NORTH DAKOTA

Behavioral Health Assessment

Gaps and Recommendations

The purpose of the North Dakota Behavioral Health Assessment is to identify priority recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting North Dakota's children, adults, families and communities in health and wellness, to reach their full potential.

The North Dakota Department of Human Services, Behavioral Health Division was tasked with reporting the outcome of this assessment by the 64th Legislative Interim Human Services Committee during the August 2015 committee meeting.

north dakota department of human services

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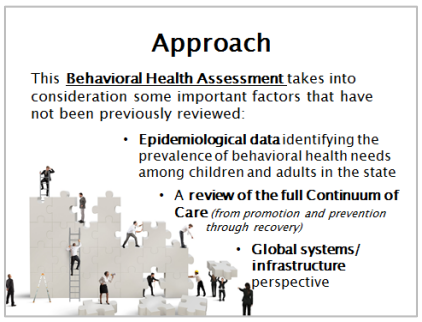
Executive Summary

The purpose of this ND Behavioral Health Assessment is to identify priority recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting North Dakota's children, adults, families and communities in health and wellness, to reach their full potential. We can prevent and reduce chronic disease and promote wellness by treating behavioral health needs on an equal footing with other health conditions.

APPROACH

To ensure a comprehensive approach, a variety of sources were utilized in the development of this assessment, including stakeholder feedback and existing reports. Also, this Behavioral Health Assessment takes into consideration some important factors that have not been previously reviewed, including:



- **Epidemiological data** identifying the prevalence of behavioral health needs among children and adults in the state is included. Basing decisions on epidemiological data ensures that efforts are selected appropriately and implemented effectively. Sample of Data Sources reviewed: Youth Risk Behavior Survey; Behavioral Risk Surveillance System; National Survey on Drug Use and Health
- The proposed vision for the North Dakota Behavioral Health System is grounded on the Institute of Medicine's **Continuum of Care** model, this assessment provided a review of the full Continuum of Care (from promotion and prevention through recovery).
- In order to see sustained effective behavioral health system changes we need to have a strong, developed infrastructure. Therefore, the discussion and initial recommendations are based on this **global systems and infrastructure perspective**.

CONSIDERATIONS

In the review of the full Continuum of Care, **funding and reimbursement**, **infrastructure** (including agency-level, workforce, oversight) and **best practice** were considerations. Below is a summary of gaps and needs identified within the Continuum of Care model.

Continuum of Care	Gaps/Needs
Promotion/ Prevention	• Limited resources for mental health promotion and mental illness prevention efforts • The field of mental health promotion and mental illness prevention is fairly new. Workforce and best practices are still being identified • No credentialing for prevention professionals • Overall, promotion and prevention tends to not be valued as a priority

Continuum of Care	Gaps/Needs
Intervention	• Gaps in collaboration/integration with the education system, including early childhood and childcare systems. • Workforce limitations (credentials needed to conduct screenings and assessments, utilization of evidence-based practices) • A consistent, universal screening is not utilized • Funding can be limited for screenings • When screenings are occurring, often there are issues with an efficient referral process to further assessment and/or treatment services • In general, the current process of conducting assessments is not efficient or effective
Treatment	• Criminalization of behavioral health disorders – There is no payment for services for individuals in jail – Limited community-based services (including housing, transportation, employment) available to allow individuals choice of services in the least restrictive environment • Current services are not integrated with each other or other community organizations; this includes the utilization and exchange of data. Changes in level of care are often not fluid. • Communication/promotion of services available is limited. • Workforce limitations – Limitations in utilization of evidence-based practices – No single registry of mental health providers • Role clarification needed between public and private service systems
Recovery	• Workforce limitations (number of trained providers in evidence-based recovery services) • Limited evidence-based services, and the infrastructure to support these services, available in the state, including sober living environments and other community-based services and supports (including housing, transportation, employment) • Limited payment to support evidence-based recovery services

ND BEHAVIORAL HEALTH SYSTEM RECOMMENDATIONS

It is the hope that this assessment lays the foundation to support an effective, efficient and sustainable behavioral health system in North Dakota. This is not the end, but the beginning.

Purpose

The purpose of the North Dakota Behavioral Health Assessment is to identify recommendations to enhance the foundation of the state's behavioral health system, with the goal of supporting North Dakota's children, adults, families and communities in health and wellness, to reach their full potential. The recommendations identified through this assessment are not "magic bullets" and are not the lone answers to filling the gaps in the state's behavioral health system. True, sustainable change takes time and investment needs to be made in the foundation. When these recommendations are implemented, the foundation will be laid where additional work can be done to ensure the individuals, families and communities in North Dakota have access to quality behavioral health services and that this work is able to be sustained.

The North Dakota Department of Human Services, Behavioral Health Division was tasked with reporting the outcome of this assessment by the 64th Legislative Interim Human Services Committee at the August 2015 committee meeting.[1]

The mission of the Department of Human Services is to provide quality, efficient and effective human services, which improve the lives of people. The Behavioral Health Division provides leadership for the planning, development and oversight of the state's behavioral health system. The Behavioral Health Division does not provide direct services, rather the role of the Division is to ensure health and safety and access to a wide-range of quality behavioral health services across the state.

