HB1012
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Testimony on HB 1012- New State Hospital- In opposition
Senate Appropriations- Human Resource Division
March 26th, 2024

Chairman Dever and members of the Committee,

My name is Madison Hanson. I hold bachelor's degrees in Social Work and Human Development and Family Science, and I am currently completing my Master of Social Work with a concentration in macro-level practice, which emphasizes systems change and public policy. I also serve as a Policy Advocate for the North Dakota chapter of the National Alliance on Mental Illness (NAMI).

But today, I'm not speaking on behalf of an organization. I'm speaking as an invested graduate student, as a young person who calls this state home, and as someone who has spent the past several years immersed in this issue and the treatment of those with serious mental illness. I've attended nearly every legislative hearing regarding the State Hospital proposal. I've studied the history of institutional care, traced the roots of our current system, analyzed the legal frameworks that govern it, and asked one central question: what truly meets the needs of people with serious mental illness in North Dakota?

I want to highlight this: Before the Legislature can even consider the construction of a new state hospital, it must first fulfill its existing legal obligations under NDCC § 50-06-06.5. This statute mandates that the Department of Health and Human Services develop and implement a comprehensive, multidisciplinary continuum of care for individuals with serious and persistent mental illness (SPMI). The law is unambiguous in stating that:

"The continuum of care must provide that a person requiring treatment be submitted to the least restrictive available conditions necessary to achieve the purposes of treatment. The department shall ensure appropriate cooperation with human service zones and private providers in achieving the continuum of care."

Yet, this continuum does not fully exist in North Dakota. According to the Treatment Advocacy Center (2023), 40% of individuals at the Jamestown State Hospital were clinically ready for discharge but remained institutionalized—not due to medical need, but because of a lack of available community-based services. This is not a system failure to be ignored. It is a clear violation of both the intent and spirit of the law.

To proceed with a new centralized institution under these conditions is not only premature—it may also be unlawful. How can the state justify a $330 million investment in a new facility while it fails to meet basic statutory requirements that prioritize community care and the least restrictive environment.

Further complicating this issue is the vague and inconsistent definition of the "specialized population" the state hospital is meant to serve. Under NDCC § 25-02-03, the state hospital is to

serve "specialized populations of individuals with severe mental illness, including individuals with a substance use disorder." While the Department of Health and Human Services determines the scope of that population, the current messaging is inconsistent. At times, it is said to serve primarily forensic and sexual offenders. Yet in practice, the majority of admissions are short-term and emergency psych holds, meaning the hospital is functioning more like a crisis stabilization unit—not a long-term recovery facility.

This ambiguity undermines any transparent assessment of whether the proposed new hospital would meet its intended purpose. Without a clearly defined population and a legally compliant continuum of care, building a new centralized facility only reinforces the current system's inefficiencies and opens the door to open-ended institutional expansion—rather than the development of scalable, regional, recovery-oriented care that North Dakotans actually need.

In the pages that follow, I present a full picture of this issue—its history, legal context, and actionable solutions. I ask you to read this testimony as both a product of rigorous graduate-level research and also a call for moral and systemic accountability. And ultimately, I ask this committee to vote no on the construction of a new state hospital.

Historical Context: The Asylum Model

The history of the state hospital model—once known as the asylum—can be traced back to Dr. Thomas Kirkbride and his 19th-century philosophy of moral treatment. His approach was grounded in the belief that individuals with mental illness would heal best when removed from their communities and placed in structured environments, far from the stressors of daily life. Yet, this very separation also severed individuals from family, community, and the social ties essential to long-term recovery.

This model was radical for its time: a deliberate shift away from punishment and neglect toward an environment designed to promote stability and dignity. Reformers like Dorothea Dix and Thomas Kirkbride championed this vision, leading to the construction of hundreds of state hospitals across North America.

Kirkbride's hospitals were designed not just to house, but to heal—through architecture itself. Yet the promise of this model quickly unraveled. As patient populations grew and funding declined, these institutions became overcrowded, custodial settings—warehousing individuals with a wide range of misunderstood or stigmatized conditions, including developmental disabilities, neurological disorders, and trauma.

