provider Practitioner Types (n = 41)*



**Respondents were able to choose more than one option for this question; totals will add up to greater than 41.*

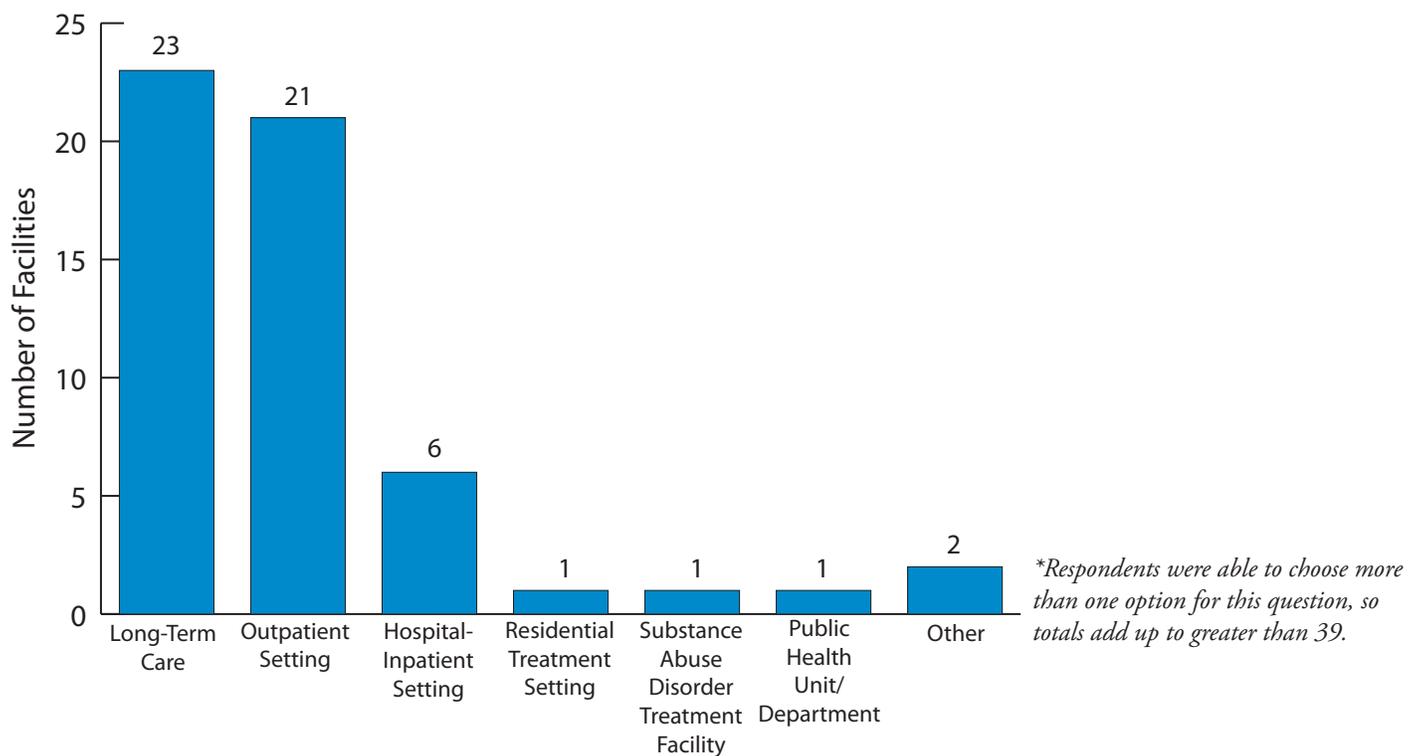
Receiver respondents were asked whether the behavioral health professionals who provided telebehavioral services to their facility were employed, contracted, or if there was another type of arrangement (n = 37). Most receiver facilities (n = 30, 81.1%) reported they contracted with the behavioral health providers to receive services. Three (8.1%) indicated they employed professionals. Six (16.2%) stated they utilized a different type of setup, such as in-kind services, independent providers, or service agreements. Respondents were able to choose more than one answer, so totals add up to greater than 37.

Receiver Site Demographics

Respondents were asked to provide the number of locations that currently received telebehavioral health services (n = 36). Most receiver facilities (n = 33, 91.7%) indicated that such services were only received at one location (i.e., their facility). Two respondents (5.6%) indicated they received telebehavioral health services at two locations, and one (2.8%) received services at five locations in North Dakota.

Respondents were also asked about the type of facility in which they received telebehavioral health services (i.e., the receiver site in which clients are seen). According to receivers, most clients were primarily seen in long-term care facilities (n = 23, 59.0%) and outpatient settings (n = 21, 53.9%), followed by hospitals – inpatient settings (n = 6, 15.4%). For answers in the “Other” category, both respondents reported that clients were seen in the emergency room (Figure 16).

Figure 16. Facility Type in which Patients Receiving Telebehavioral Health Services Are Being Seen (n = 39)*



The number of patients who received telebehavioral health services in each facility also varied greatly (n = 38). While some respondents indicated they were unsure or stated that services were available as needed (n = 3, 7.9%), others noted that their system implementation was still too new to report numbers yet (n = 2, 5.3%). Seventeen (44.7%) reported they typically saw fewer than 10 clients at their receiver site; four (10.5%) said they received between 10 and 15 clients; and five (13.2%) saw between 20 and 27 clients. Four (10.5%) reported seeing between 30 and 40 clients per month, and three (7.9%) saw more than 50.

Telebehavioral Health Services Availability

Respondents were also asked open-ended questions to indicate the number of days per week and hours per day that their facilities received telebehavioral health services for clients (n = 39). Regarding the number of days that services were received, 13 respondents (33.3%) indicated they received services for clients approximately 1-2 days per month, although some offered them as few as 1 day every 2-3 months, or ½ day every other month (n = 2, 5.1%). Eleven respondents (28.2%) reported delivering services two or fewer days per week; two (5.1%) received services between three and five days a week. Only two respondents (5.1%) respondents indicated that services were received seven days a week. In one facility (2.6%), services were only used in the emergency department. Finally, many of the receivers reported they only delivered services to clients as needed (n = 8, 20.5%).

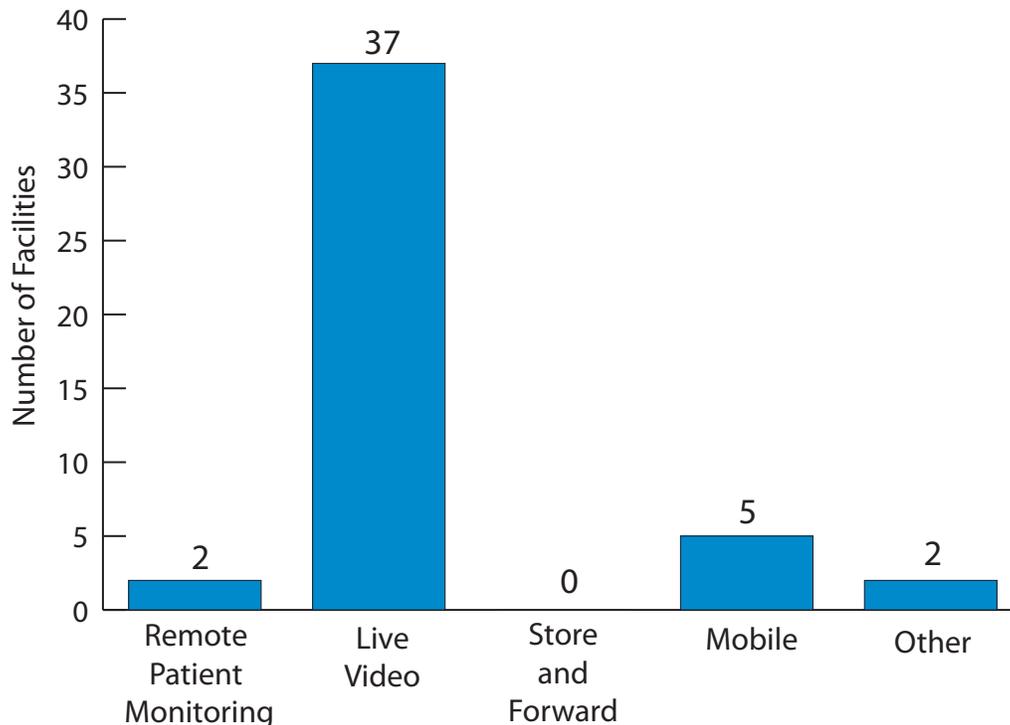
The number of hours per day that receiver facilities delivered telebehavioral health services also varied (n = 38). Eight (21.1%) reported that appointments were provided as needed or they were unsure of the number of hours. Two facilities (5.3%) offered 3-4 hours of telebehavioral health services every other month. In addition, seven respondents (18.4%) offered services between one hour and eight hours each month. Most locations indicated they received services for six or fewer hours each day (n = 18, 47.4%), with only three (7.9%) reporting eight hours a day.

Receivers were also asked how long it takes to obtain a telebehavioral health appointment (n = 30). Thirteen (43.3%) indicated they were unsure or that the provider facility handled scheduling, that services were received as needed, that there was a standing arrangement, or that appointments were already made on a scheduled basis. Three respondents (10.0%) said clients could get an appointment the same day, whereas seven (23.3%) reported that clients could get an appointment in a week or less. Additionally, seven (23.3%) indicated it took one month for clients to get an appointment. In emergency cases, however, many respondents reported that clients could obtain appointments sooner.

Technology

Receiver respondents were also asked what technology equipment was necessary in order to receive telebehavioral health services in their facilities. Results are shown in Figure 17. The majority of respondents (n = 37, 92.5%) indicated they utilized live video as the primary method of receiving telebehavioral health services. Mobile (n = 5, 12.5%) and remote patient monitoring (n = 2, 5.0%) were also utilized. No respondents utilized Store and Forward technology. The “Other” category was based on one response in which the respondent noted a laptop app was used.

Figure 17. Type of Technology Used to Deliver Telebehavioral Health Services (n = 40)*

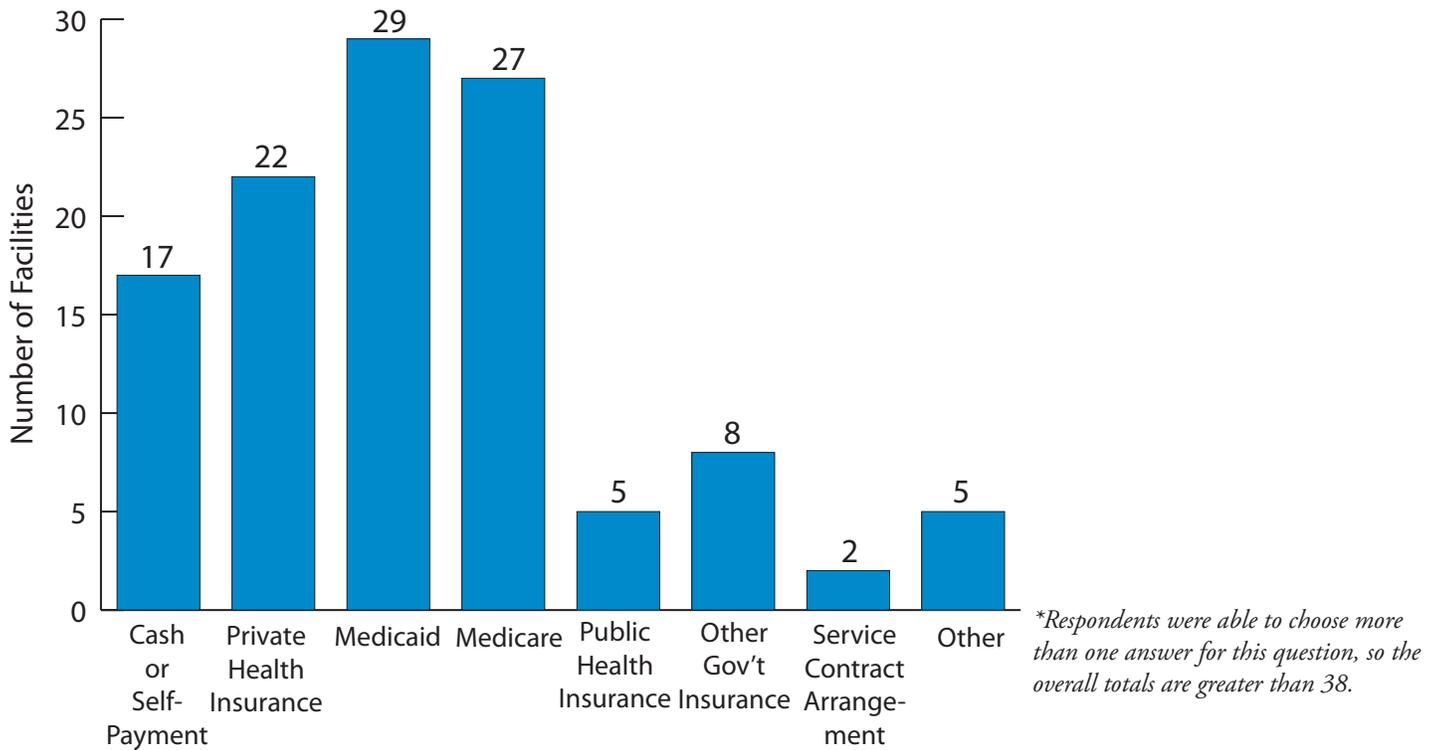


** Respondents were able to choose more than one option for this question, so totals add up to greater than 40.*

Payment Information

Receivers were asked to indicate what payment and insurance options were accepted for telebehavioral health services received by their facility. As seen in Figure 18, facilities were most likely to accept Medicaid (n = 29, 76.3%), Medicare (n = 27, 71.1%), private health insurance (n = 22, 57.9%), and cash or self-payment (n = 17, 44.7%), among others. Of those who indicated “Other,” one respondent reported Medicare supplements; the remaining indicated the provider of telebehavioral health services does the billing. Twenty-seven respondents (75.0%) did not offer payment assistance. Among the nine (25.0%) that did, charity care was frequently mentioned; other options included grants, substance use disorder (SUD) vouchers, and other forms of financial assistance.

Figure 18. Receiver Payment and Insurance Options for Telebehavioral Health Services (n = 38)*



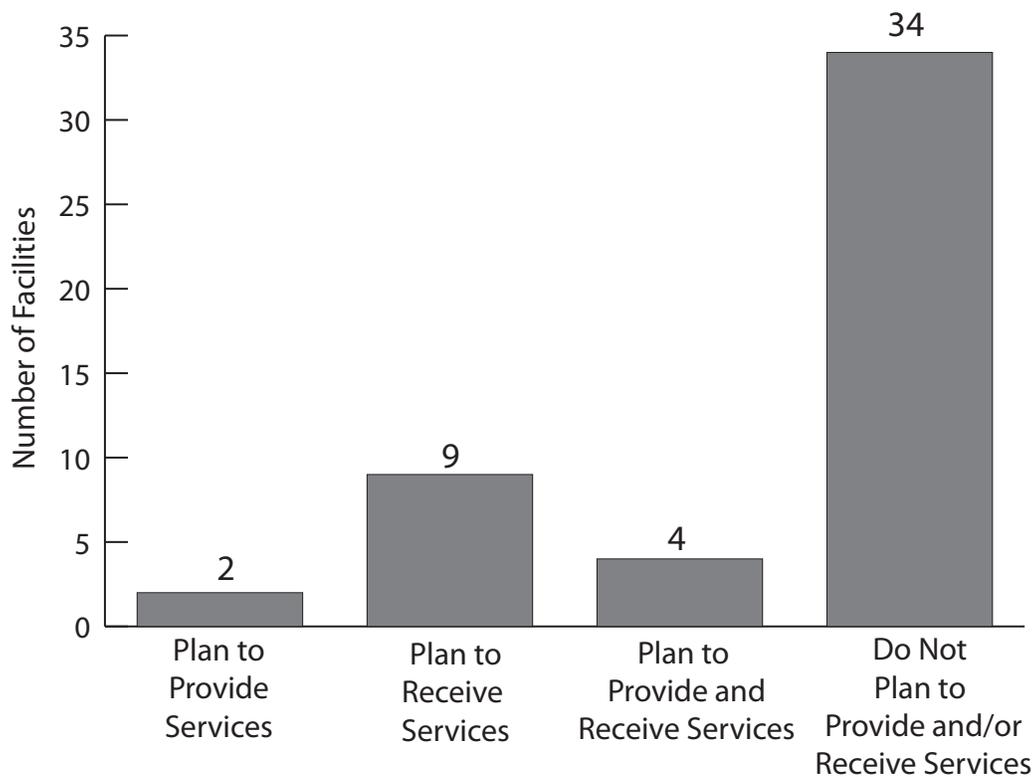
No Current Telebehavioral Health Services

There were 51 facilities (50.5%) that reported they had neither provided nor received telebehavioral health services.