[1] www.legis.nd.gov/assembly/64-2015/committees/interim/human-services-committee

Introduction and Approach

In recent years, the state's behavioral health system has received much attention and review, with stakeholders from multiple disciplines coming together initiating dialogue that would lead to effective change. Numerous suggestions, recommendations and priorities have previously been identified. This important work was considered through the development of this Behavioral Health Assessment. However, this Behavioral Health Assessment takes into consideration some important factors that have not been previously reviewed:

- Epidemiological data identifying the prevalence of behavioral health needs among children and adults in the state.
- A review of the full Continuum of Care (from promotion and prevention through recovery).
- Global systems infrastructure perspective.

This assessment identifies global recommendations, which when implemented, will set the foundation to support further enhancements to the state's behavioral health system in a comprehensive, efficient and effective way. This assessment is one piece of the puzzle on the road to a comprehensive and effective behavioral health system. The goal of this document is to identify, as a foundation, where stakeholders can align to develop and support a comprehensive behavioral health system.

The following provides some additional background on how this assessment was approached:

- It is acknowledged there are **regional and community-level differences** in need and available services across the state. However, in order to provide a comprehensive look at the state's behavioral health system and infrastructure, this assessment takes a statewide and global perspective. Communities are encouraged to take the information from this assessment and overlay with any local-specific information to ensure efforts are relevant.
- It is important to identify the structure and readiness of the current system when assessing and making recommendations. Matching strategies to a community/**system's level of readiness** is absolutely essential for success. Efforts that are too ambitious are likely to fail because community members or stakeholders will not be ready or able to respond.
- The current structure of the behavioral health system in the state is **not fully integrated**. Most often, substance use disorder and mental health services are delivered in separate systems, or at best co-located. It is recognized that true integration is a key objective in order to be most effective. Because of this lack of integration, this assessment is broken up into the following topic areas: children's behavioral health; adult mental health; and adult substance use. Also, efforts are continuing to further integrate behavioral health and primary care.
- It is acknowledged that **multiple efforts are occurring,** each impacting the state's behavioral health system. These efforts include the recently finalized brain injury needs assessment, the substance exposed newborns task force recommendations, seclusion and restraint task force recommendations, problem gambling needs assessment, justice reinvestment efforts, opioid addiction efforts and other local/regional work. It is important to note this assessment does not include any specific information or recommendations from these efforts. Instead, it is encouraged to use the recommendations of this assessment as the foundation for moving these efforts forward.

- Through the process of developing this assessment and the many conversations with stakeholders, it was identified that people want change and are working toward change at the community and regional-level. There are **good examples** of efforts to integrate and deliver services effectively in areas throughout the state. It will be important to garner these successes and consider the ability to scale these efforts statewide.

In addition to the review of previously developed reports focused on the state's behavioral health system, this assessment sought perspectives from service providers, key stakeholders, and consumers and families in both the state's public and private behavioral health systems. The following table summarizes the information utilized in the development of this assessment to ensure a well-rounded approach:

STAKEHOLDER FEEDBACK	REPORTS	DATA
• Tribal Behavioral Health meeting • Medicaid Waiver Stakeholder meetings • Behavioral Health Conference breakout sessions • County Social Services Directors • Education System (ND Regional Education Association and School Administration representatives) • Early Childhood system representatives (Child Care Aware) • Juvenile Court • Division of Juvenile Services • Residential Child Care Facility (RCCF) representatives • Psychiatric Residential Treatment Facility (PRTF) representatives • Foster Care (PATH and families) • Substance Use Disorder Leadership meetings • Mental Health advocates • behavioral health public and private providers • behavioral health consumers and family members	• Interim Human Services Committee testimony • Schulte Consulting, LLC Behavioral Health Planning Final Report July 22, 2014 • North Dakota Behavioral Health Stakeholders Group Reports - Building Stronger Behavioral Health Services in North Dakota: Framing Key Issues and Answers – 7/18/2014 - November 17, 2015 Summary Reports - Behavioral Health Stakeholder Survey, June 2016	• National Survey on Drug Use and Health • Crime in North Dakota. North Dakota Office of Attorney General, Bureau of Criminal Investigation • North Dakota Crash Summary, North Dakota Department of Transportation • Behavioral Risk Factor Surveillance System Survey • Youth Risk Behavior Survey • ND Community Readiness Survey • North Dakota epidemiological profile: Alcohol, tobacco and illicit drug prevalence, root causes, and consequences in North Dakota.

See Appendix A for links to reports and data.

Overview of Behavioral Health

What is Behavioral Health?

