Mental Health Advocacy Network

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Fraser, Ltd.
Individual Consumers & Families

House Appropriations-Human Resources Committee
SB 2012 Testimony
March 16, 2023
Representative Nelson, Chair

Good morning, Chairman Nelson and Members of the House Appropriations- Human Resources Committee. I am Carlotta McCleary, Executive Director of Mental Health America of North Dakota and Executive Director of the North Dakota Federation of Families for Children's Mental Health. Today I speak on behalf of the Mental Health Advocacy Network (MHAN). MHAN advocates for a consumer/family driven mental health system of care that provides an array of service choices that are timely, responsive and effective. Our vision is for every North Dakotan to have access to the right service—whether it be preventative, treatment, or recovery; at the right time—when the service is needed; and at the right place—as near his or her home as possible.

MHAN is testifying in support of SB 2012. First, let me acknowledge the last legislative session. North Dakota, like much of the nation, was experiencing budget shortfalls and the (then) Department of Human Services was tasked with the unenviable position of making substantial budget cuts in order for the state to balance its budget as required. Today we look forward to North Dakota's positive budgetary environment by encouraging the continuation of the hard work of reforming our mental health system of care.

Interim Activities

Outside the activities of the frantic legislative session, North Dakota has continued to enact needed reforms and pursue funding opportunities. The rollout of the 1915(i) State Plan Amendment happened as the session was underway. We know that the results are not where we

want them to be, but DHHS staff, including Monica Haugen (the 1915(i) Program administrator), have demonstrated inexhaustible passion in increasing the number of enrolled providers and service recipients. The 1915(i) team has provided incredibly detailed information to the public and stakeholders about where we stand on both the provider and client fronts and where we can hope to continue to make improvements in this wonderful service array. It is not an exaggeration to say that North Dakota's 1915(i) plan has among the best service delivery options in the nation.

We have also seen the continued expansion of peer support service reimbursement in North Dakota. Over the last year, Blue Cross Blue Shield of ND has included peer support in its insurance policies and peer support reimbursement is now in North Dakota Medicaid Expansion policies.

This past year, ND DHHS applied for and received federal funding for 5 years that will provide $3 million per year toward community-based services for our children. This is not a one-time opportunity. States who are not current awardees can apply for this funding opportunity every year. This grant will fund activities in the Devils Lake and Bismarck regions. This is a significant boon to North Dakota. Back in the early 1990s, this was the grant program that helped us create the children's mental health system in North Dakota.

Let us also mention 988. Yes, the creation of a national behavioral health crisis hotline was a national activity required by federal law, but North Dakota can take credit for the quality of the implementation thus far, because from what we have been hearing from our national partners, North Dakota's experience is running comparatively smooth. We think this from FirstLink's extensive experience with call centers and 211.

North Dakota has also made great strides in their mobile crisis teams, with teams in all 8 regions of the state, physically serving members of the public within a 45-mile radius of each regional Human Service Center. Those outside the 45-mile radius receive telehealth services. Both Dr. Etherington and Dr. Cramer have provided information to the public that finetuning the implementation of mobile crisis units will be an ongoing issue. Dr. Cramer has said that community feedback on how well the handoffs between each system partner are going is important, and they are also striving to improve data collection procedures.

MHAN Priorities For 68th Legislative Assembly

Our priorities and recommendations rely on implementing best practice models of service delivery. Best practices understand that we first need to ensure our citizens receive assistance before they have emergencies. We must have a robust community mental health system of care so that we can reduce the reliance on our costly, intensive institutional care settings. We must have substantial and multifaceted mental health workforce, which includes utilizing those with lived experience to help people navigate services and embark on their recovery.

SAMHSA's best practices models also include crisis response systems. When a crisis emerges, we must rely on three pillars of crisis response. Those pillars are: 1) a place to call (988), 2) someone to respond (mobile crisis teams), 3) a place to go (crisis stabilization beds/safe beds).

Peer Support: MHAN's number one priority has been increasing the prominence of peer support services in North Dakota. MHAN supports the transition of the existing

temporary peer support specialist positions at the Human Service Centers into full time FTEs. MHAN also believes that these peer support specialist positions should have benefits. MHAN is also looking forward to reports that DHHS will be implementing reimbursement for peer support services to Medicaid recipients by 2024. The legislature has previously authorized resources to this effort for multiple biennia, and we are hopeful that that work will continue and that by 2024 CMS will have approved North Dakota's plan to provide peer support reimbursement for those in Medicaid.