Future Intent to Provide and/or Receive Telebehavioral Health Services

Respondents currently not involved in telebehavioral health services were asked if they planned to provide or receive services in the future. As seen in Figure 19, most facilities did not plan on incorporating telebehavioral health services into their behavioral health program (n = 34, 69.4%). If facilities did plan on utilizing telebehavioral health, they were most likely to report planning to receive it (n = 9, 18.4%).

Figure 19. Future Intent to Utilize Telebehavioral Health Services (n = 49)



Respondents who did not plan to utilize telebehavioral health services in the future consisted of 13 long-term care facilities, 11 public health unit/departments, 5 CAHs, as well as 1 respondent each from a psychiatric hospital, substance use disorder treatment facility, outpatient setting, partial hospitalization/day treatment, and residential treatment setting. Respondents who planned to receive services included five long-term care facilities, three CAHs, and one public health unit/departments. Those who planned to provide services included one tertiary health system, and one CAH. Finally, those who planned to provide and receive telebehavioral health services included two public health units/departments and two federally qualified health centers.

Potential Barriers in Utilizing Telebehavioral Health Services

Respondents were asked what the primary challenges or barriers were that prevented them from utilizing telebehavioral health services (Table 2). The most commonly reported barrier was lack of behavioral health providers (n = 17, 36.2%), followed by equipment and staff costs (n = 13, 27.7%), and lack of clear, standardized regulatory guidelines (n = 13, 27.7%). Additionally, 13 respondents (27.7%) reported being able to meet their behavioral health service needs with in-house/local behavioral health providers. There were some respondents who supplied additional reasons, including lack of infrastructure space, telebehavioral health being outside their area of expertise, underutilized services, and being in the process of exploring potential options.

Table 2. Potential Challenges and Barriers in Utilizing Telebehavioral Health Services (n = 47)*

Barrier	N	Percent
Lack of Behavioral Health Providers	17	36.2%
Equipment and Staff Costs	13	27.7%
Lack of Clear, Standardized Regulatory Guidelines	13	27.7%
Practice/Organization Able to Meet Needs with In-house/Local Behavioral Health Providers	13	27.7%
Difficult to Implement and Sustain	10	21.3%
Privacy and Security Concerns	9	19.2%
Providers and Other Health Professional Staff Learning, Utilizing, and Keeping Current on the Equipment/Technology	8	17.0%
Patient/Client Acceptance of Receiving Behavioral Health Services Using Telebehavioral Health	7	14.9%
Telebehavioral Health Services Are Reimbursed at a Lower Rate than In-person or Not-At-All	6	12.8%
IT Staff Not Familiar with Equipment/Telebehavioral Health Technology	5	10.6%
Inadequate Technology and Connectivity Issues	5	10.6%
Provider Acceptance, Still Considered Experimental	3	6.4%
Telemedicine Company	1	0.9%
SUD/Facility/Treatment Provider	1	0.9%
Private-for-Profit Behavioral Health Agency	1	0.9%

*Respondents were able to choose more than one option for this question, so percentages add up to greater than 100.0%.

Discussion

Telebehavioral health services fill an important role in delivering mental health and substance abuse services to individuals in North Dakota. Because these services are able to connect health professionals and clients across distances, this technology has the potential to deliver behavioral healthcare to areas that are currently underserved.

The current study examined demographic factors regarding facilities in North Dakota that either provided or received telebehavioral health services, in addition to those that were not presently utilizing it. In this context, providers of telebehavioral health services again refer to facilities that offer the clinical intervention of telebehavioral health services; receivers are those facilities that host the client who receives the clinical telebehavioral health intervention. A brief overview of each telebehavioral health respondent type is provided below.

Telebehavioral Health Providers

There are currently at least nine facilities providing telebehavioral health services to North Dakota. With two facilities providing substance abuse services, three providing mental health services, and four providing both, there was not a significant difference in types of telebehavioral health programs offered among the nine. Provider facilities were most likely operating out of a clinic (n = 4, 44.4%), and although they served clients of all age groups, they were especially likely to report providing services to young adults (ages 18-25; 100.0%), adults (ages 26-64; 100.0%), and seniors (ages 65 and older; n = 8, 88.9%).

The majority of telebehavioral health providers had been providing services for approximately 1-3 years (n = 4, 44.4%); most did not offer emergency telebehavioral health services (n = 6, 66.7%). Provider respondents indicated that advance practice RNs/nurse practitioners (n = 6, 66.7%) and psychiatrists (n = 6, 66.7%) were most likely to provide telebehavioral health services to clients in receiver facilities.

On average, respondents provided services to 11 receiver facilities, most of which were outpatient settings (n = 7, 77.8%). The number of clients the facility provided services to varied, with some reporting at least 35 clients and others serving approximately 2,900 per month. All respondents reported using live video (100.0%) as the primary technological requirement.

Regarding payment services, cash or self-payment (n = 7, 77.8%), private health insurance (n = 6, 66.7%), and Medicaid (n = 6, 66.7%) were the most commonly accepted; slightly more than half (n = 5, 55.6%) did not offer payment assistance.

Telebehavioral Health Receivers

There are currently at least 44 facilities that are receiving telebehavioral health services in North Dakota. The majority of receiver facilities reported primarily delivering mental health services (38), two provided substance abuse services, and three provided both types. Receivers of telebehavioral health were most likely to be in either long-term care (n = 23, 59.0%) or an outpatient setting (n = 21, 53.9%). Similarly, most respondents received services for seniors (ages 65 and older; n = 37, 90.2%), although adults (ages 26-64; n = 28, 68.3%) were also frequently reported.

Half (n = 21) of the facilities had received telebehavioral health services for less than one year, although 11 (26.2%) reported between one and three years. Twenty-three facilities (52.3%) did not receive emergency telebehavioral health services. Receiver respondents were most likely to indicate that psychiatrists (n = 35, 85.4%) were the main behavioral health professionals providing services to their clients.

Most receiver sites only received services from one provider (n = 33, 91.7%). Such services were typically provided to fewer than 10 clients (n = 17, 44.7%), although 16 (42.1%) saw more than 10 clients. With regard to technology, most receiver facilities utilized live video (n = 37, 92.5%), although mobile technologies were also sometimes used (n = 5, 12.5%). Concerning payment, most facilities accepted Medicaid (n = 29, 76.3%) and Medicare (n = 27, 71.1%), among others. Approximately 75.0% did not offer payment assistance.

Facilities Not Currently Utilizing Telebehavioral Health Services

Of the 101 survey respondents, 51 did not report providing or receiving telebehavioral health services. When asked about future intentions, most indicated they did not plan to utilize telebehavioral health services in the future (n = 34, 69.4%), although some facilities did report planning to receive them (n = 9, 18.4%). The most common barrier listed among those not utilizing telebehavioral health services was lack of behavioral health providers (n = 17, 36.2%), followed by equipment and staff costs (n = 13, 27.7%), and lack of clear, standardized regulatory guidelines (n = 13, 27.7%).

DHS Regions

There is at least one telebehavioral health provider facility in each of the eight DHS state regions in North Dakota, with the exception of Region 8; however, there are currently plans in preparation to provide services in that region. As a whole, slightly more of the receiver sites are present on the eastern side of North Dakota, particularly in Regions 4, 5, and 6, although they exist throughout the state.

Rural versus Urban

Among providers of telebehavioral health in North Dakota, eight (72.7%) were located in urban areas and three (27.3%) were in rural areas (one respondent completed the survey for more than one location). One additional provider respondent was a facility located out of state that provided services to North Dakota locations. Of the 44 facilities receiving telebehavioral health services, 33 (75.0%) were in rural areas. Among the 51 facilities that were not currently utilizing telebehavioral health services, 34 (66.7%) were located in rural areas.

Limitations

Telebehavioral services within the state of North Dakota are a very interconnected network of programs, with many facilities providing services to a number of locations, others receiving services from several providers, and some facilities sharing services between multiple locations. As a result, despite efforts to reach out to all the places that could have possibly offered or received telebehavioral health services, it is possible that some locations may not have been surveyed or that some responses may be incomplete. For example, all provider respondents indicated using live video as their only type of technology, yet receiver respondents also reported using remote patient monitoring and mobile services. This discrepancy suggests that not all sites providing or receiving telebehavioral health services to North Dakota were surveyed.

Additionally, despite providing definitions, some facilities may have been mistaken regarding their roles as providers or receivers of services, and may therefore have completed the wrong section of the survey. Responses of this nature were flagged and corrected as necessary. To the best of our knowledge, all potential duplicates of information were removed. For example, if one facility filled out the survey on behalf of other facilities, and responses were obtained from the other facilities, we did not count both responses.

Conclusion

With most provider facilities of telebehavioral health services existing in urban areas and providing services primarily to rural areas, telebehavioral health services provides one way to increase access to behavioral health services for individuals in underserved areas. In addition, many receiver locations had reported offering services for less than one year, indicating that the use of telebehavioral health services in North Dakota is a growing trend in the state.

Although most providers reported offering mental health and/or substance abuse services, receivers of telebehavioral health primarily delivered only mental health services to their clients; reports of substance abuse programs were relatively low. This may be reflective, to some degree, of the type of receiver sites utilizing telebehavioral health services, as 59.0% identified as long-term care facilities, although 53.9% were outpatient settings. In addition, while most provider and receiver facilities reported delivering telebehavioral services to young adults, adults, and seniors, comparably few offered services to children and adolescents 17 and younger (55.6% of providers and 36.6% of receivers).

Results suggest that working to increase the number of behavioral health providers who can provide telebehavioral health services may be beneficial, as 88.9% of provider facilities reported they did not have enough provider time to meet the need for telebehavioral health services. Similarly, lack of behavioral health providers was the most commonly cited barrier among facilities not currently utilizing telebehavioral health services. However, each facility's current demand for telebehavioral health services must be taken in to account, as many locations not currently utilizing services also indicated they were able to meet their behavioral health needs with local providers.

The telebehavioral health programs in North Dakota appear to be in various stages of progress. Many of the receiver programs are still in their early stages and therefore may not deliver services to a large number of clients. In contrast to this are the larger, more established provider facilities that serve close to 3,000 clients per month at receiver sites across the state. As a whole, telebehavioral health programs appear to be serving an important role in connecting clients with needed mental health and substance abuse services across the state.

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Introduction:

In the following study, the term ***telebehavioral health services*** refers to the use of electronic communication and information technologies to provide or support real-time psychiatric, psychological, mental health, marriage and family, social work services, and/or addiction counseling at a distance. This includes the use of video conferencing (i.e., the internet, smartphone, tablet, PC desktop system, etc.) or other interactive communication technology to provide behavioral health assessment, diagnosis, intervention, consultation, supervision, education and information to a client/patient across a distance.

Providing telebehavioral health services refers to the practice/organization that offers the clinical intervention of telebehavioral health services.

Receiving telebehavioral health services refers to the practice/organization that hosts the client/patient that receives the clinical telebehavioral health intervention.

1. What is the name of your practice/organization?
2. What type of facility most accurately reflects your practice/organization?
 - Tertiary Health System
 - Human Service Center
 - Hospital – Inpatient Setting
 - Residential Treatment Setting
 - Partial Hospitalization/Day Treatment
 - Outpatient Setting
 - Corrections
 - Long-Term Care
 - Substance Use Disorder Treatment Facility
 - Public Health Unit/Department
 - Home
 - Other:
3. Please list the *primary* location of your practice/organization.
4. Does your practice/organization engage in the following? Please check all that apply:
 - Provides substance abuse telebehavioral health services
 - Provides mental health telebehavioral health services
 - Receives substance abuse telebehavioral health services
 - Receives mental health telebehavioral health services
 - Neither provides nor receives substance abuse or mental health telebehavioral health services

Providers of Substance Abuse and/or Mental Health Telebehavioral Health Services:

Please answer the following questions about telebehavioral health services that your practice/organization ***provides***.

Providing telebehavioral health services refers to the practice/organization that offers the clinical intervention of telebehavioral health services.

5. To what populations does your practice/organization provide telebehavioral health services?
Please check all that apply.
- Children/Adolescents (Age 17 and Under)
 - Young Adults (Ages 18-25)
 - Adults (Ages 26-64)
 - Seniors (Ages 65 and Older)
 - Veterans
 - American Indians
6. In your practice/organization, what type of practitioners provide telebehavioral health services?
Please check all that apply.
- Non-Psychiatric Physician(s)
 - Psychiatrist(s)
 - Psychologist(s)
 - Advance Practice Registered Nurse (APRN)/Nurse Practitioner
 - Physician Assistant (PA)
 - Licensed Addiction Counselor (LAC)
 - Licensed Independent Clinical Social Worker (LICSW)
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapist (LMFT)
 - Other:
7. How many years has your practice/organization offered telebehavioral health services?
- Less than 1 year
 - 1-3 years
 - 3-5 years
 - 5 years or more
8. Does your practice/organization provide emergency telebehavioral health services? Emergency telebehavioral health services refers to the provision of behavioral health services using electronic communication, video conferencing (i.e., telephone, the internet, smartphone, tablet, a PC desktop system, etc.), or other secure interactive communication technology for clients/patients who present to an emergency department or urgent care and are identified as having a behavioral health crisis that may present a danger to themselves or others and are in need of immediate assistance.
- Yes
 - No
9. From what type of practice/organization do you provide telebehavioral health services?
- Clinic
 - Community Health Center
 - Hospital without Psychiatric Unit
 - Psychiatric Hospital
 - Psychiatric Unit of a Non-Psychiatric Hospital
 - Residential Treatment Center

- Other Residential Treatment Facility
- Partial Hospitalization/Day Treatment
- Outpatient Mental Health Facility
- Human Service Center
- Multi-setting Mental Health Facility
- Substance Use Treatment Facility
- Local Public Health Unit/Department
- Long-Term Care Facility
- Social Services
- Provider's Home
- Other: _____

10. Please list the practice/organization name and city of the location(s) (North Dakota only) to which your practice is currently providing telebehavioral health services.

11. How many days per week (in total) does your practice/organization provide telebehavioral health services?

12. How many hours per day (in total) does your practice/organization provide telebehavioral health services?

13. How many patients (in total) does your practice/organization provide telebehavioral health services to each month?

14. On average, how long does it take for clients/patients to get an appointment for telebehavioral health services from your practice/organization?

15. Does your practice/organization have enough provider time to meet the need for telebehavioral health services?

- Yes
- No: _____

16. In what type of facility are the clients/patients that you provide telebehavioral health services being seen? Please check all that apply.

- Hospital – Inpatient Setting
- Residential Treatment Setting
- Partial Hospitalization/Day Treatment
- Outpatient Setting
- Corrections
- Long-Term Care
- Substance Use Disorder Treatment Facility
- Public Health Unit/Department
- Home
- Other: _____

17. What technology does your practice/organization use to deliver telebehavioral health services?

- Remote Patient Monitoring
 - Live Video
 - Store and Forward
 - Mobile
 - Other: _____
18. Does your practice/organization utilize an electronic health record? If yes, please indicate what vendor.
- Yes: _____
 - No
19. Do your providers access patient information using the North Dakota Health Information Network (NDHIN)? If not, please indicate why.
- Yes
 - No: _____
20. What payment/insurance options are accepted for telebehavioral health services that are provided by your practice/organization?
- Cash or Self-Payment
 - Private Health Insurance
 - Medicaid
 - Medicare
 - Public Health Insurance
 - Other Government Insurance
 - Service Contract Arrangement
 - Other: _____
21. Is there payment assistance available for telebehavioral health services provided by your practice/organization? If yes, please explain.
- Yes: _____
 - No

Receivers of Substance Abuse and/or Mental Health Telebehavioral Health Services:

Please answer the following questions about telebehavioral health services that your practice/organization **receives**.