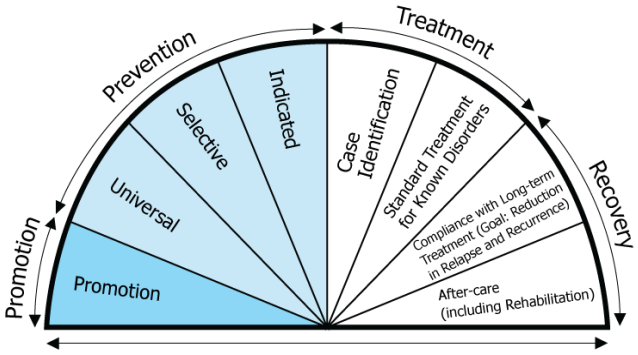
Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health conditions affect people from all walks of life and all age groups. These illnesses are common, recurrent, and often serious, but they are treatable and people recover.[2] Such conditions are far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society.

Behavioral health is an essential part of health service systems and effective community-wide strategies. Behavioral health and physical health are also connected. Good behavioral health often contributes to good physical health. Likewise, the presence of behavioral health disorders is frequently associated with physical health disorders.

Vision for an Effective Behavioral Health System

Behavioral health is an essential part of overall health in which prevention works, treatment is effective and people recover. The North Dakota behavioral health system is built to support people – at both the individual and community levels.

The proposed vision for the North Dakota Behavioral Health System is grounded on the Institute of Medicine's Continuum of Care model. The goal of this model is to ensure there is **access to a full range of high quality services** to meet the various needs of North Dakotans. The services available throughout this continuum should **reflect current knowledge and technology** and be **grounded in evidence-based practice**. Throughout all levels of the continuum, there should be a **continuous promotion of healthy behaviors and lifestyles**, a primary driver of health outcomes.



Institute of Medicine Continuum of Care

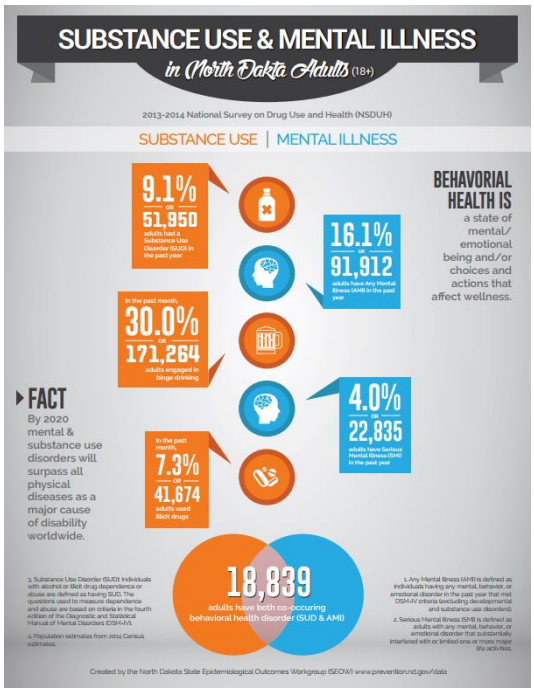
In summary, the goal of the state's behavioral health system is to ensure there is access to quality services across the continuum of care supporting the behavioral health of North Dakotans across the lifespan. See Appendix B for some excerpts from the "*Description of a Good and Modern Addictions and Mental Health Service System*", which describes some key components of an effective behavioral health system in more detail.

[2] SAMHSA

Behavioral Health Data Review

Basing decisions on epidemiological data ensures that efforts are selected appropriately and implemented effectively. By understanding the true scope of the problem, decision-makers are able to identify priority areas and reach the populations of greatest need.

The North Dakota Department of Human Services' Behavioral Health Division initiated the State Epidemiological Outcomes Workgroup (SEOW) in 2006, though funding received from the Substance Abuse and Mental Health Services Administration (SAMHSA). Initially created with the purpose of bringing data on substance abuse to the forefront of the prevention planning process, the SEOW broadened its scope in 2014 to include broader behavioral health issues. The mission of the North Dakota SEOW is to identify, analyze and communicate key substance abuse and related behavioral health data to guide programs, policies and practices. The SEOW has built a broad representation of diverse partners and continues to provide leadership in identifying data needs. For more information on the SEOW and data products, visit: www.prevention.nd.gov/data.



This section presents a set of behavioral health indicators as found through existing statewide and national datasets, much of which through the state's SEOW. This array of indicators provides an overview of the state's behavioral health at a point in time. The data presented in this assessment is a sampling and does not intend to be exhaustive. The purpose of this brief review is to identify some key data available to guide decision-making, and simultaneously identify gaps in available data. It will be important to continue this data collection, analysis and review, with specific considerations for health disparities. This information is vital in the state's efforts to reduce the impact of behavioral health conditions on North Dakota individuals, families and communities.

Overview/General

Behavioral health conditions can have a powerful effect on the health of individuals, their families, and communities. These conditions are among the top conditions that cause disability and carry a high burden of disease in the United States, resulting in significant costs to families, employers, and publicly funded health systems. By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.[3]

According to SAMHSA's 2013-2014 National Survey on Drug Use and Health (NSDUH) an estimated 91,912 (16.1%) North Dakotans ages 18 and up experienced some form of mental illness. In the past year, 51,950 adults (9.1%) had a substance use disorder. Of these, 18,839 people had both a mental disorder and substance use disorder, also known as co-occurring mental and substance use disorders.