Family Support Organizations: Family organizations such as North Dakota Federation of Families for Children's Mental Health, Family Voices of ND, and the Experienced Parent Program do great work will small budgets, serving children with disabilities and their families throughout the state of North Dakota. Those organizations and programs should continue to be supported and funded, so that children with mental health needs, children with special healthcare needs, and children in early intervention and their families can receive assistance. Families would be lost without them.

IMD Exclusion: MHAN stands opposed to any attempts to move forward with an IMD Exclusion Waiver for behavioral health services. An IMD Exclusion Waiver would require North Dakota to be "budget neutral" to the federal government, which means that, during the project federal Medicaid expenditures will not be more than federal spending without the demonstration. As institutional facilities are far more expensive than community-based programs, funding that goes to institutional placements is ultimately funding that inhibits the creation and maintenance of a functioning community-based service delivery system. As a result, community-based mental health services, or the expansion of community-based mental health services as recommended over the last

decade, could be in jeopardy. After the release of the most recent Schulte report, Renee Schulte addressed the omission of this topic in her report by stating that North Dakota had a lot of work to do to build up its community services that consideration of an IMD Exclusion Waiver was too premature.

988 Funding: MHAN supports the need to provide FirstLink additional funding for 988, as outlined in SB 2149. 988 is a critical piece to our crisis response system. But, it desperately needs to be funded. Without this essential funding, North Dakota's 988 system, and therefore North Dakota's Crisis System, would be in jeopardy.

Mobile Crisis Teams: MHAN strongly supports the expansion of mobile crisis teams statewide. MHAN notes that the Governor's budget has a recommendation of 4 FTE. MHAN recommends that that be increased to a total of 9 FTE.

Crisis Stabilization Beds & Safe Beds: MHAN has been monitoring the situation regarding the third pillar of North Dakota's crisis response system: a place to go. In the past couple of years, North Dakota's crisis stabilization bed programs for adults experiencing a mental health crisis were largely in good shape. It is with regret that we are learning that there have been struggles acquiring or maintaining providers to provide this needed service in different regions. Among the reported challenges are staff turnover, technology issues, and the need for standardization. Whereas the adult crisis stabilization bed program is struggling, the safe bed programs for children and youth are practically nonexistent. DHHS has said this is a priority of theirs and we ask that the legislature also support safe beds across the state for North Dakota children and youth.

Certified Community Behavioral Health Clinics (CCBHCs): MHAN is urging North Dakota to have CCBHCs in every region of the state. North Dakota is only one of three states in the country without CCBHCs. CCBHCs would serve anyone with behavioral health needs 24 hours a day, 7 days a week. They provide an array of services such as: crisis services, treatment planning, screening, diagnosis and risk assessment, outpatient behavioral health services, targeted case management, and outpatient primary care screening, community services for veterans, peer support, and psychiatric rehabilitation services.

Children's Mental Health Services: MHAN urges the state of North Dakota to make a substantial investment in community-based mental health services for children and youth with Serious Emotional Disturbance (SED). One in ten children in North Dakota has a SED, which is over 18,000 children. According to recent data from DHHS, during the 2021-2022 fiscal year, 1,101 children with SED have received services from the regional Human Service Centers, but only 135 children receive case management services. These are not simply children who have any mental illness or moderate mental illness, they are those with the most significant mental health challenges. The HSRI implementation team knows that we have plenty of work to do on this front, and we hope to see significant progress over the course of the biennium with support from the legislature.

Autism Voucher/Waiver: MHAN understands the desire to maximize federal dollars by eliminating the Autism voucher. However, we do have concerns that some of the children currently utilizing the voucher would not be eligible for the autism waiver. What MHAN would like to see is the formation of a cross-disability waiver, as suggested by the Alvarez and Marsal Study, and to begin work this biennium to have it for children up to

the age of 5. We believe that this would be a good first step, because for those children at or below the age of five, a lot of these children are falling off of services and will have no services, as they are not yet in school.

New State Hospital: MHAN supports the establishment of a new State Hospital that is both therapeutic and separated from any prison complex. In previous reports and in an extensive interview with MHAN for its podcast, Dr. Etherington stated that the physical conditions at the existing State Hospital are as such that North Dakota has a significant risk of a catastrophic systems failure at any time. The expenses of repairing those facilities are so extensive that building a new facility became necessary. The current backup plan to a system failure is a temporary plan for a handful of days, in which everyone (including the sex offender wing) will be relocated to the Jamestown Civic Center. MHAN urges the legislature to build a new State Hospital.

This concludes my testimony, and I will be happy to answer any questions you may have.

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