Receiving telebehavioral health services refers to the practice/organization that hosts the client/patient that receives the clinical telebehavioral health intervention.

22. What populations, within your practice/organization, receive treatment through telebehavioral health services? Please check all that apply.
- Children/Adolescents (Age 17 and Under)
 - Young Adults (Ages 18 – 25)
 - Adults (Ages 26 – 64)
 - Seniors (Ages 65 and Older)

- Veterans
 - American Indians
23. What type of practitioner(s) provides the telebehavioral health services to your clients/patients? Please check all that apply.
- Non-Psychiatric Physician(s)
 - Psychiatrist(s)
 - Psychologist(s)
 - Advanced Practice Registered Nurse (APRN)/Nurse Practitioner
 - Physician Assistant (PA)
 - Licensed Addiction Counselor (LAC)
 - Licensed Independent Clinical Social Worker (LICSW)
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapists (LMFT)
 - Other: _____
24. Are the behavioral health professionals providing telebehavioral health services for your practice/organization:
- Employed
 - Contracted
 - Other: _____
25. How many years has your practice/organization received telebehavioral health services?
- Less than 1 year
 - 1-3 years
 - 3-5 years
 - 5 years or more
26. Please list the practice/organization name, city, and state currently providing telebehavioral health services to your clients/patients.
27. Does your practice/organization receive emergency telebehavioral health services? Emergency telebehavioral health services refers to the provision of behavioral health services using electronic communication, video conferencing (i.e., telephone, the internet, smartphone, tablet, a PC desktop system, etc.), or other secure interactive communication technology for clients/patients who present to an emergency department or urgent care and are identified as having a behavioral health crisis that may present a danger to themselves or others and are in need of immediate assistance.
- Yes
 - No
28. From what type of practice/organization do you receive telebehavioral health services?
- Clinic
 - Community Health Center
 - Hospital without Psychiatric Unit
 - Psychiatric Hospital

- Psychiatric Unit of a Non-Psychiatric Hospital
 - Residential Treatment Center
 - Other Residential Treatment Facility
 - Partial Hospitalization/Day Treatment
 - Outpatient Mental Health Facility
 - Human Service Center
 - Multi-setting Mental Health Facility
 - Substance Use Treatment Facility
 - Local Public Health Unit/Department
 - Long-Term Care Facility
 - Social Services
 - Other: _____
29. Please list the practice/organization name and city of the location(s) (North Dakota only) currently receiving telebehavioral health services.
30. How many days per week (in total) does your practice/organization receive telebehavioral health services?
31. How many hours per day (in total) does your practice/organization receive telebehavioral health services?
32. How many patients (in total) does your practice/organization receive telebehavioral health services from each month?
33. On average, how long does it take for clients/patients to get an appointment for telebehavioral health services?
34. In what type of facility are the clients/patients that receive telebehavioral health services being seen? Please check all that apply.
- Hospital – Inpatient Setting
 - Residential Treatment Setting
 - Partial Hospitalization/Day Treatment
 - Outpatient Setting
 - Corrections
 - Long-Term Care
 - Substance Use Disorder Treatment Facility
 - Public Health Unit/Department
 - Home
 - Other: _____
35. What technology does your practice/organization use to receive telebehavioral health services?
- Remote Patient Monitoring
 - Live Video
 - Store and Forward
 - Mobile

- Other: _____
36. What payment/insurance options are accepted for telebehavioral health services that are received by your practice/organization?
- Cash or Self-Payment
 - Private Health Insurance
 - Medicaid
 - Medicare
 - Public Health Insurance
 - Other Government Insurance
 - Service Contract Arrangement
 - Other: _____
37. Is there payment assistance available for telebehavioral health services received by your practice/organization? If yes, please explain.
- Yes: _____
 - No

Do Not Provide or Receive Telebehavioral Health Services:

38. If your practice currently does not provide or receive telebehavioral health services, do you plan to in the future?
- Yes, we plan to provide services
 - Yes, we plan to receive services
 - Yes, we plan to provide and receive services
 - No
39. If you do not currently provide or receive telebehavioral health services, what are the primary challenges or barriers for not doing so? Please check all that apply.
- Lack of behavioral health providers
 - Equipment and staff costs
 - Providers and other health professional staff learning, utilizing, and keeping current on the equipment/technology
 - IT staff not familiar with equipment/telehealth technology
 - Inadequate technology and connectivity issues
 - Difficult to implement and sustain
 - Provider acceptance, still considered experimental
 - Client/Patient acceptance of receiving behavioral health services using telehealth
 - Lack of clear, standardized regulatory guidelines
 - Privacy and security concerns
 - Telebehavioral health services are reimbursed at a lower rate than in-person or not at all
 - Our practice/organization is able to meet the needs with in-house/local behavioral health providers
 - Other: _____

Appendix G: Center for Rural Health Report – North
Dakota Survey of Behavioral Health Workforce
Interventions



Center *for* Rural Health

Impact and Likelihood of Behavioral Health Workforce Interventions

Results of the North Dakota Survey of Behavioral Health Stakeholders

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Introduction

In December 2017, the Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences conducted a survey assessing the impact and likelihood of 16 behavioral health workforce interventions. All North Dakota behavioral health stakeholders were invited to participate in the electronic survey; 284 completed the assessment. Respondents represented advocates, licensed providers, and urban and rural stakeholders. This survey was funded by the North Dakota Department of Human Services (DHS) and is part of a larger effort to identify key recommendations for the state, along with a detailed implementation plan to improve access to behavioral health services through workforce development.

Key Findings

- On average, 11 of the 16 proposed interventions were perceived to have a good or great impact on increasing the behavioral health workforce in North Dakota.
- On average, no intervention was perceived as likely to be implemented in North Dakota within the next two years.
- Tuition assistance for behavioral health students was perceived as having the greatest impact on increasing the behavioral health workforce.
- There was no variable trend in perceived likelihood or impact between rural and urban stakeholders.
- A larger percentage of those not licensed in behavioral health perceived the interventions as having good or great impact compared to those with licenses.
- For nearly all interventions, a greater percentage of those in administrative, programmatic, or advocacy roles perceived the interventions as likely compared to those providing direct clinical care.
- It may be that those who are licensed and providing direct care services are aware of the barriers and previous efforts to increase workforce, and therefore, they were less likely to identify each intervention as likely or having a significant impact.

Research staff identified the behavioral health workforce interventions with overlapping priorities and those with both a higher average impact and likelihood score. North Dakota stakeholders will continue discussion around, and develop implementation plans for:

Three North Dakota Behavioral Health Workforce Priorities

1. Pipeline interventions for behavioral health students
2. Telebehavioral health interventions
3. Interventions related to licensure requirements and regulatory guidelines

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Background

In September 2016, the North Dakota DHS issued the report *Behavioral Health Assessment: Gaps and Recommendations*.¹ Tasked with identifying the priority recommendations to enhance the state's behavioral health system, this report addressed the system of behavioral health services, including workforce. Although the report discussed the broader issues surrounding access and utilization of services, the gaps regarding workforce centered around credentialing, certification, and licensure; no single tracking or reporting registry for behavioral health professionals; a limited workforce trained in evidence-based services; and, inadequate funding and reimbursement to sustain the existing workforce. This report was compiled using the 2014 resource by Schulte Consulting titled *Behavioral Health Planning Final Report*.² The Schulte report discussed the larger behavioral health system in North Dakota. However regarding workforce, the report indicated that the state must: expand the workforce; address licensing concerns and create a standard registry for all behavioral health providers; increase the use of lay persons (to include peers and family members) in expanding treatment options; address reciprocity language to encourage out-of-state providers to open practice in North Dakota; increase behavioral health training among law enforcement, primary care providers, and educators; and ensure that the licensing/certification requirements for each provider type is addressed in the educational requirements for the respective professions. The survey employed by the CRH included all workforce recommendations from previous reports and was developed in concert with Human Services Research Institute, which is preparing the report, *North Dakota Behavioral Health System Study*.³ This report addresses systemic changes that must occur for the state to adequately address the behavioral health needs originally identified in the 2016 DHS report.

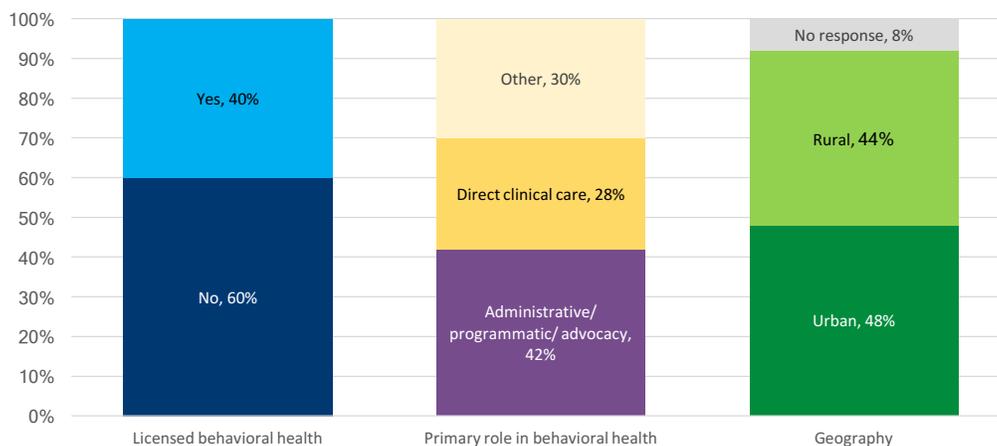
Methods

Utilizing previous reports and behavioral health workforce stakeholder recommendations, the CRH research team developed a survey to identify stakeholders' perceived impact and likelihood of 16 behavioral health workforce interventions. The research team sent the electronic survey and the invitation to participate to all behavioral health stakeholders on an existing listserv and to each behavioral health licensing board. The invitation encouraged recipients to share the survey with other interested parties, employing a snowball sampling technique. North Dakota DHS also disseminated the survey to each regional director and encouraged them to share the invitation with all providers. The survey was open from November 27, 2017, through December 15, 2017, and was approved by the University of North Dakota's Institutional Research Board.

Results

In total, 284 individuals completed the survey. Among those who responded, 40% were licensed behavioral health providers (60% were not). There was representation for both rural and urban communities as well as individuals who provided direct clinical care, those who worked in behavioral health as advocates, program leads, or administrators, and other stakeholders. See Figure 1.

Figure 1. North Dakota Behavioral Health Stakeholder Demographics, December 2017



Participants were asked to identify the impact each intervention would have on increasing the available behavioral health workforce in North Dakota. Response options included: no impact (1); fair impact (2); good impact (3); and, great impact (4). Additionally, they identified how likely it was that each workforce intervention could be implemented within two years. Response options included: very unlikely (1); unlikely (2); somewhat unlikely (3); somewhat likely (4); likely (5); and, very

likely (6). On average, a majority (11/16) of the interventions were perceived to have a good or great impact (score of three or higher). However, on average no intervention was rated likely (five or higher). See Table 1. A full description of each intervention as it appeared in the survey may be found in Appendix A.

Table 1. Average Likelihood and Impact of Each Behavioral Health Workforce Intervention

Intervention	Mean Impact ^a (1-4)	Impact Rank	Mean Likelihood ^b (1-6)	Likelihood Rank
Tuition assistance for behavioral health students	3.34	1	3.18	15
Provide financial assistance to facilities/providers to secure equipment and staff	3.29	2	3.56	10
Establish behavioral health licensure reciprocity with bordering states	3.27	3	3.56	9
Development and implementation of a behavioral health coordinator	3.27	4	3.33	13
Integrate behavioral health prevention screenings	3.24	5	3.69	4
Increase practices/organizations receiving telebehavioral health services	3.16	6	3.68	5
Increase practices/organizations providing telebehavioral health services	3.16	7	3.74	1
Increase utilization of telebehavioral health services for emergency behavioral health	3.15	8	3.55	11
Provide opportunities for, and require, behavioral health training	3.14	9	3.60	8
Review ND state licensure requirements for all behavioral health provider types	3.12	10	3.72	3
Development, training, credentialing, and utilization of peer support specialists in ND	3.05	11	3.53	12
Review the State Loan Repayment Program (SLRP)	2.98	12	3.17	16
Educate behavioral health providers on benefits of student internships and rotations	2.96	13	3.67	6
Need to develop clear, standardized regulatory guidelines	2.91	14	3.73	2
Develop a single electronic database of available statewide vacancies for all professional behavioral health provider types	2.76	15	3.65	7
Establish a central, coordinating body responsible for supporting behavioral health workforce implementation	2.73	16	3.32	14
a. 1 = No impact, 2 = Fair impact, 3 = Good impact, 4 = Great impact				
b. 1 = Very unlikely, 2 = Unlikely, 3 = Somewhat unlikely, 4 = Somewhat likely, 5 = Likely, 6 = Very likely				

Licensed and Direct Care Providers Perceived Impact and Likelihood

While a majority of the proposed interventions (11/16) were identified on average to have a good or great impact on improving the access to behavioral health services, there was variation between those licensed and providing direct care and those who were not licensed and working in programs, administration, or advocacy. A smaller percentage of respondents who were licensed in behavioral health services rated the interventions as having a good/great impact when compared to those who did not hold a license in behavioral health services. See Figures 2-17. Similarly, a larger percentage of those who worked in advocacy, administration, or programs perceived the interventions as likely when compared to those providing direct care. See Figures 18-33.

It may be that those who are licensed and providing direct care services are aware of the barriers and previous efforts to increase workforce, and therefore, they were less likely to identify each intervention as likely or having a significant impact.

Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure

Figure 2. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Tuition Assistance for Behavioral Health Students

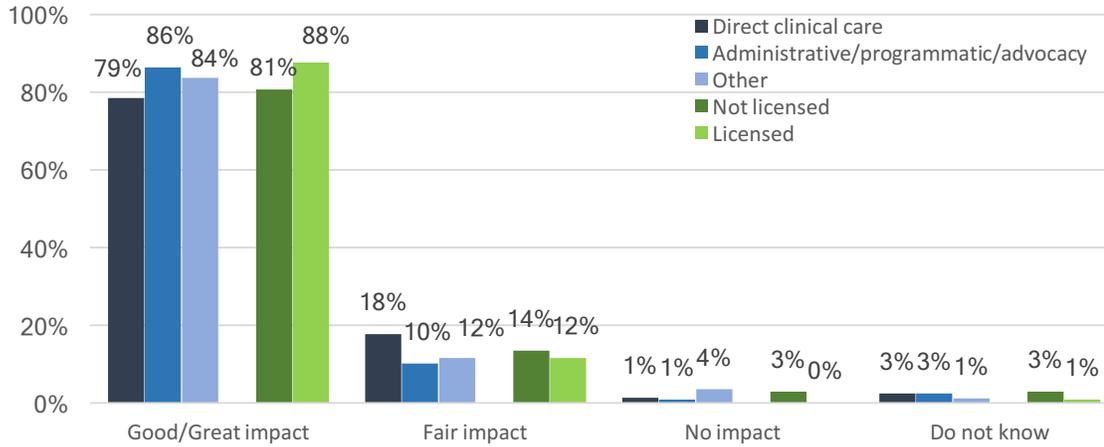


Figure 3. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Provide Financial Assistance to Facilities/Providers to Secure Equipment and Staff

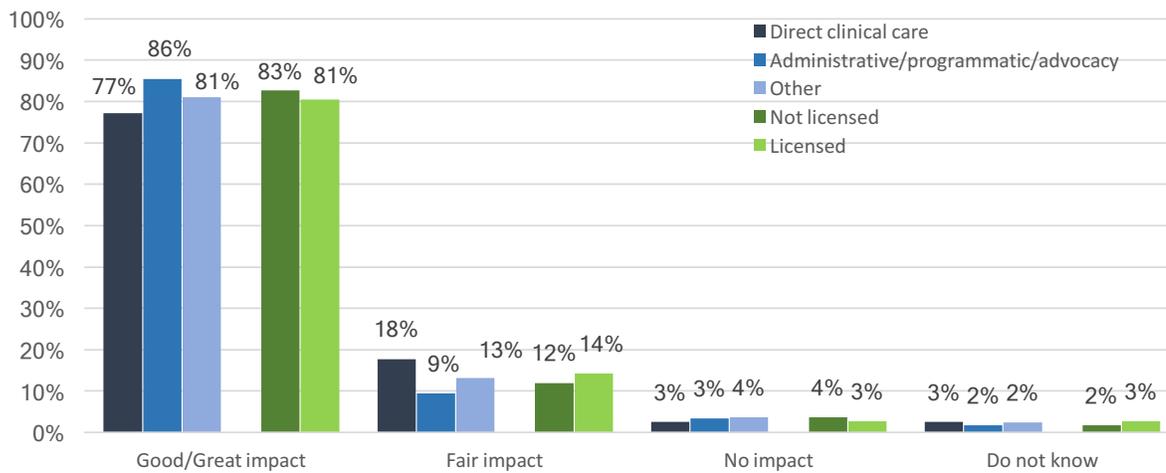


Figure 4. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Establish Behavioral Health Licensure Reciprocity with Bordering States

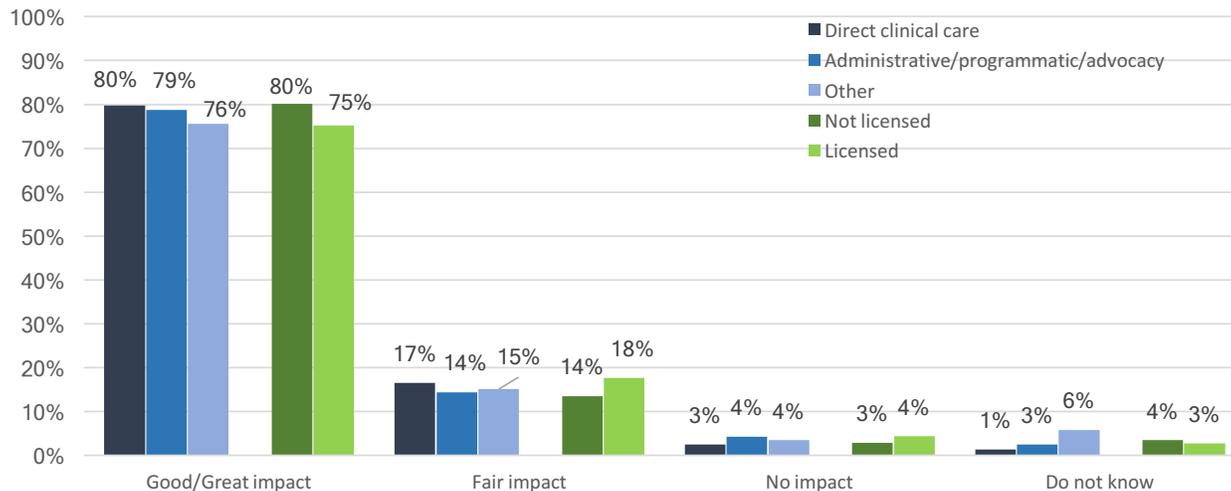


Figure 5. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Development and Implementation of a Behavioral Health Coordinator

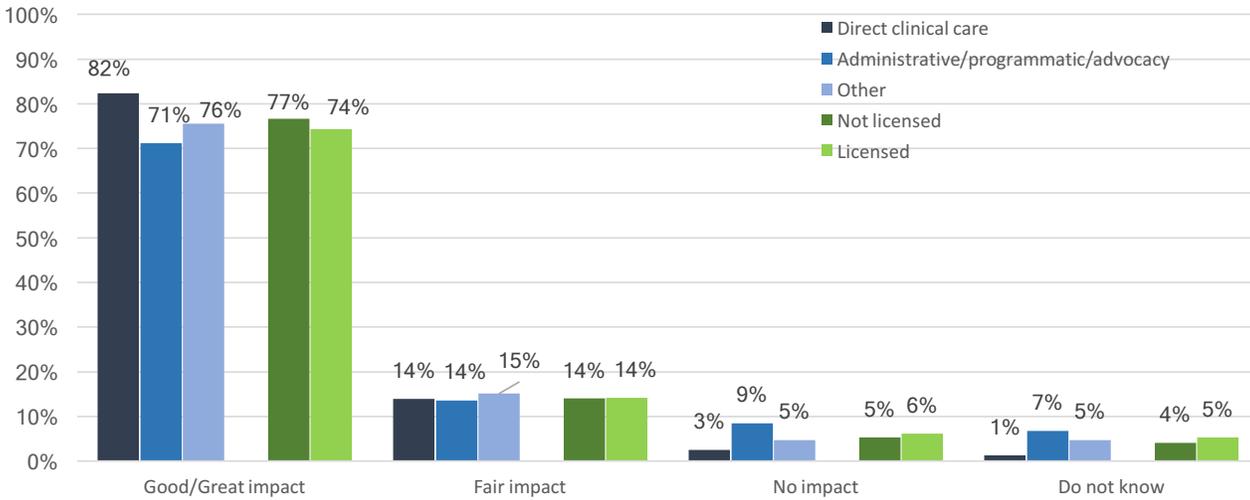


Figure 6. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Integrate Behavioral Health Prevention Screenings

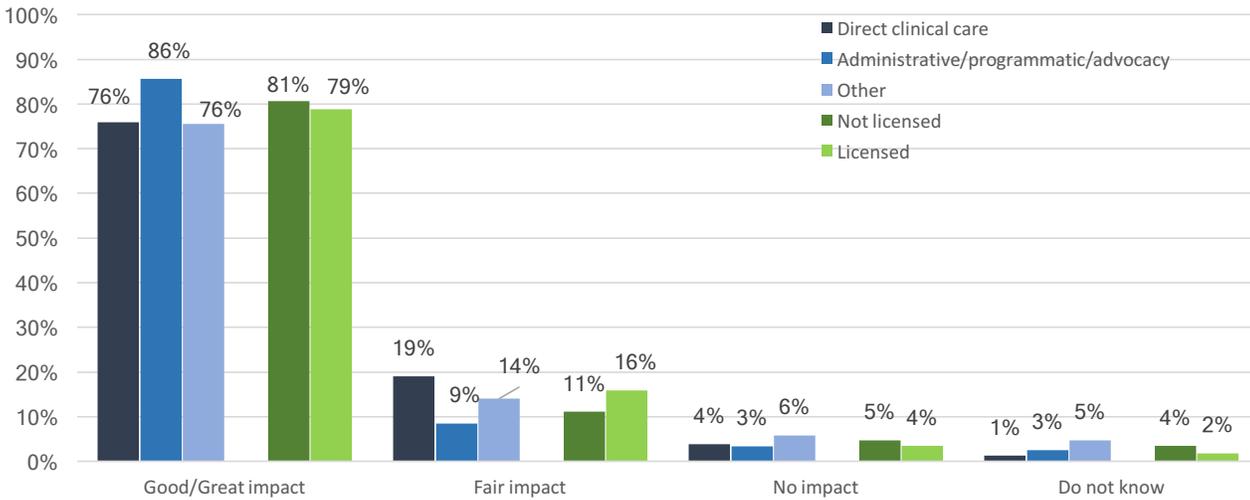


Figure 7. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Increase Practices/Organizations Receiving Telebehavioral Health Services

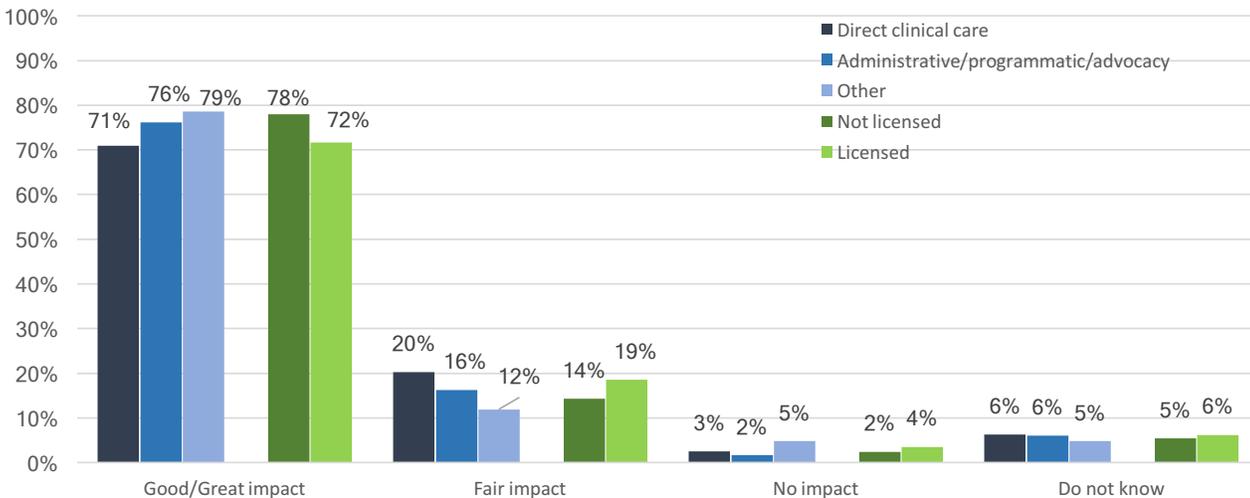


Figure 8. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Increase Practices/Organizations Providing Telebehavioral Health Services

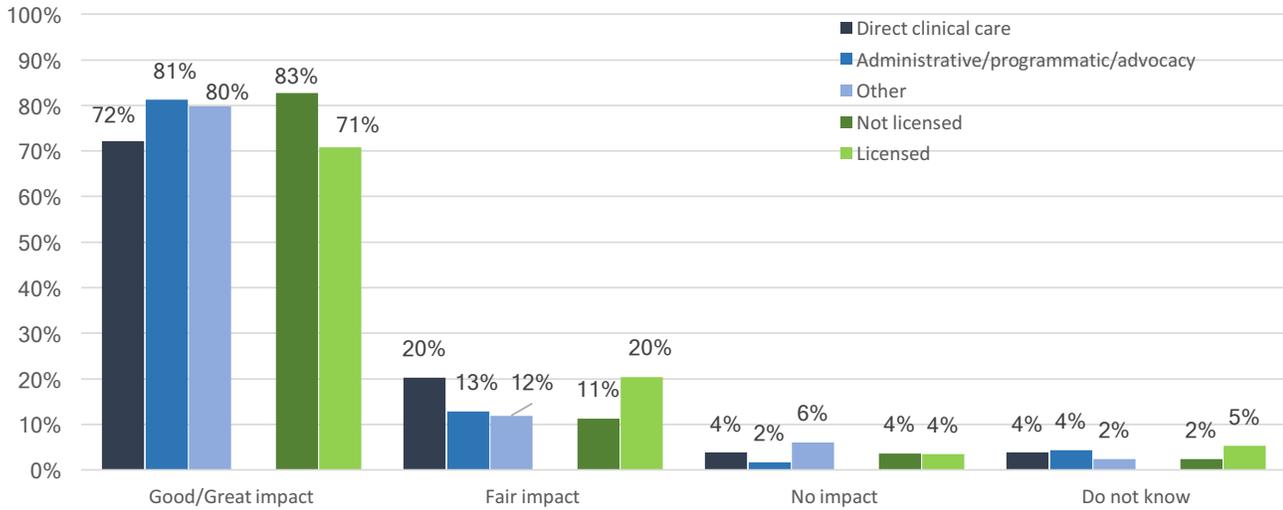


Figure 9. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Increase Utilization of Telebehavioral Health Services for Emergency Behavioral Health

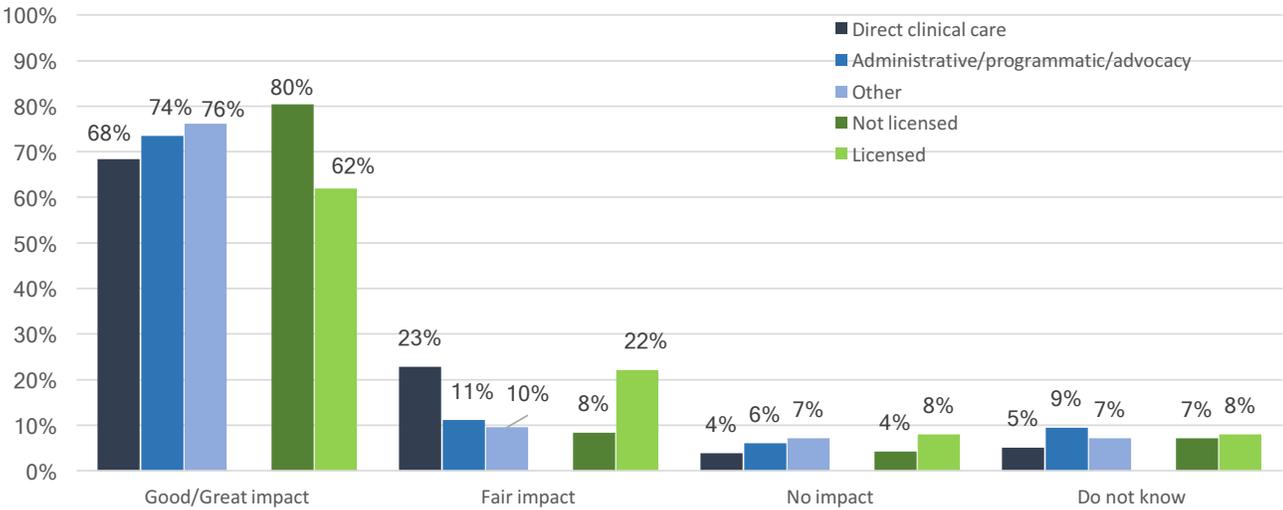


Figure 10. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Provide Opportunities for, and Require, Behavioral Health Training

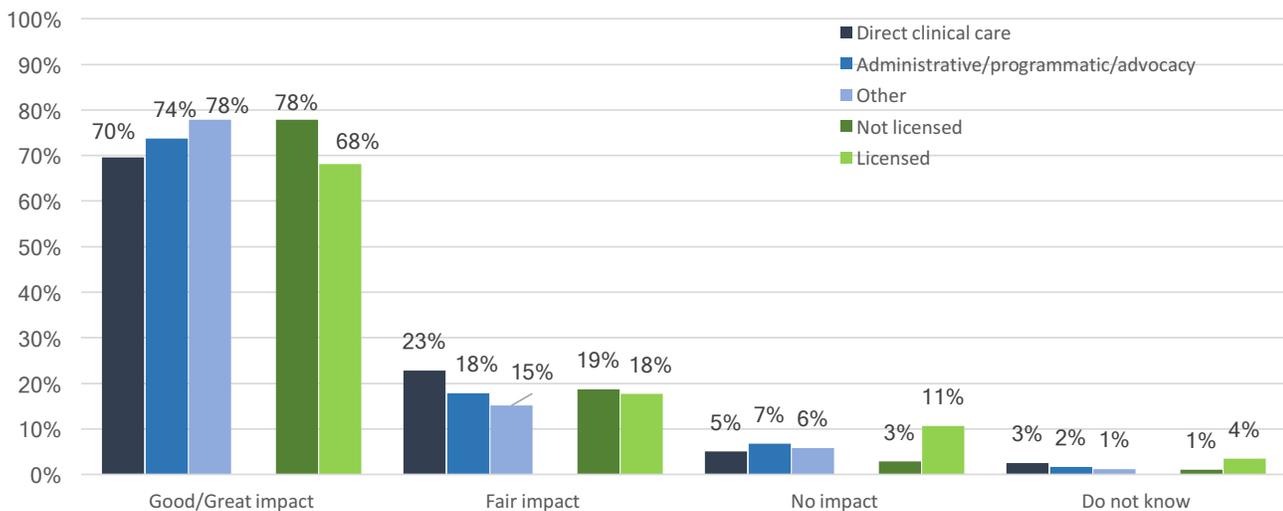


Figure 11. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Review ND State Licensure Requirements for all Behavioral Health Provider Types