Persons with mental illness and/or substance use disorders die, on average, about 5 years earlier than persons without these conditions.[4] And, persons with serious mental illness (SMI) are now dying 25 years earlier than the general population.[5] In addition, behavioral health conditions can lead to other chronic diseases such as diabetes and heart disease. Individuals with a mental illness may develop cancer at a 2.6 times higher rate on account of late stage diagnosis and inadequate treatment and screenings.[6] Addressing the impact of substance use alone is estimated to cost Americans more than $600 billion each year.[7]

F-M Ambulance Service (FMA) is the largest ambulance operator in North Dakota responding to more than 26,000 calls for service annually. Of those calls, one-third are behavioral health related. Common calls include substance abuse, depression, suicidal ideation, anxiety and depression. Too often psychological maladies are often accompanied by chronic physical illnesses.[8]

Children's Behavioral Health

MENTAL HEALTH

Over one in four (27.2%) ND high school students report feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past year. This percentage was highest among high school females (35.2% compared to 19.6% males). At North Dakota Human Service Centers (statewide), an average of 1,556 youth are receiving mental health services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).

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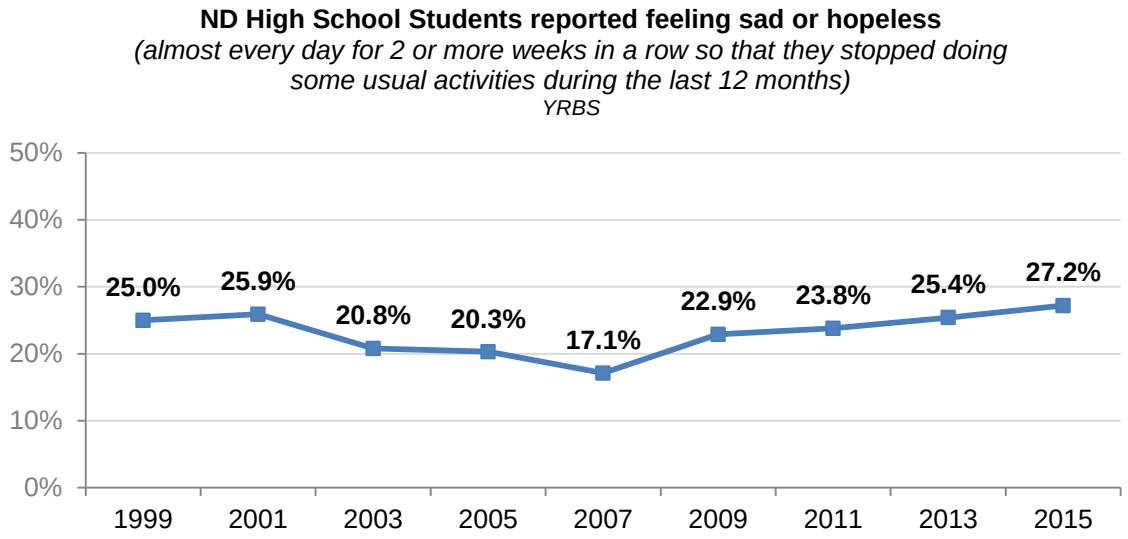
[3] SAMHSA: http://www.samhsa.gov/prevention
[4] Druss BG, et al. Understanding Excess Mortality in Persons With Mental Illness: 17-Year Follow Up of a Nationally Representative US Survey. Medical Care 2011; 49(6), 599–604.
[5] http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf
[6] McGinty EE, et al. (2012). Cancer incidence in a sample of Maryland residents with serious mental illness. Psychiatric Services, 63(7), 714-717.
[7] SAMHSA: http://www.samhsa.gov/prevention
[8] 3-8-16 Interim Human Services Committee Testimony