In 1880, Kirkbride's colleague Pliny Earle revealed that institutional success rates had been grossly exaggerated. Annual reports falsely inflated the number of "cured" patients, misleading both policymakers and the public. These revelations sparked growing disillusionment and criticism of the asylum model.

Ultimately, the Kirkbride Plan failed—not because its architectural ideals lacked merit, but because infrastructure alone cannot meet the complex, long-term needs of individuals with serious mental illness. No amount of symmetry, natural light, or structured routine can substitute for comprehensive, community-based, individualized care. The asylum model was eventually discredited and abandoned (Kirkbride, 2024).

Deinstitutionalization and Federal Policy

The movement toward deinstitutionalization in the United States did not begin with the 1960s—it was shaped by decades of changing attitudes and professional insight. After World War II, the public and policymakers began to question the morality and effectiveness of large psychiatric institutions. Reports of neglect and overcrowding, combined with growing evidence that people recovered more effectively when supported in their own communities, helped lay the groundwork for reform. Mental illness began to be recognized as a public health concern, not just a custodial issue. These developments led to the rise of the Community Mental Health movement, which envisioned care delivered in local, outpatient settings, rather than in remote, state-run asylums (Grob, 2023).

In 1963, President John F. Kennedy signed the Community Mental Health Act, marking a turning point in federal mental health policy. The legislation was informed in part by his personal experience—his sister Rosemary had undergone a failed lobotomy and was institutionalized for the rest of her life. Kennedy championed the idea of replacing large hospitals with community-based care that prioritized dignity and reintegration. However, the law was underfunded after his assassination and lacked planning for individuals with serious mental illness (SMI). Early implementation focused more on people with developmental and intellectual disabilities, leaving critical gaps in services for adults with complex psychiatric needs.

In 1965, the Institutions for Mental Diseases (IMD) Exclusion Rule was enacted as part of the Social Security Amendments. This rule prohibits Medicaid reimbursement for individuals aged 65 or older or those under 21 years old receiving care in specialized psychiatric facilities with more than 16 beds. The IMD Exclusion created a structural funding barrier that still limits the development of residential mental health programs and the sustainability of IMDs.

For states like North Dakota, the historical underdevelopment of appropriate infrastructure and IMD Exclusion Rule have contributed to a system of repeated hospitalizations and incarcerations, compounded by emergency room visits and law enforcement interventions, outstripping the cost of a well-designed community care system.

Contemporary Consequences of an Outdated System

North Dakota is now facing the long-term consequences of a fragmented continuum of care for individuals with SMI. Decades of policy decisions—some well-intentioned, others shortsighted—have resulted in a behavioral health system that relies too heavily on centralized, acute care at the Jamestown State Hospital. The lack of a fully developed, community-based continuum of care for this specific population has created unsustainable pressure on healthcare providers, law enforcement, and the judicial system while failing to offer timely, appropriate care for those in crisis.

The strain is visible across multiple systems. In 2022, individuals with SMI made up one of the largest subpopulations experiencing homelessness in North Dakota (North Dakota Statewide CoC, 2022). In 2023, just 15 individuals accounted for over 400 police calls—equivalent to the workload of three full-time officers. These individuals were not engaged in criminal behavior; rather, they were trapped in a system where their only options were jail, the emergency room, or a long transport to the state hospital, which often lacked capacity or denied admission (Carvell, 2024). Local judges have also raised concerns about long delays in providing court-ordered treatment, leaving people without care and communities without resolution (Port, 2024).

These patterns reflect a broader systemic failure—one that criminalizes psychiatric symptoms and displaces medical responsibility onto systems that were never designed to handle them. What we're witnessing is not just a healthcare gap, but a systemic design that undermines dignity, recovery, and public safety. This fragmentation is not accidental- it stems from decades of misaligned funding, legal limitations, and underdeveloped infrastructure. We must address

what was never implemented in the era of deinstitutionalization- a full continuum of community based services for individuals with SMI.

Legal and Ethical Concerns

Federal law is clear: individuals with disabilities, including those with serious mental illness (SMI), have the right to receive care in the least restrictive environment appropriate to their needs. Foundational cases such as *Lake v. Cameron* (1966), *O'Connor v. Donaldson* (1975), and *Olmstead v. L.C.* (1999) have consistently affirmed this principle.