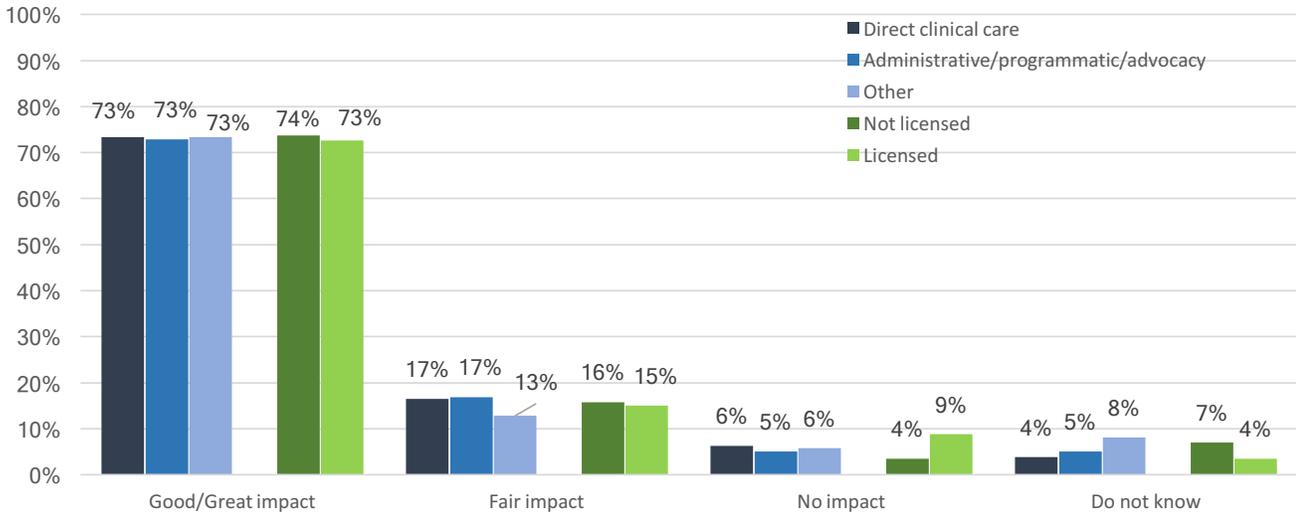


Figure 12. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Development, Training, Credentialing, and Utilization of Peer Support Specialists in ND

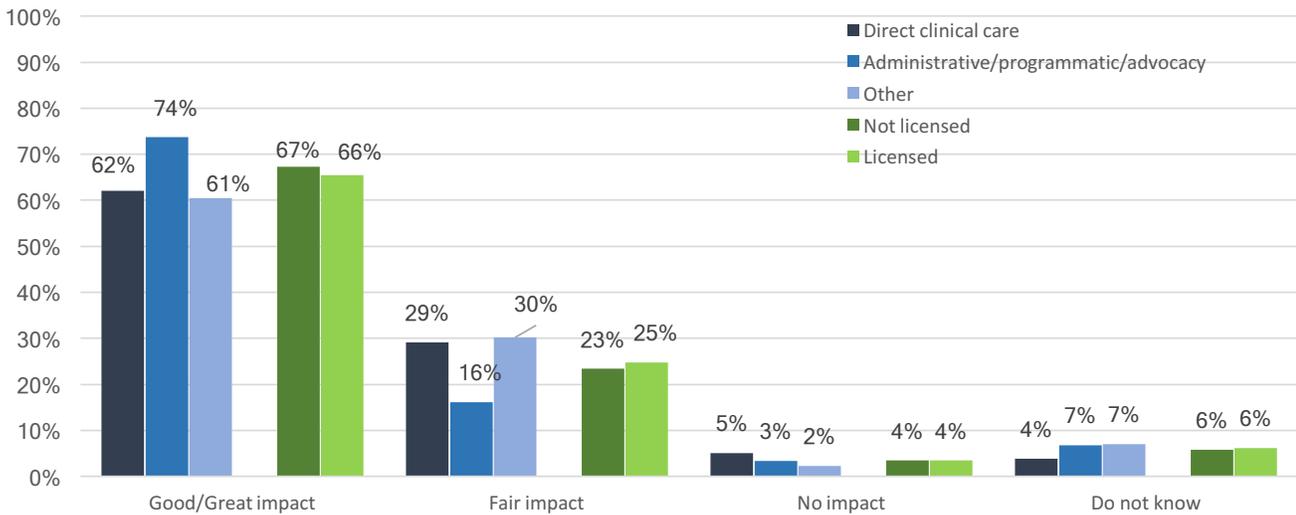


Figure 13. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Review the State Loan Repayment Program

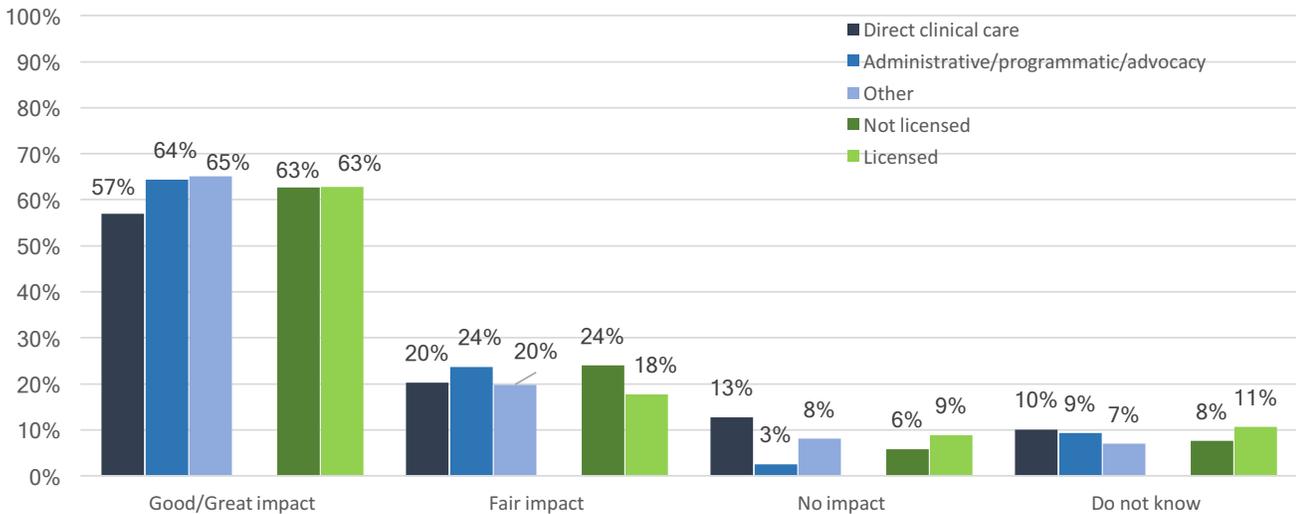


Figure 14. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Educate Behavioral Health Providers on Benefits of Student Internships and Rotations

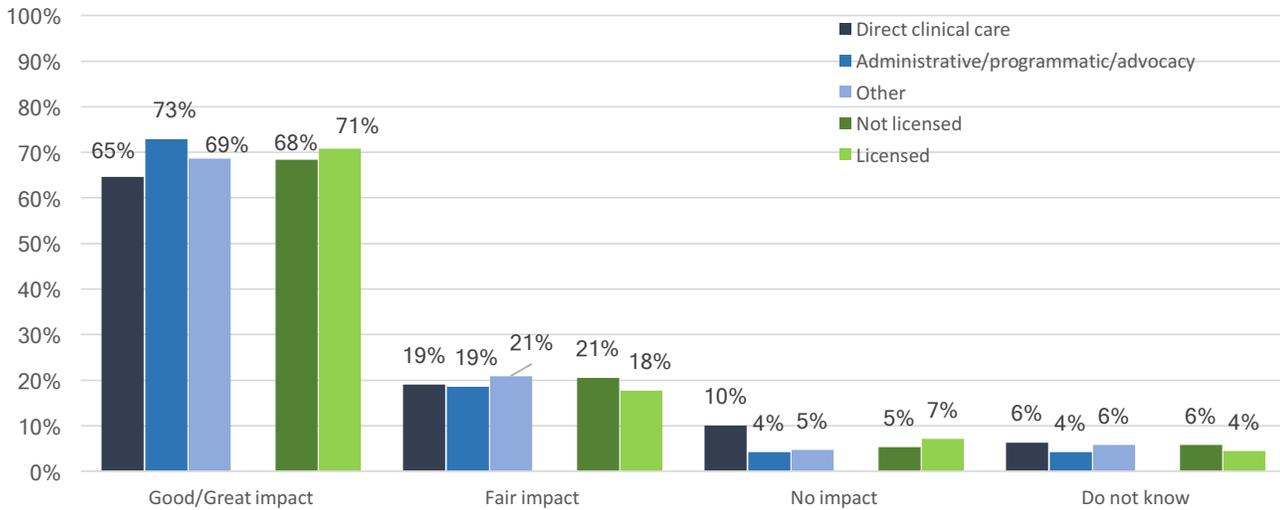


Figure 15. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Need to Develop Clear, Standardized Regulatory Guidelines

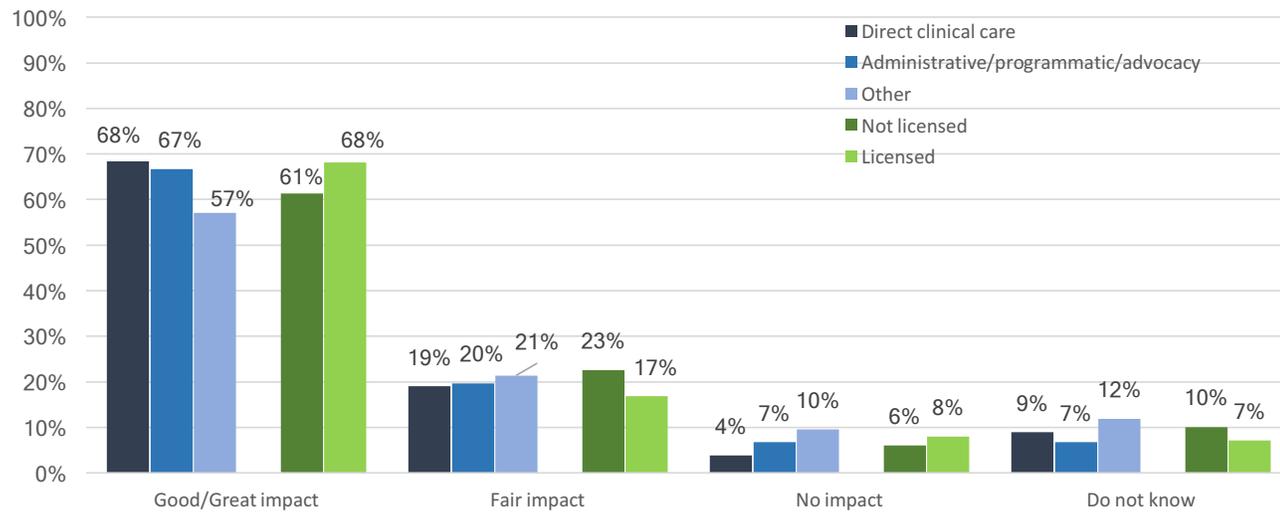


Figure 16. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Develop a Single Electronic Database of Available Statewide Vacancies for all Professional Behavioral Health Provider Types

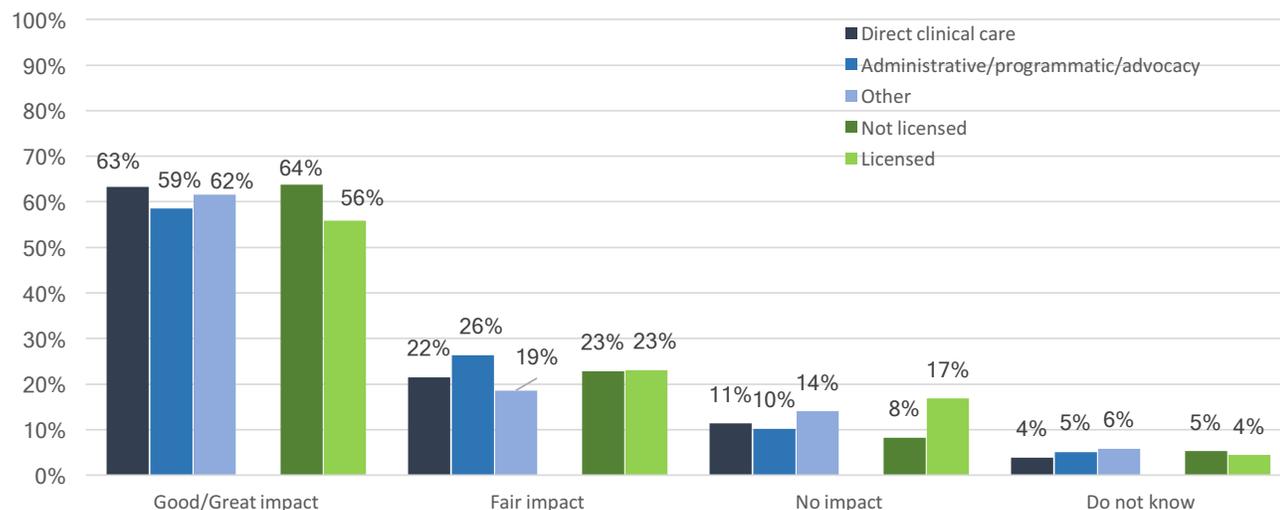
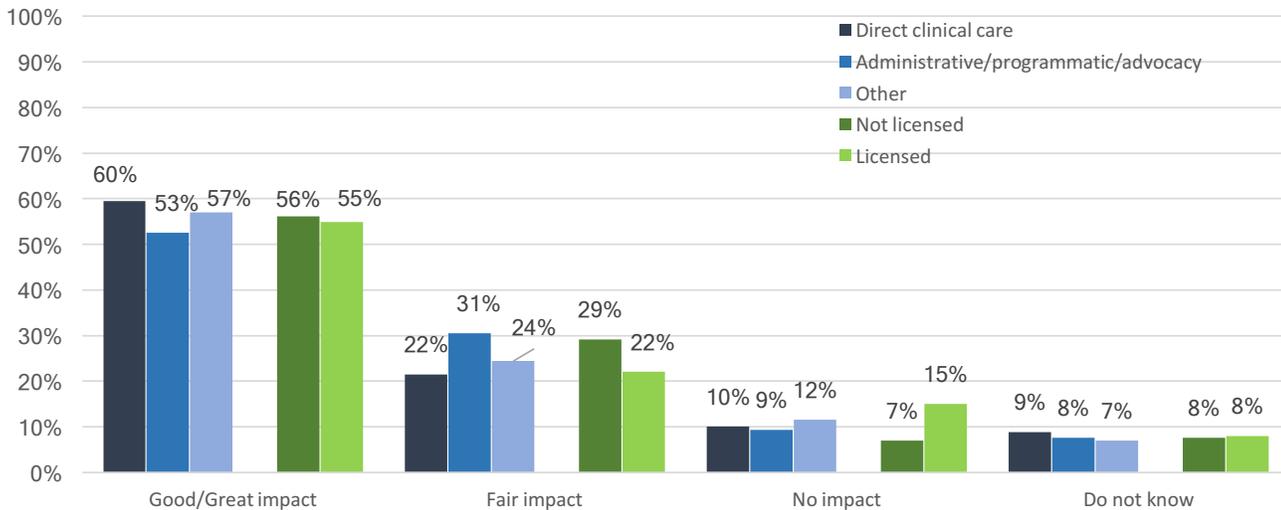


Figure 17. Perceived Impact by Stakeholders' Role in Behavioral Health and Licensure: Establish a Central Coordinating Body Responsible for Supporting Behavioral Health Workforce Implementation



Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure

On average, none of the proposed workforce interventions were identified as likely to be implemented within the next two years. However, perspectives varied between those licensed and those not licensed and those who worked in direct behavioral healthcare and those who did not. Following is a Figure for each proposed intervention, in average likelihood rank order (Table 2). The Figures present the percentage of respondents who perceived each intervention as likely (combines very likely, likely, and somewhat likely into one category), unlikely (combines very unlikely, unlikely, and somewhat unlikely into one category), or do not know.

