Mental Health Advocacy Network

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Interim Human Services Committee
Study 3017 Testimony
August 29, 2023
Representative Ruby, Chair

Good morning, Chairman Ruby and Members of the Interim Human Services 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 to provide the committee an overview of the children's mental health system in North Dakota, including relevant historical information. In sum, we make the argument that throughout the last 50 years North Dakota has been caught in the *Olmstead* problem: prioritizing resources for institutional settings rather than building up a community-based service delivery system.

First, we should define the population of children who are experiencing the most significant mental health challenges: those who are defined as children with Serious Emotional Disturbance (SED). The federal definition of SED has remained fairly consistent over the past thirty years. SED is defined as, "children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role in family, school, or community activities." Although national prevalence rates for SED may vary depending on research,

a meaningful consensus has been that roughly 10% of all children in the United States have SED. That translates to over 18,000 children in North Dakota.

Now that we have addressed how we define children facing the most significant mental health issues as well as how many children we have in North Dakota with SED, it is vital to understand what North Dakota's legal obligations are regarding providing services to them. Since the *Olmstead* U.S. Supreme Court decision of 1999 (based on the Americans with Disabilities Act), states have had many rulings that state that: people with disabilities have a right to community-based services rather than be asked to only seek institutional care: 1) when treatment professionals determine that community placement is appropriate; 2) when the individual does not oppose being served in the community; and 3) when the placement is a reasonable accommodation when balanced with the needs of others with disabilities. Since that ruling, Courts have determined that these protections also extend to those who are *at risk of* institutionalization.

The legislature commissioned two studies over the last decade that highlighted the *Olmstead* issue: the 2014 Schulte Report and the 2018 Human Services Research Institute Report. Those studies warned that North Dakota's behavioral health system was not providing community-based services as required by the *Olmstead* decision.

In practical terms, what does this mean for the legal obligations of states to provide community-based services to children with Serious Emotional Disturbance (SED)? In effect, all 18,000+ children with SED have the right to community-based services provided by state and/or private providers. Our federal partners at the Substance Abuse and Mental Health Services Administration (SAMHSA) also confirm this interpretation. This does not mean one entity or the other must provide all services without assistance

from the other, but it does mean that a state's infrastructure must be able to meet the community-based service needs of children with SED and their families. These services can include: psychiatry, psychology, and counseling services; peer support for families, targeted case management; case aides and respite care, just to name a few.

As this committee is also studying the needs of children who have acute psychiatric needs, we also want to make sure to address the best practices model for a crisis response system in North Dakota. SAMHSA says that a core service and best practices model for a crisis response system must include three components: 1) a place to call, 2) someone to respond, 3) and a place to go. For North Dakotans, that means a place to call is 988, someone to respond are our mobile crisis teams, and a place to go are our crisis stabilization centers (or crisis beds). The last resort, out-of-home placement (such as psychiatric hospitalization or psychiatric residential treatment) may need to be utilized. When out-of-home placements are to occur, they should be as near their home as possible. A proper crisis response system can actually divert many from needing more costly out-of-home placements such as hospitalization.

When a child is experiencing a mental health crisis, our state needs these three components to be up and ready to go. 988 needs to be able to take the call, a mobile crisis team must be able to respond to the crisis, and if a child is needing a place to go, a crisis stabilization center (or crisis bed) should be available. If those options will not meet the needs of a child, and an out-of-home placement is needed, those beds should be located as near their home community as possible.

Now that we have a brief overview of the type of mental health system our children and families ought and/or are legally obligated to receive, we can discuss where we are at as a

system of care. As was stated before, there are over 18,000 children in North Dakota who have a SED. How many children are we serving today? According to recent figures from ND DHHS, 1,101 children with SED were served in the Human Service Centers. However, only 135 children with SED have received case management services (ongoing services) between July 1, 2021 and June 30, 2022. In addition, Pam Sagness, the Director of the Behavioral Health Division recently testified that 70% of all North Dakotans who had entered the Human Service Centers seeking services were turned away.

As for the crisis response system for children, there are significant gaps as well. While we do have 988 and mobile crisis teams, mobile crisis team utilization is low in our schools because law enforcement (either the School Resource Officer or other police officers on duty) are routinely called instead. This may be because schools are unaware of mobile crisis teams or because, as some schools have admitted to us, they think a law enforcement response (particularly an SRO) is quicker, despite not being an appropriate resource during a mental health crisis. As far as our crisis stabilization centers (or crisis beds) are concerned, only two regions of the state have formally created crisis beds for children (Minot and Dickinson). While Minot's is operational, the one in Dickinson is in poor shape. It is seen by regional human service center staff as functionally useless for a crisis stabilization center, as children displaying symptoms consistent for needing such a service have been routinely kicked out of the facility.

As far as children needing an out-of-home placement are concerned, we can also report that there are glaring gaps. We too have tried to help families find a psychiatric bed for a child, only to be left with few (or no) answers. But it is important to note that the entire mental health system has collapsed, leading more and more children and families risking

their mental health conditions worsening to the point where they may eventually need out-of-home placements. All despite the fact that services in the community are legally obligated to be there.

This may sound dire already, but it is even more of a tragedy when you consider our history. Is this crisis new? Not at all. In the 1980s, North Dakota had close to no children's mental health system at all. If there is a historical analogue to where we are at today, we are closer to the late 1980s and early 1990s, when the state had commissioned multiple studies to turn around the mental health system for citizens of all ages. It was not until the mid-1990s with the federal System of Care grant that the plans made in the early 1990s became a reality. Thankfully we have a new System of Care grant for the Bismarck and Devils Lake regions--the first of its kind since the early 1990s, but families in those regions have yet to receive services funded from that grant.

Back in the early 1990s, the researchers the North Dakota legislature commissioned argued that to have an "adequate" children's mental health system, North Dakota had to have a community-based mental health system that was capable of serving 3,502 children with SED. That was well-before *Olmstead* and the increasing federal expectation that *all* children with SED have access to community-based services. We never met that mark, peaking our service delivery in 2002. From then on, North Dakota has provided services to fewer and fewer children each year. We are currently providing services to a fraction of the children who received services in the 1990s. And 1993's standards are nowhere near sufficient to meet the legal requirements of today.

Where do we go from here? In short, we need a massive expansion of community-based services, with an enormous jump in the number of children with SED who are being

served and are receiving services such as targeted case management. We need to see the utilization of high-fidelity wraparound process for children with SED. We need an overhaul of our crisis response services, with a much better utilization of mobile crisis teams in our schools, and an overhaul of crisis beds for children. As far as in-patient psychiatric needs are concerned, if the state of North Dakota determines a need for more beds, we recommend that they be in community hospitals throughout the state, rather than a centralized location such as the State Hospital.

What is the biggest priority for children with mental health needs? Community-based services, instead of relying only on institutional care. If we continue to not serve children in the community as they are entitled to under federal law, we will continue to see a rise in demand for more beds. Will we find that there is a need for more beds? Perhaps. But since the 1980s, North Dakota has known that the central problem is a lack of community-based services. Some decades were better or worse than others, but that is the central problem that we must address. For a brief moment, perhaps less than a decade, North Dakota had made progress in children's mental health services. But it only took from 2003 to 2009 for our state to make several decisions that would not prioritize community services for children, leading to less services for fewer children. Those decisions lead to similar decisions in the adult mental health service system. By 2010, those conscious decisions lead to the systemic collapse of our entire mental health system, which for the last decade we have been trying to undo.

I think we can do better and build a children's mental health system to be proud of.

Thank you for your time, and I would be happy to respond to any questions you may have.

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