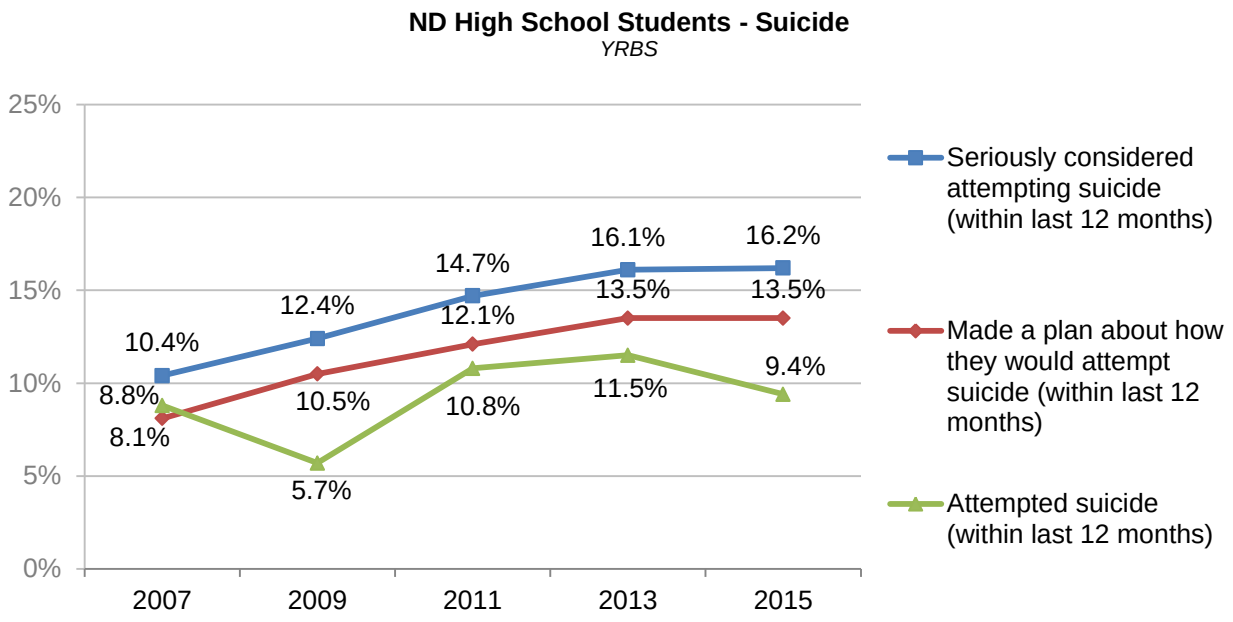


From July through December 2015, Child Care Aware of ND provided technical assistance to 89 child care providers regarding 204 children. Fifty-five percent of the needs for these children were developmental, which includes autism, ADHD and prenatal drug exposure. Thirty-nine percent of needs were behavioral needs (screaming, biting, kicking, etc.).[9]

Good mental health often contributes to good physical health. Likewise, the presence of mental and/or substance use disorder is frequently associated with physical health disorders. 17.2% of ND high school students have a long-term health problem.[10]

Suicide: Sixteen percent of ND high school students seriously considered attempting suicide at some point during the past year and 13.5% of made a plan about how they would attempt suicide. Again, these rates were higher among females than males (20.4% compared to 12.2% and 16.1% compared to 10.9% respectively). Almost one in ten (9.4%) ND high school students attempted suicide one or more times during the past year.[11]

[9] Child Care Providers Caring for Children with Special Needs; Child Care Aware® of North Dakota Data; July-December 2015
[10] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/
[11] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/



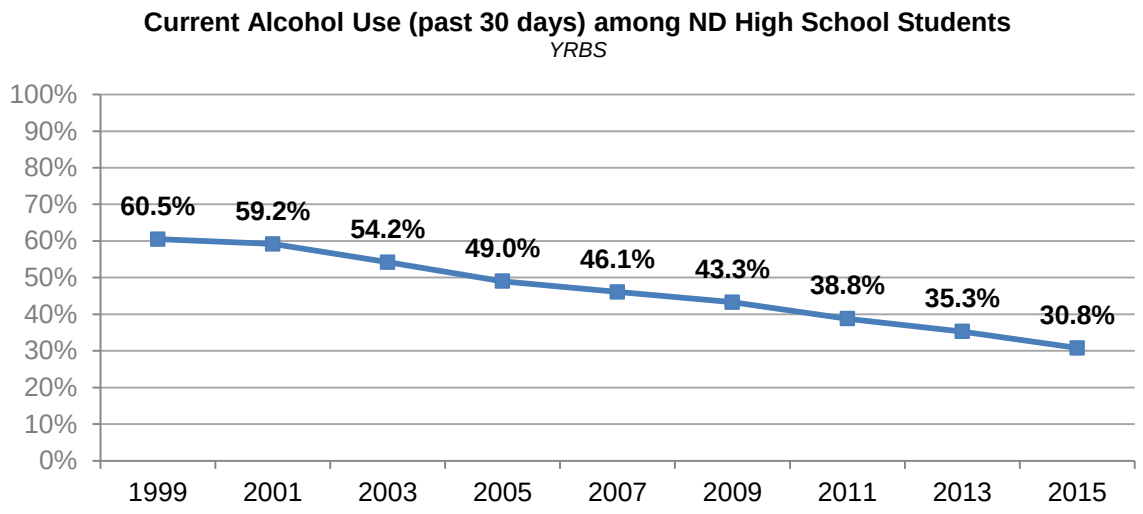
Gambling: Almost one third (29.4%) of ND high school students have gambled on a sports team, gambled when playing cards or a dice game, played one of their state's lottery games, gambled on the Internet, or bet on a game of personal skill such as pool or a video game at least once in the past year.[12] Nationally, approximately 4-5% of youth, ages 12-17, meet one or more criteria of having a gambling problem. Another 10-14% are at risk of developing an addiction, which means that they already show signs of losing control over their gambling behavior.[13]

Substance Use and Abuse: Even with great declines in the past decade, alcohol and tobacco are still the most currently used substances among youth in the state. The percentage of North Dakota high school students who reported having one or more drinks of alcohol during the past 30 days, decreased from 60.5% in 1999, to 30.8% in 2015. Just over 17% report binge drinking on at least one day during the past 30 days.[14]