Figure 18. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Increase Practices/Organizations Providing Telebehavioral Health Services

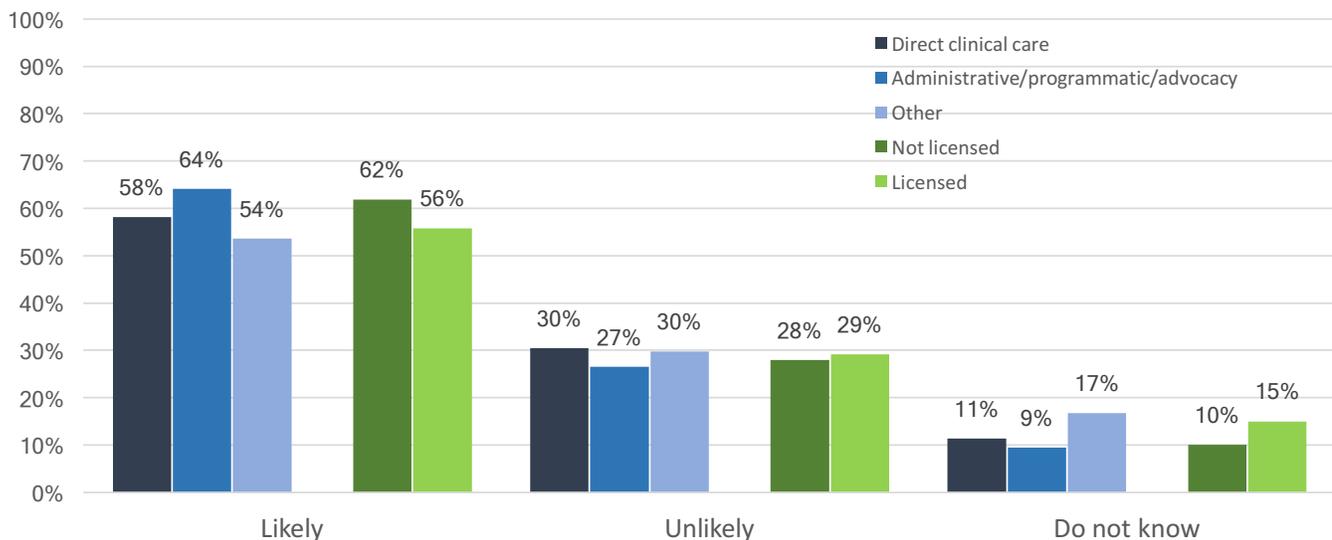


Figure 19. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Need to Develop Clear, Standardized Regulatory Guidelines

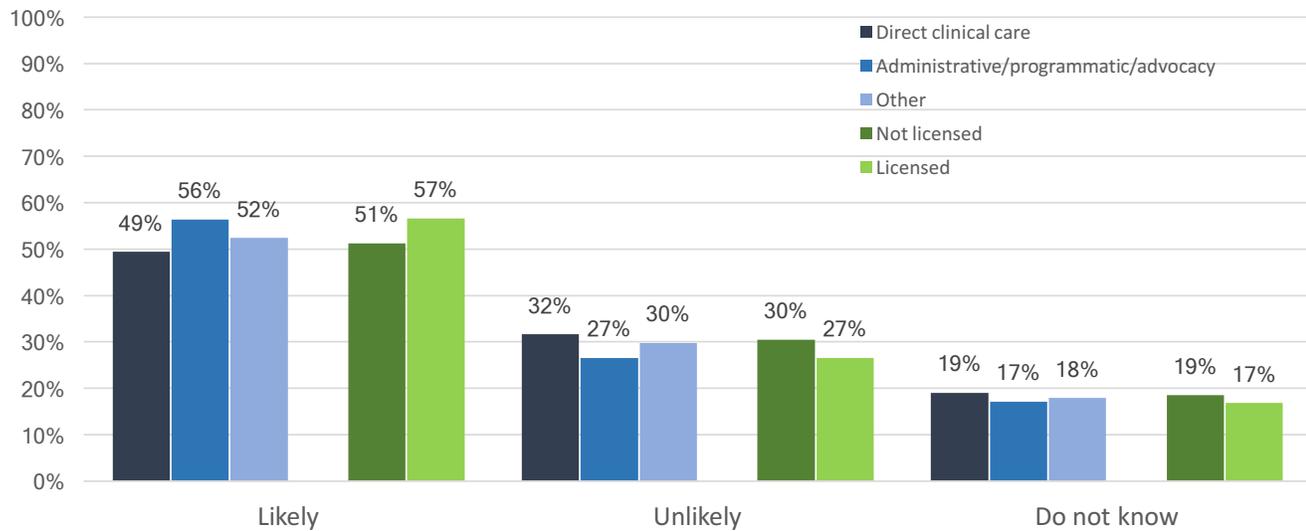


Figure 20. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Review ND State Licensure Requirements for all Behavioral Health Provider Types

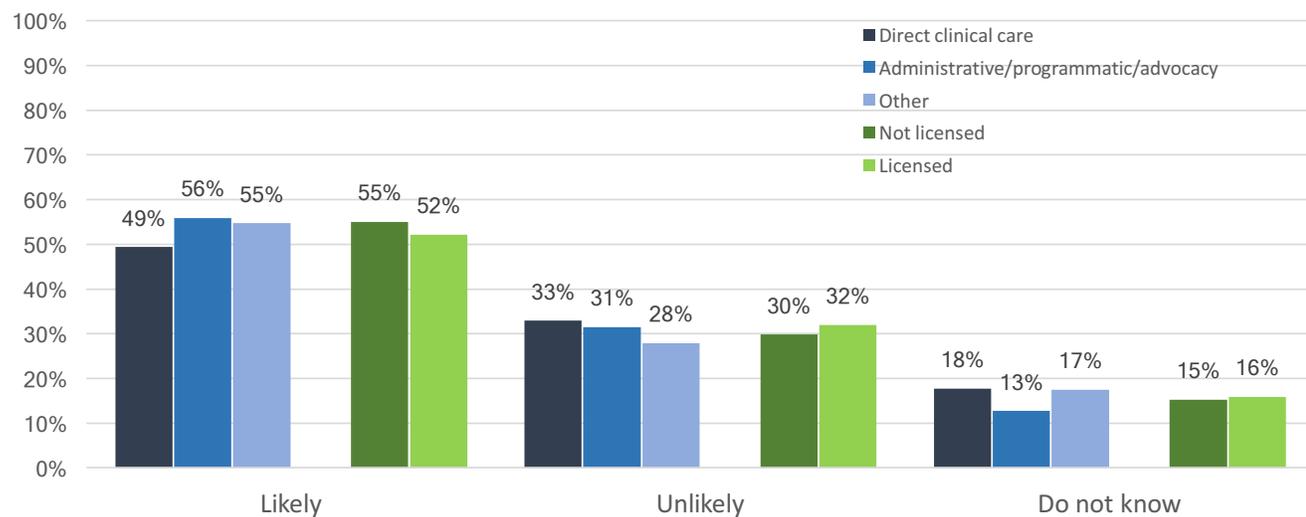


Figure 21. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Integrate Behavioral Health Prevention Screenings

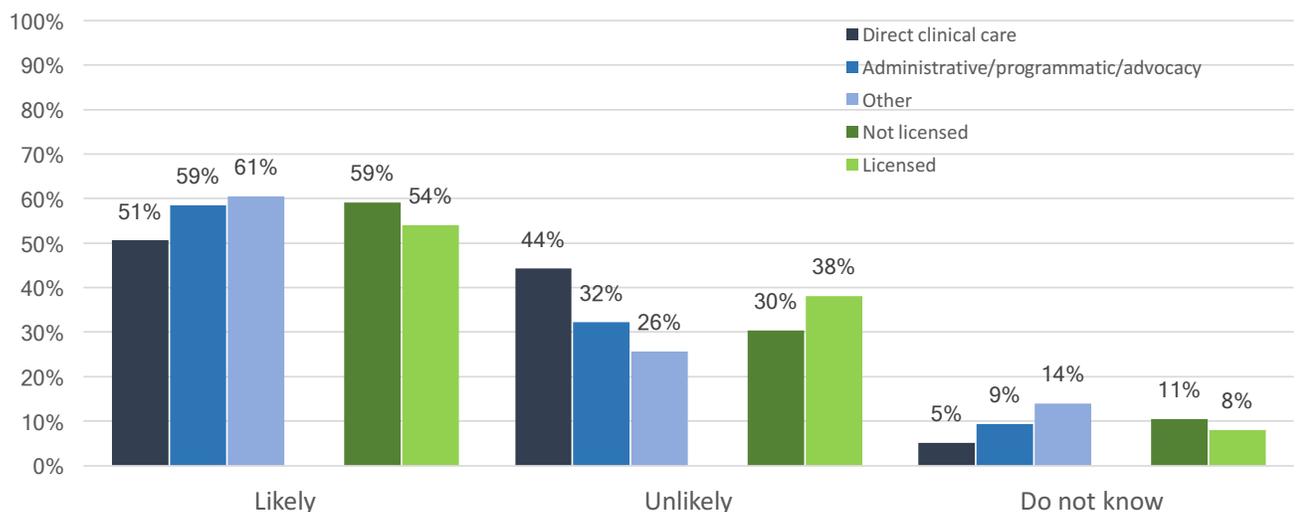


Figure 22. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Increase Practices/Organizations Receiving Telebehavioral Health Services

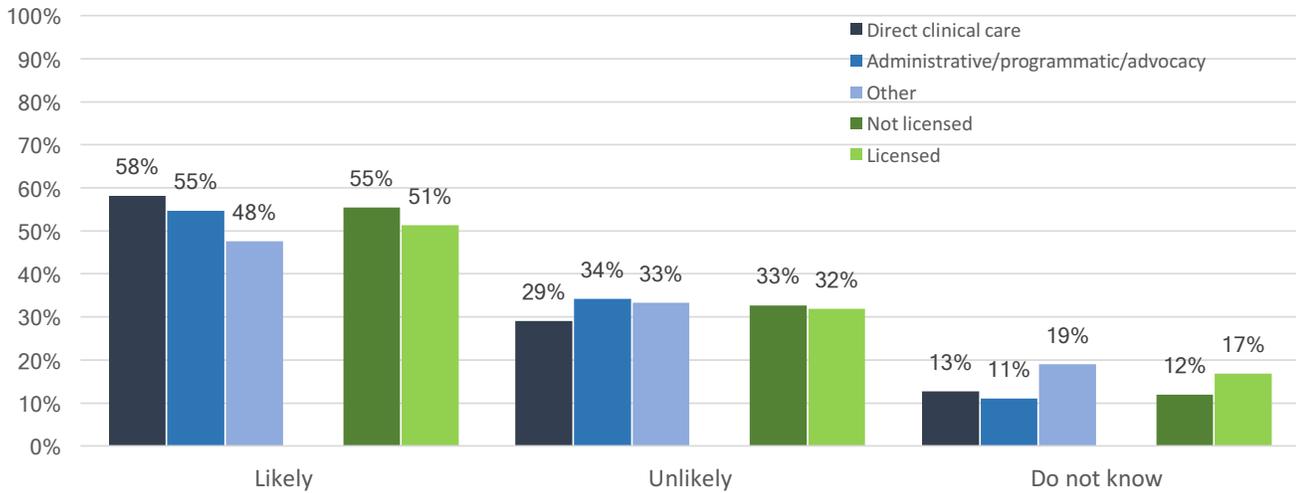


Figure 23. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Educate Behavioral Health Providers on Benefits of Student Internships and Rotations

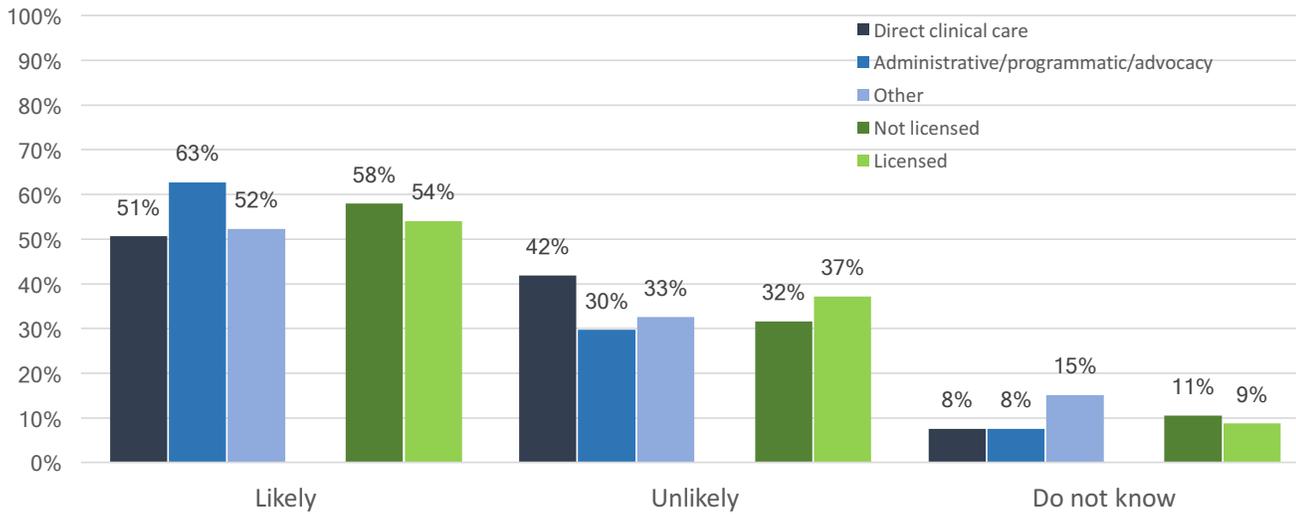


Figure 24. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Develop a Single Electronic Database of Available Statewide Vacancies for all Professional Behavioral Health Provider Types

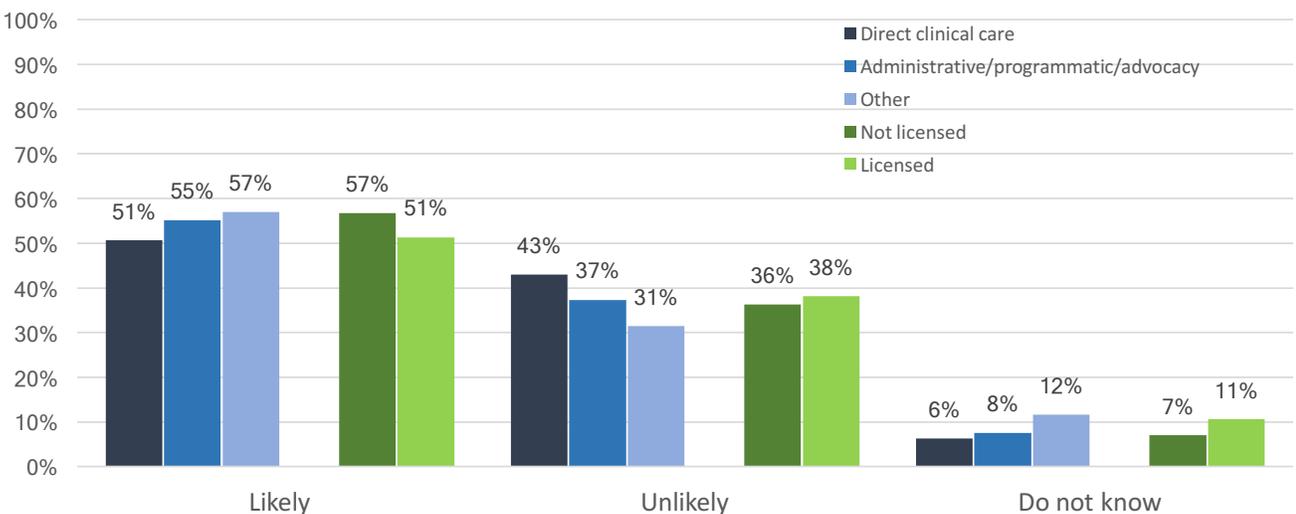


Figure 25. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Provide Opportunities for, and Require, Behavioral Health Training