In the mid-2010s, the U.S. Department of Justice (DOJ) opened an Olmstead investigation into North Dakota's institutional practices, resulting in a 2020 settlement agreement. However, that agreement has been most specifically interpreted to individuals with intellectual and developmental disabilities (IDD).

This omission leaves people with SMI at continued risk of institutionalization in violation of federal law. In 2023, the Treatment Advocacy Center found that 40% of individuals at the Jamestown State Hospital were clinically ready for discharge but remained confined due to a lack of appropriate community-based services. The current system does not just reflect operational inefficiency—it raises serious legal and ethical concerns.

During recent hearings, the state's Behavioral Health Director confirmed that some individuals have lived at NDSH since the early 1990s. If these individuals no longer meet the criteria for hospitalization but remain institutionalized due to the lack of step-down services, the state may be in violation of both federal mandates and its own ethical obligations.

State law reinforces this concern. Under NDCC § 25-01-16, institutionalized individuals must not be treated with "severity, harshness, or cruelty." Prolonged confinement without medical necessity could reasonably be interpreted as a violation of this statute.

Further, NDCC § 25-02-03 states that the state hospital should serve "specialized populations of individuals with severe mental illness, including individuals with a substance use disorder." However, the statute does not define who qualifies as a "specialized population." While the law delegates that responsibility to the Department of Health and Human Services, no formal administrative rule or publicly accessible definition appears to exist. Without clear guidance or codified criteria, it becomes nearly impossible to determine whether a new state hospital would effectively meet its intended purpose.

This lack of clarity carries serious implications. Without a well-defined population, the state risks building a facility that is misaligned with recovery-oriented models and incapable of addressing regional and demographic variations in need.

Recommendations for Reform

The financial and human costs of this system are unsustainable. North Dakota must take decisive action to expand community-based treatment options that reduce unnecessary institutionalization and ensure individuals with serious mental illness receive care in the least restrictive setting possible. Investing in these services will not only improve outcomes for those affected but also alleviate strain on public resources and ensure compliance with federal legal standards requiring access to community-based care.

1. **Assertive Community Treatment (ACT):**
   Intensive, mobile, team-based care for individuals with SMI. Multidisciplinary teams provide treatment, medication management, housing support, and crisis response. Proven to reduce hospitalizations, arrests, and homelessness.

2. **Certified Community Behavioral Health Clinics (CCBHCs):**
   A federally supported model now expanding in North Dakota. CCBHCs must be equipped to offer ACT.

3. **Regional Acute Care Units:**
   Strengthen Short-term psychiatric stabilization units embedded within local communities. These alternatives to hospitalization reduce travel burdens and increase access to timely care—particularly in rural areas.

4. **Psychiatric Residential Treatment Facilities (PRTFs) for Adults:**
   A missing level of care entirely in North Dakota. PRTFs provide structured, step-down services between inpatient hospitalization and community living, especially for individuals needing longer-term stabilization and supervision.

This continuum of care would address the most urgent system gaps while reducing unnecessary institutionalization. With the $330 million currently proposed for a new centralized hospital, North Dakota has a historic opportunity to choose instead to fund a statewide behavioral health infrastructure that is truly responsive, regional, and recovery-focused.

n conclusion, when we reflect on the history of deinstitutionalization, the origins of the state hospital model, and the laws that continue to shape how care is delivered for people with serious mental illness, a clear truth emerges: we have relied on the institutional model for generations, and it has repeatedly failed to deliver the comprehensive, humane care that people deserve.

Today, we face a defining choice. We can invest $330 million into an outdated system of institutionalization—or we can chart a new course. One that embraces people with mental illness as full members of our communities. One that offers housing, not just hospital beds; opportunity, not just medication; and dignity, not just confinement.

I respectfully ask you to vote no on the proposal for a new state hospital. You have the power—and the responsibility—to shape the future of mental health care in North Dakota. Please, do not let this moment pass.

Thank you for your time and consideration.

Madison Hanson
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