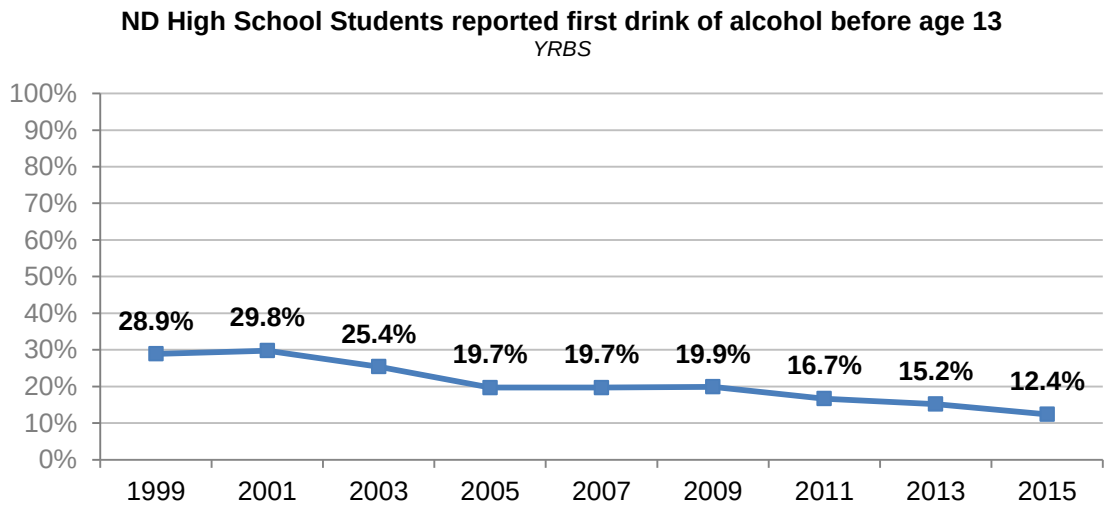
51.3% of ND adults are concerned about whether their community has sufficient alcohol and other drug abuse prevention programs

2015 ND Community Readiness Survey

[12] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/
[13] National Council on Problem Gambling; http://www.ncpgambling.org/files/HS_Fact_Sheet.pdf
[14] drinking five or more drinks of alcohol in a row (within a couple of hours); North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/



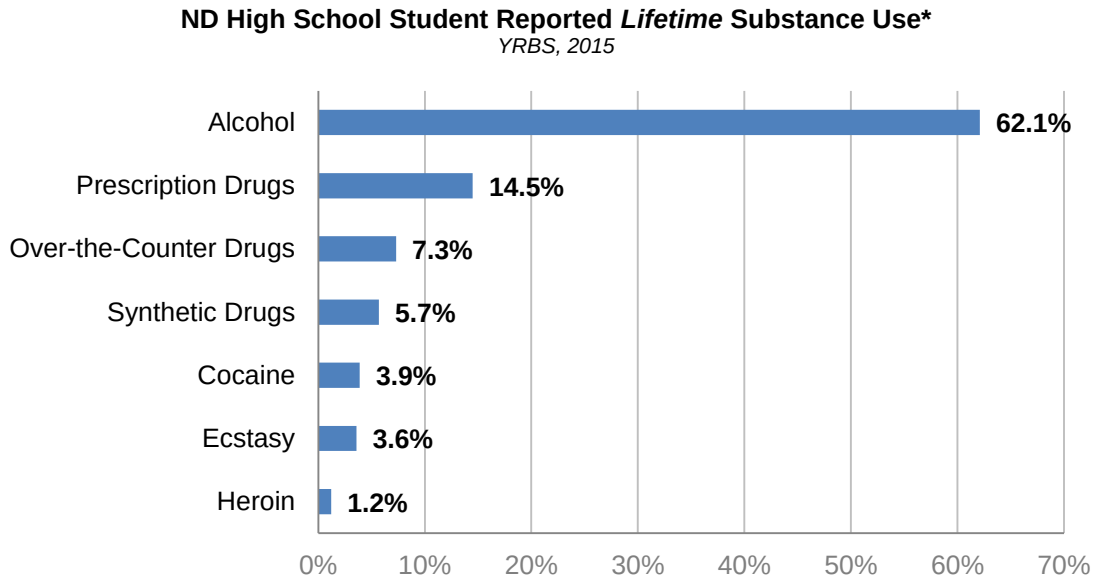
Just over one in ten (12.4%) ND high school students report having their first drink of alcohol before age 13.[15] Research has shown that individuals who begin drinking before age 15 are four times more likely to become addicted than those who wait until they are 21.[16]