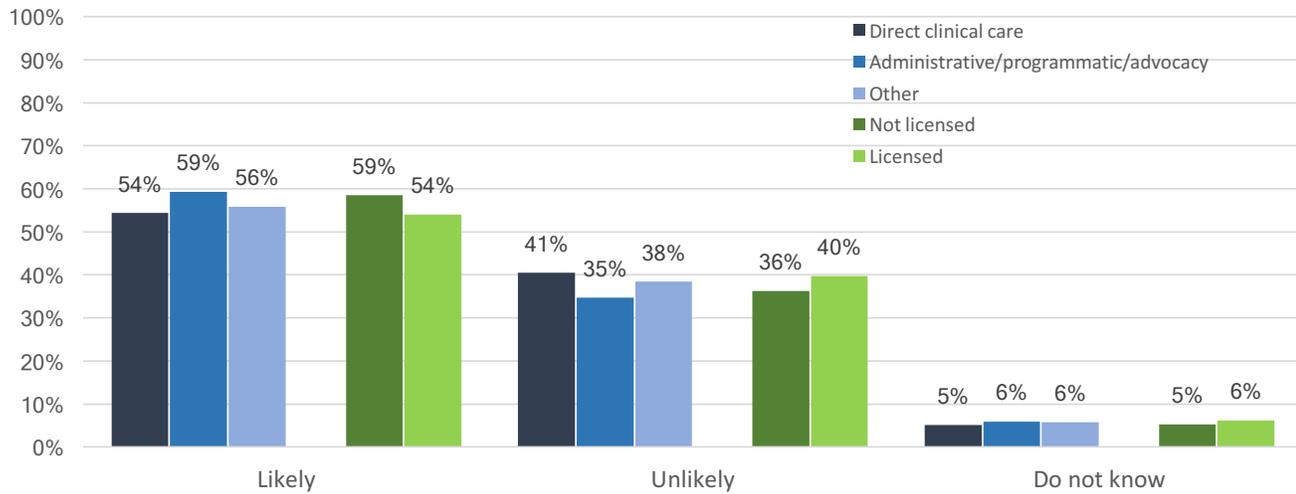


Figure 26. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Establish Behavioral Health Licensure Reciprocity with Bordering States

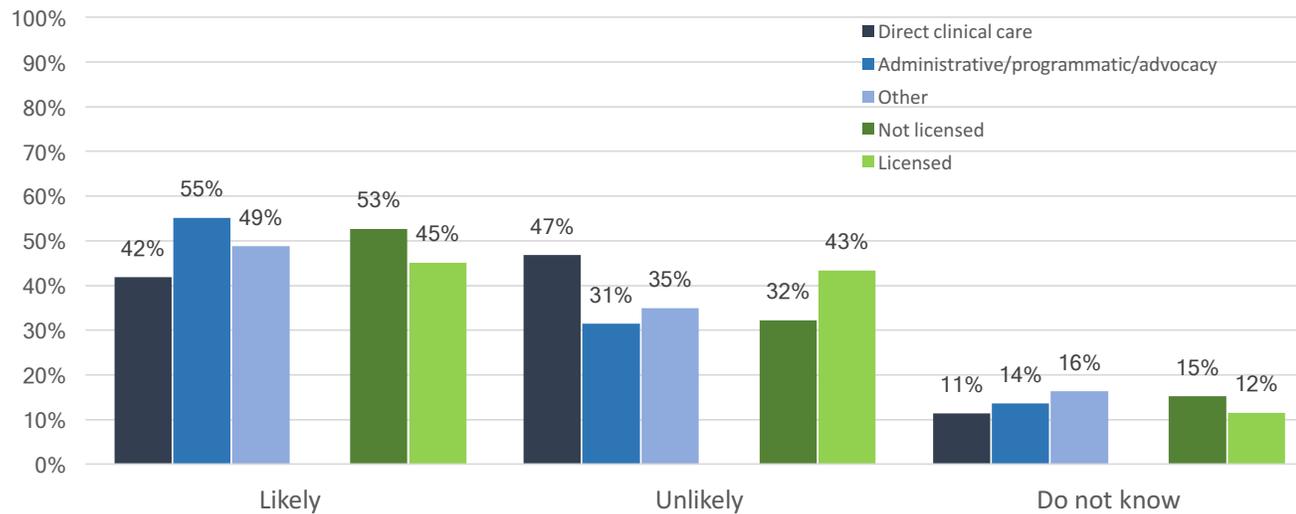


Figure 27. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Provide Financial Assistance to Facilities/Providers to Secure Equipment and Staff

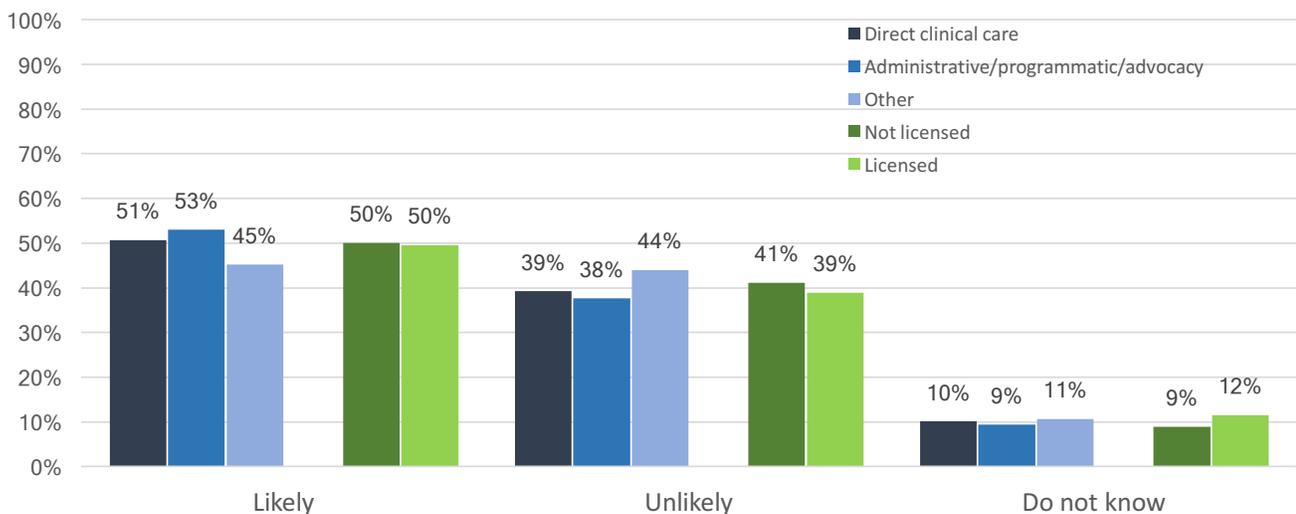


Figure 28. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Increase Utilization of Telebehavioral Health Services for Emergency Behavioral Health

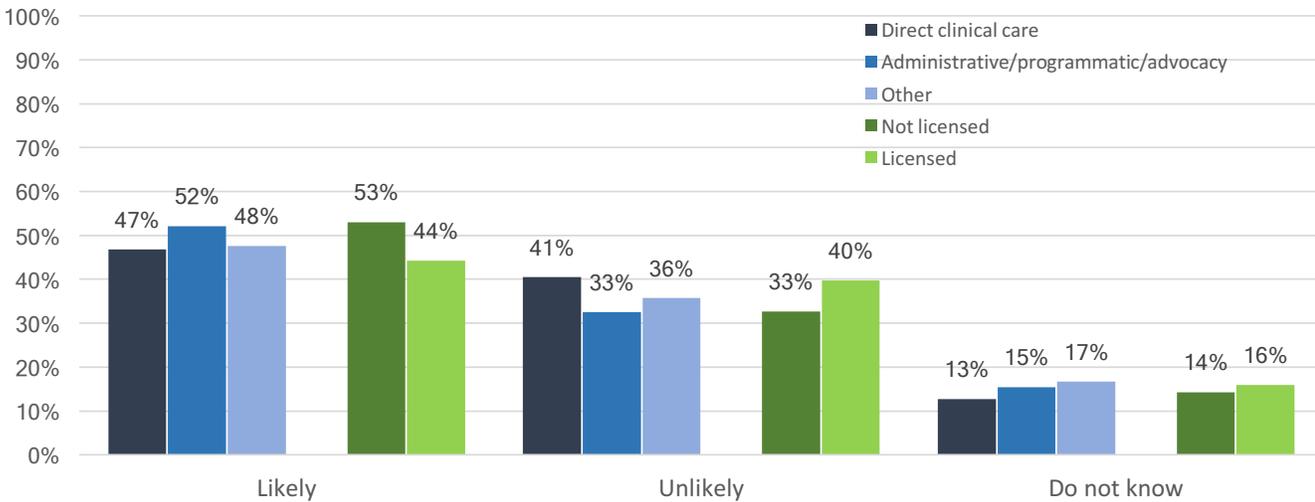


Figure 29. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Development, Training, Credentialing, and Utilization of Peer Support Specialists in ND

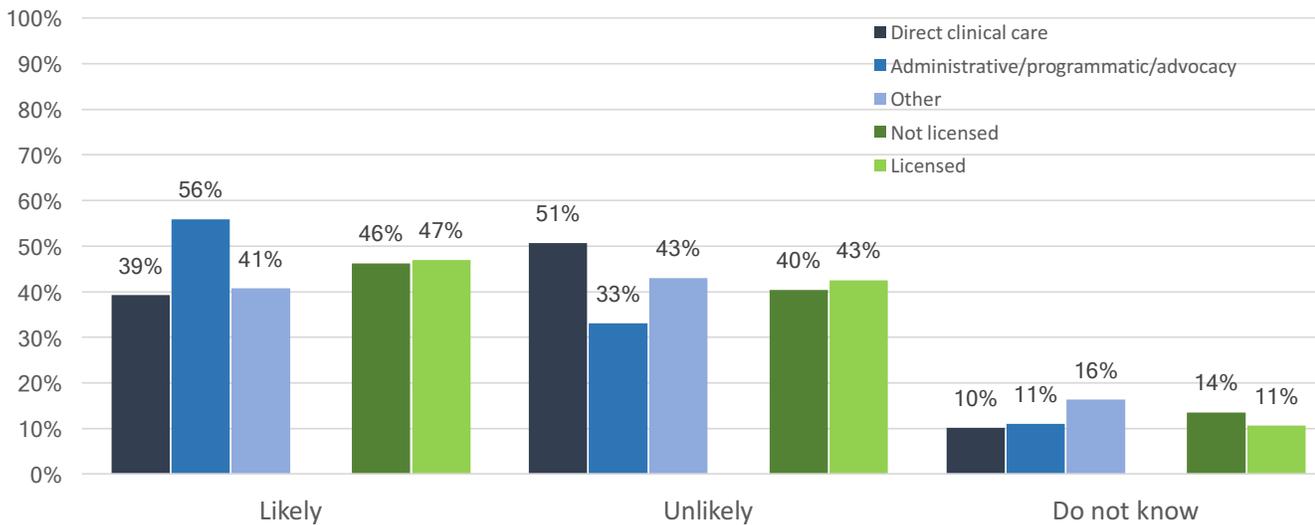


Figure 30. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Development and Implementation of a Behavioral Health Coordinator

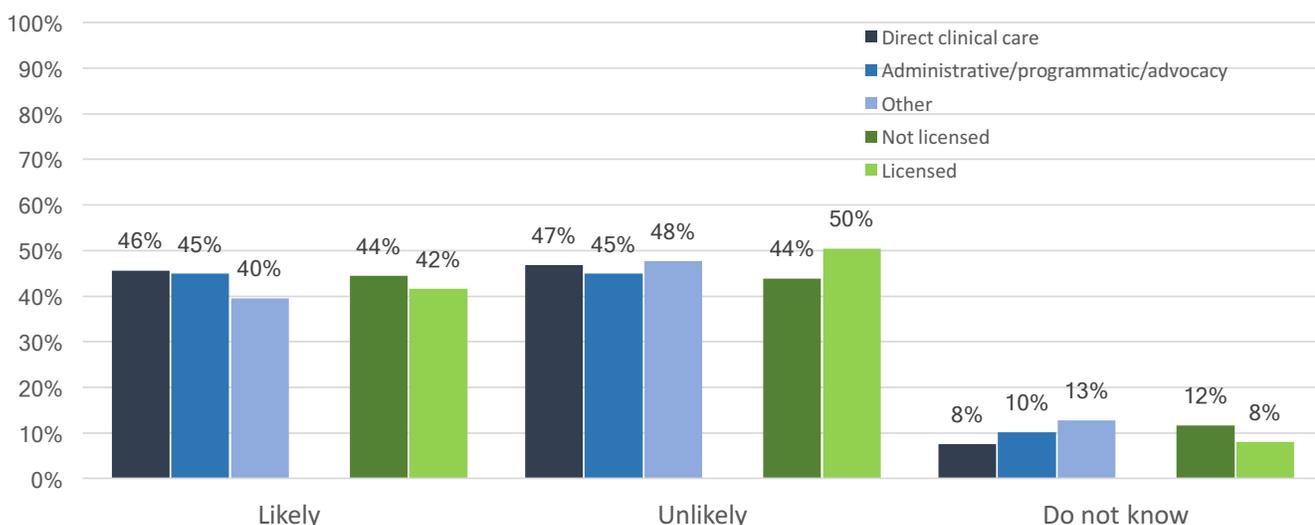


Figure 31. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Establish a Central, Coordinating Body Responsible for Supporting Behavioral Health Workforce Implementation

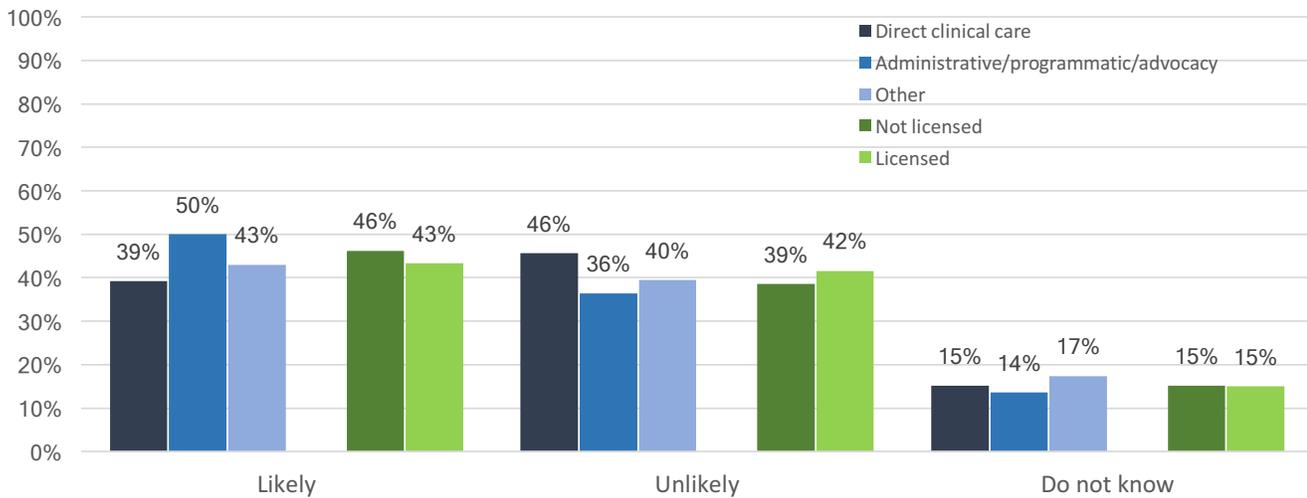


Figure 32. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Tuition Assistance for Behavioral Health Students