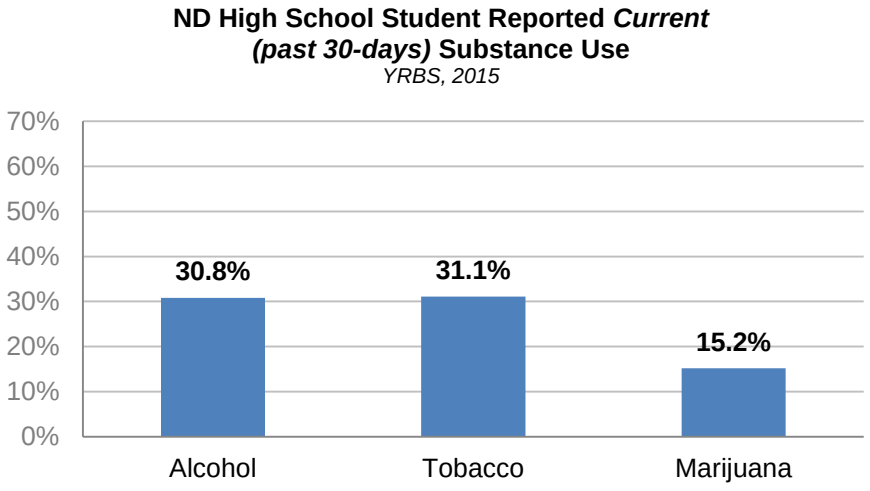
Approximately one third (31.1%) of ND high school students report current use (within the past 30 days) of a tobacco product. Cigarettes remain the most commonly used tobacco product by North Dakota youth.[17] Fifteen percent report current use of marijuana (a decrease from 18.8% in 1999) and 14.5% report taking a prescription drug without a doctor's prescriptions at least one time in their life. Among ND high school students, almost four percent report ever using cocaine,

[15] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/
[16] Center for Adolescent Health
[17] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/ ; National Survey on Drug Use and Health, North Dakota, 2013-2014

one percent report ever using ecstasy, and almost six percent report ever using synthetic drugs.[18]



*In 2009 *(the last time the question was asked)*, lifetime use of marijuana among ND high school students was 30.7%.



The percentage of North Dakota high school students who reported driving a vehicle after consuming alcohol one or more times during the past 30 days, decreased from 31.4%, in 1999 to 7.8% in 2015.[19] In the 2013-2014 school year, 58 students were suspended or expelled for alcohol-related incidents in the public school system and 189 students were suspended or expelled for drug incidents.[20] The percentage of North Dakota high school students that were

[18] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/
[19] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/
[20] ND Department of Public Instruction

offered, sold, or given an illegal drug on school property during the past year, increased from 14.1% in 2013 to 18.2% in 2015.[21]

Approximately three percent of North Dakotans aged 12 through 17 reported alcohol abuse or dependence in the previous year. Similarly, three percent report illicit drug abuse or dependence.[22] At North Dakota Human Service Centers (statewide), an average of 712 youth are receiving addiction services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).[23]

At a point in time (May 2, 2016), 22% of youth on the state's Juvenile Court caseload were identified as having substance abuse needs; 31% had mental health needs; and 14% had needs in both substance abuse and mental health.

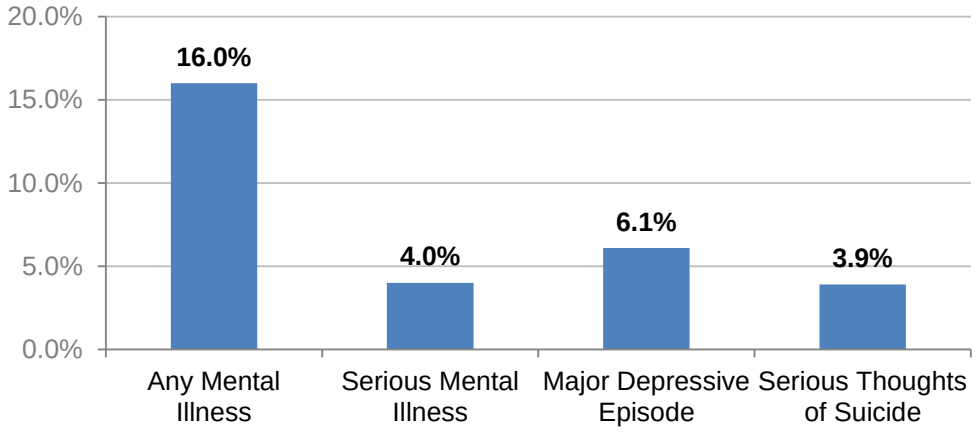
Adult Mental Health

Approximately one in three (31.2%) ND adults report their mental health (including stress, depression, and problems with emotions) was not good on at least one day within the past 30 days. Similarly, one in three (33.9%) report poor physical or mental health kept them from doing their normal usual activities, such as self-care, work or recreation (within the past 30 days).[24]

Approximately 17% of ND adults report they have been told at some time in their life that they have a depressive disorder (including depression, major or minor depression and dysthymia).[25] And, an estimated six percent of ND adults (ages 18 and older) have experienced a major depressive episode in the past year.[26]