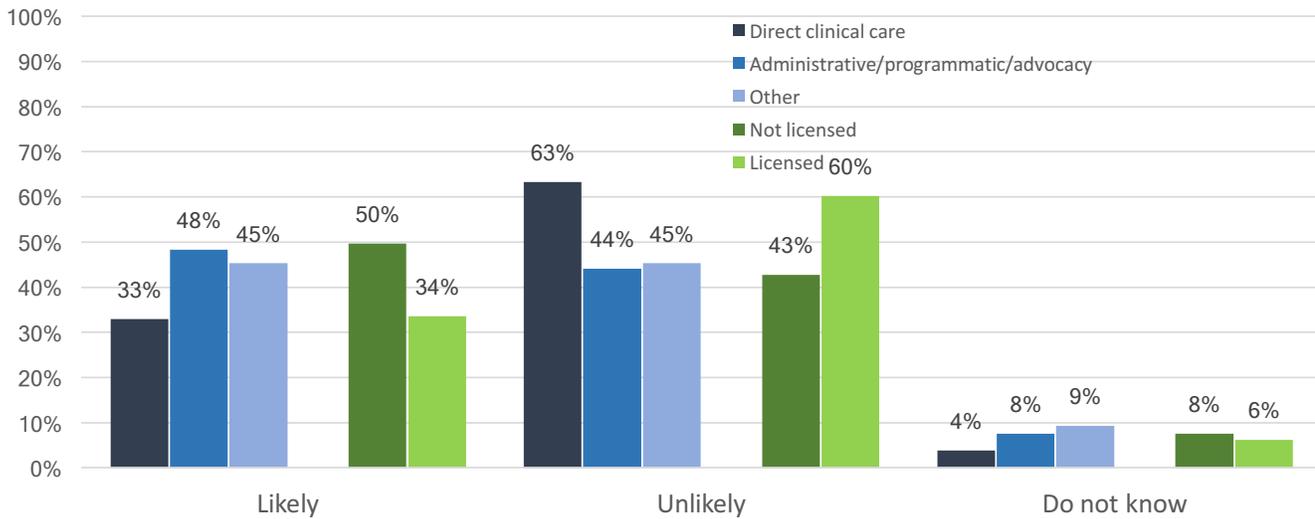
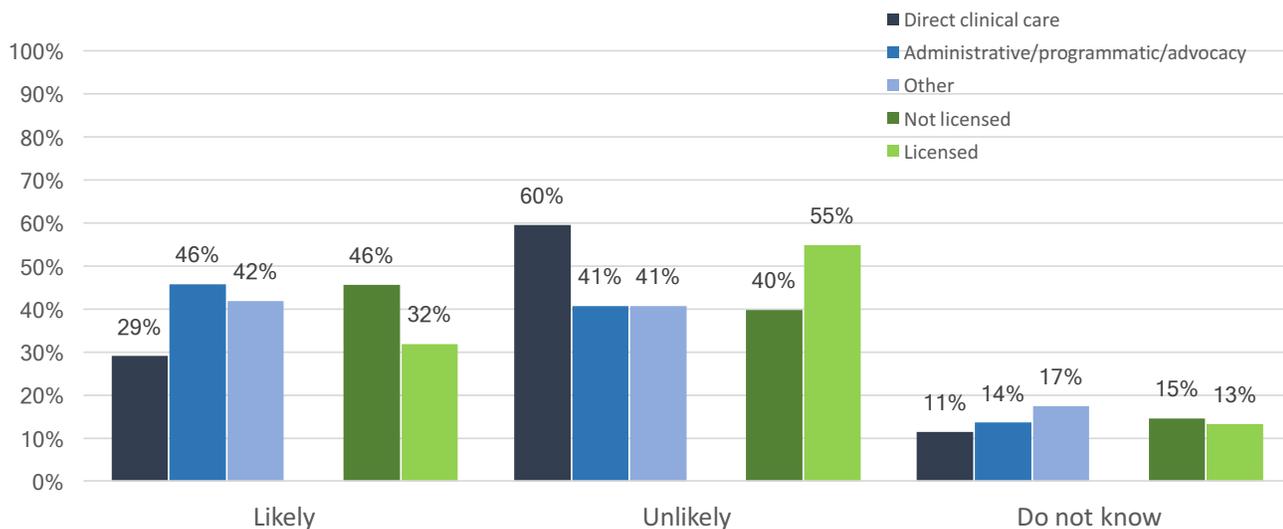


Figure 33. Perceived Likelihood by Stakeholders' Role in Behavioral Health and Licensure: Review the State Loan Repayment Program



Perceived Impact and Likelihood by Rural and Urban Communities

There was no consistent trend nor variability in perceived likelihood or impact of the proposed behavioral health workforce interventions between rural and urban stakeholders. However, that information is available in Figures formatted like those previously presented in this report. If you would like Figures comparing the rural and urban perceived likelihood and impact, please contact the CRH at 701-777-3848.

Summary

Behavioral health stakeholders were invited to rate the impact and likelihood of 16 behavioral health workforce interventions that had previously been identified by both DHS and outside consultants as areas of need for North Dakota. The intent of the survey was to identify the top three priority areas for the state – those interventions that rated high for both impact and likelihood. Staff at the CRH would then work with stakeholders and identified partners to develop concrete implementation plans for each of the three priorities. However, the survey results indicated similar and high impact for nearly all proposed interventions (11/16), and no intervention, on average, was identified as likely to be implemented within a two-year period. The CRH behavioral health stakeholders, and DHS will continue the conversation around three priority areas identified through review of existing reports and identified as high impact in the current survey. See Appendix B for the matrix intended to identify priority interventions. The three specific interventions rated with highest impact (on average) and as somewhat likely included:

1. Review the State Loan Repayment Program (SLRP), and identify opportunities to transition the program away from loan repayment and into student scholarship with a required service component post-graduation.
2. Establish behavioral health licensure reciprocity with bordering states in an effort to recruit and grow the available behavioral health workforce. These efforts will include identifying places of employment in North Dakota for individuals with out-of-state licensure.
3. Increase utilization of telebehavioral health services for emergency behavioral health.

However, given the limited variability in impact and the numerous interventions identified as high impact, the three themes recommended for further review include:

1. Pipeline interventions for behavioral health students
2. Telebehavioral health interventions
3. Interventions related to licensure requirements and regulatory guidelines

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Behavioral Health Intervention as Appeared in Survey

Code for Data Presentation

<p>Develop a single electronic database of available statewide vacancies for all professional behavioral health provider types. The registry would not serve as a licensing authority, but as a separate tracking mechanism.</p>	<p>Develop a single electronic database of available statewide vacancies for all professional behavioral health provider types</p>
<p>Tuition assistance for behavioral health students, to include internship stipends and other financial assistance for those working in areas of need in North Dakota.</p>	<p>Tuition assistance for behavioral health students</p>
<p>Review the State Loan Repayment Program (SLRP) and identify opportunities to transition the program away from loan repayment, and into student scholarship with a required service component post-graduation.</p>	<p>Review the State Loan Repayment Program</p>
<p>Educate behavioral health providers on the benefits of student internships and rotations, growing a statewide list of available student placements for all behavioral health provider types. This will include identifying financial incentives, or cost coverage, for facilities willing to host behavioral health student internship/rotations.</p>	<p>Educate behavioral health providers on benefits of student internships and rotations</p>
<p>Provide opportunities for, and require, behavioral health training for health providers, teachers and daycare providers, law enforcement, correction officers, and other employees within the criminal justice system.</p>	<p>Provide opportunities for, and require, behavioral health training</p>
<p>Integrate behavioral health prevention screenings, which are reimbursable, into primary health.</p>	<p>Integrate behavioral health prevention screenings</p>
<p>Establish behavioral health licensure reciprocity with bordering states in an effort to recruit and grow the available behavioral health workforce. These efforts will include identifying places of employment in North Dakota for individuals with out-of-state licensure.</p>	<p>Establish behavioral health licensure reciprocity with bordering states</p>
<p>Review North Dakota state licensure requirements for all behavioral health provider types and ensure there are training/education opportunities available within the state to meet the set requirements. Revise licensure requirements and/or available educational programs to ensure they match.</p>	<p>Review ND state licensure requirements for all behavioral health provider types</p>
<p>Development and implementation of a behavioral health coordinator whose role it is to connect individuals in need of care to the appropriate services while also addressing issues of</p>	<p>Development and implementation of a behavioral health coordinator</p>

Behavioral Health Intervention as Appeared in Survey

Code for Data Presentation

transportation and continuity of care across service providers. Ensure the behavioral health coordination services are reimbursable.

Development, training, credentialing, and utilization of a peer support specialists in North Dakota; to include reimbursement for care. A peer support specialist is a person with lived experience of mental illness or addiction who is now in sustained recovery and trained to support others in non-clinical, person-centered and recovery-focused ways

Establish a central, coordinating body responsible for supporting behavioral health workforce implementation, including providing resources and conducting workforce-related research and evaluation.

Provide financial assistance to facilities/providers to secure equipment and staff needed to offer telebehavioral health services.

Increase practices/organizations providing telebehavioral health services. Providing telebehavioral health services refers to the practice/organization that offers the clinical intervention of telebehavioral health services.

Increase practices/organizations receiving telebehavioral health services. Receiving telebehavioral health services refers to the practice/organization that hosts the client/patient that receives the clinical telebehavioral health intervention.

Increase utilization of telebehavioral health services for emergency behavioral health.

Need to develop clear, standardized regulatory guidelines for this workforce model.

Development, training, credentialing, and utilization of peer support specialists in ND

Establish a central, coordinating body responsible for supporting behavioral health workforce implementation

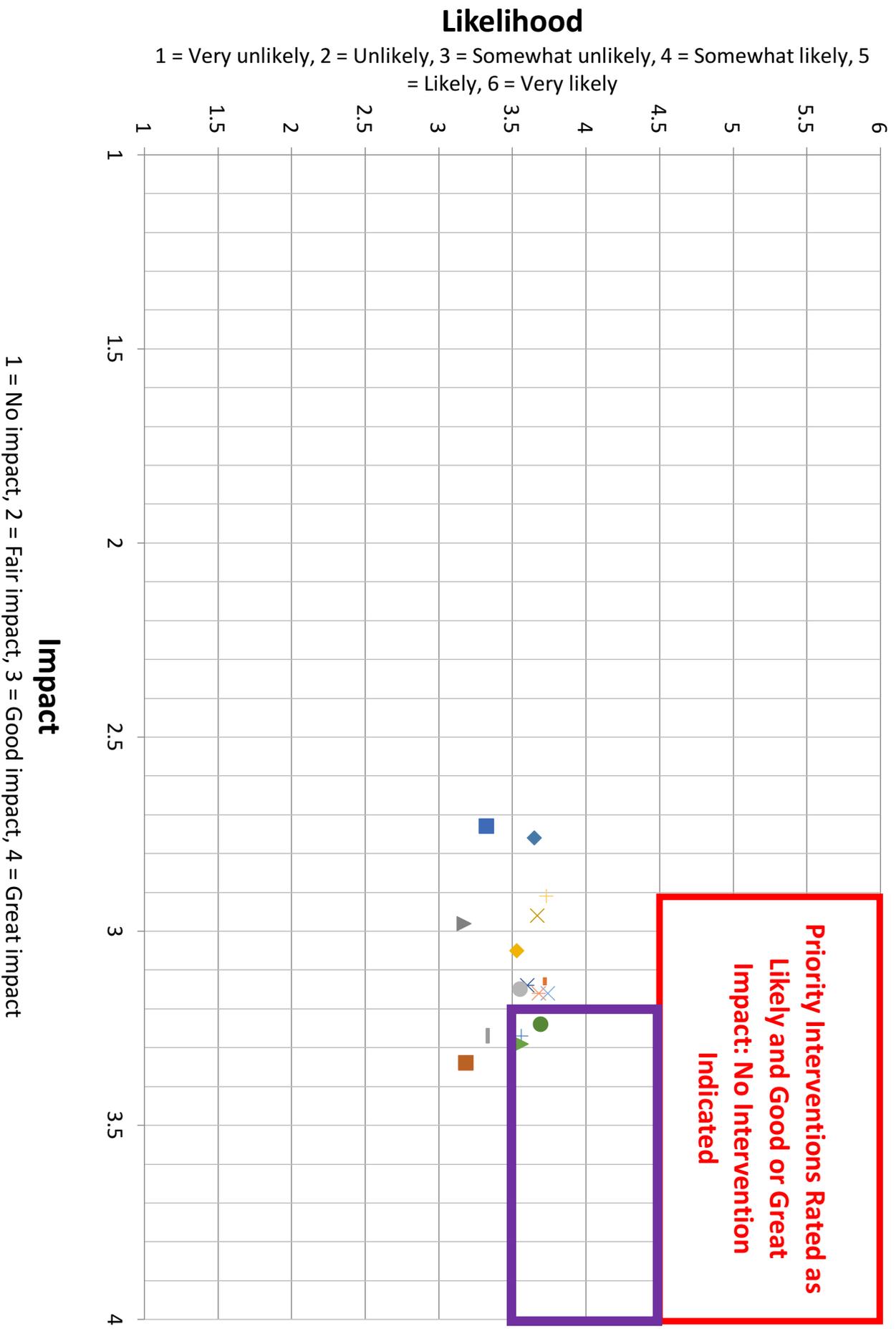
Provide financial assistance to facilities/providers to secure equipment and staff

Increase practices/organizations providing telebehavioral health services

Increase practices/organizations receiving telebehavioral health services

Increase utilization of telebehavioral health services for emergency behavioral health

Need to develop clear, standardized regulatory guidelines



- 1 Develop a single electronic database of available statewide vacancies for all professional behavioral health provider types. The registry would not serve as a licensing authority, but as a separate tracking mechanism.
- 2 Tuition assistance for behavioral health students, to include internship stipends and other financial assistance for those working in areas of need in North Dakota.
- 3 **Review the State Loan Repayment Program (SLRP) and identify opportunities to transition the program away from loan repayment, and into student scholarship with a required service component post-graduation.**
Educate behavioral health providers on the benefits of student internships and rotations, growing a statewide list of available student placements for all behavioral health provider types. This will include identifying financial incentives, or cost coverage, for facilities willing to host behavioral health student internship/rotations.
- 4 Provide opportunities for, and require, behavioral health training for health providers, teachers and daycare providers, law enforcement, correction officers, and other employees within the criminal justice system.
- 5 Integrate behavioral health prevention screenings, which are reimbursable, into primary health.
- 6 **Establish behavioral health licensure reciprocity with bordering states in an effort to recruit and grow the available behavioral health workforce. These efforts will include identifying places of employment in North Dakota for individuals with out-of-state licensure.**
Review North Dakota state licensure requirements for all behavioral health provider types and ensure there are training/education opportunities available within the state to meet the set requirements. Revise licensure requirements and/or available educational programs to ensure they match.
- 7 Development and implementation of a behavioral health coordinator whose role it is to connect individuals in need of care to the appropriate services while also addressing issues of transportation and continuity of care across service providers. Ensure the behavioral health coordination services are reimbursable.
- 8 Development, training, credentialing, and utilization of a peer support specialists in North Dakota; to include reimbursement for care. A peer support specialist is a person with lived experience of mental illness or addiction who is now in sustained recovery and trained to support others in non-clinical, person-centered and recovery-focused ways.
- 9 Establish a central, coordinating body responsible for supporting behavioral health workforce implementation, including providing resources and conducting workforce-related research and evaluation.
- 10 Provide financial assistance to facilities/providers to secure equipment and staff needed to offer telebehavioral health services.
- 11 Increase practices/organizations providing telebehavioral health services. Providing telebehavioral health services refers to the practice/organization that offers the clinical intervention of telebehavioral health services.
- 12 Increase practices/organizations receiving telebehavioral health services. Receiving telebehavioral health services refers to the practice/organization that hosts the client/patient that receives the clinical telebehavioral health intervention.
- 13 **Increase utilization of telebehavioral health services for emergency behavioral health.**
- 14 Need to develop clear, standardized regulatory guidelines for this workforce model.

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