Reported Mental Illness within the Past Year among ND Adults ages 18 and older

National Survey on Drug Use and Health, 2013 and 2014

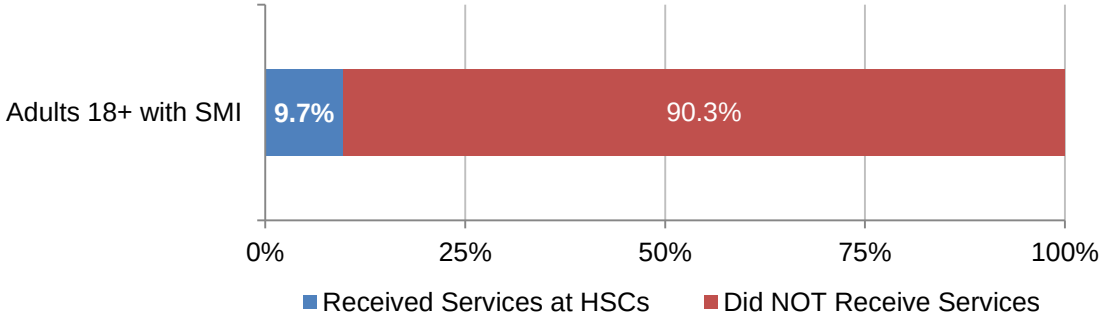


[21] North Dakota Youth Risk Behavior Survey, 2015 https://www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/
[22] National Survey on Drug Use and Health, North Dakota, 2013-2014
[23] Unduplicated count of youth and adult mental health clients and addiction clients - Jan-March 2016
[24] Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+
[25] Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+
[26] National Survey on Drug Use and Health, North Dakota, 2013-2014

The percentage of North Dakotans with any mental illness in the past year is 16%. While an estimated four percent have had a serious mental illness in the past year. Almost four percent of ND adults have had serious thoughts of suicide in the past year.[27]

At North Dakota Human Service Centers (statewide), an average of 6,102 adults are receiving any mental health services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).[28] The National Survey on Drug Use and Health estimates four percent of ND adults to have a serious mental illness, which equals approximately 22,556 individuals age 18 and older in the state. In 2015, the Human Service Centers identified approximately 2,200 adults with serious mental illness as receiving services, which comes to 9.7% of the population needing services.

Percentage of Adults with Serious Mental Illness (SMI) Receiving Services at a Human Service Center, 2015



At times, it is appropriate and effective for inpatient treatment for individuals with mental illness. Conservative estimates suggest a need for 50-60 adult beds per 100,000 population. Based on this estimate, North Dakota total need would be an approximate 350-420 beds. The total beds currently available is right around 323.

Adult Substance Use

Alcohol is the most commonly abused substance among adults in North Dakota. Among North Dakotans aged 18 or older, 63.2% reported having at least one drink of alcohol in the past 30 days and 30% reported having five or more drinks on the same occasion on at least one day in the past 30 days. North Dakota ranks third in the nation for binge drinking rates among those ages 18 or older (30% in ND compared to 24.7% in U.S.).[29]

Approximately four percent of ND adults ages 18 or older report nonmedical use of pain relievers in the past year. Just under three percent report current illicit drug use, other than marijuana (within the past 30 days) and five percent report current marijuana use.[30] Just about

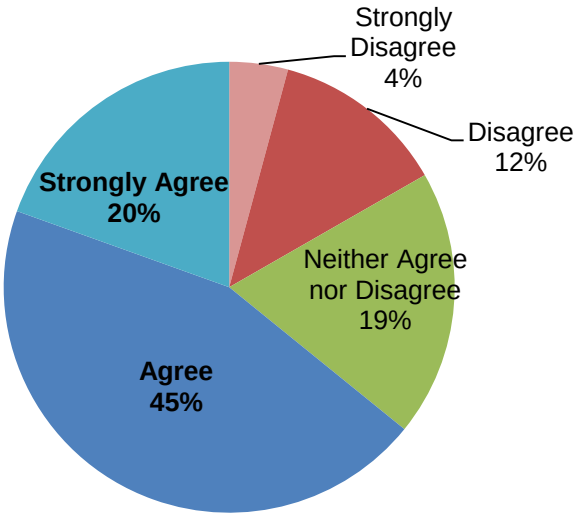
[27] National Survey on Drug Use and Health, North Dakota, 2013-2014
[28] Unduplicated count of youth and adult mental health clients and addiction clients - Jan-March 2016
[29] National Survey on Drug Use and Health, North Dakota, 2013-2014
[30] National Survey on Drug Use and Health, North Dakota, 2013-2014

one in six (15.6%) North Dakotans aged 18 or older report using tobacco products every day.[31] Cigarettes remained the most commonly used tobacco product. [32]

About half of all fatal crashes on North Dakota roads are alcohol-related (nationally, alcohol is typically involved in 30% of fatal crashes).[33] One in three (33.7%) arrests in the state are for driving under the influence and liquor law violations (nationally this rate is 12.8%).[34] In 2014, 56 drivers involved in traffic crashes (fatal and injury) were cited for driving under the influence of drugs.[35] The number of arrests made for drug-related offenses increased from 1,106 in 1996 to 3,431 in 2013.[36] Assessment of new arrivals to prison over the past three years indicates that approximately 72% are recommended to complete substance abuse treatment.[37]

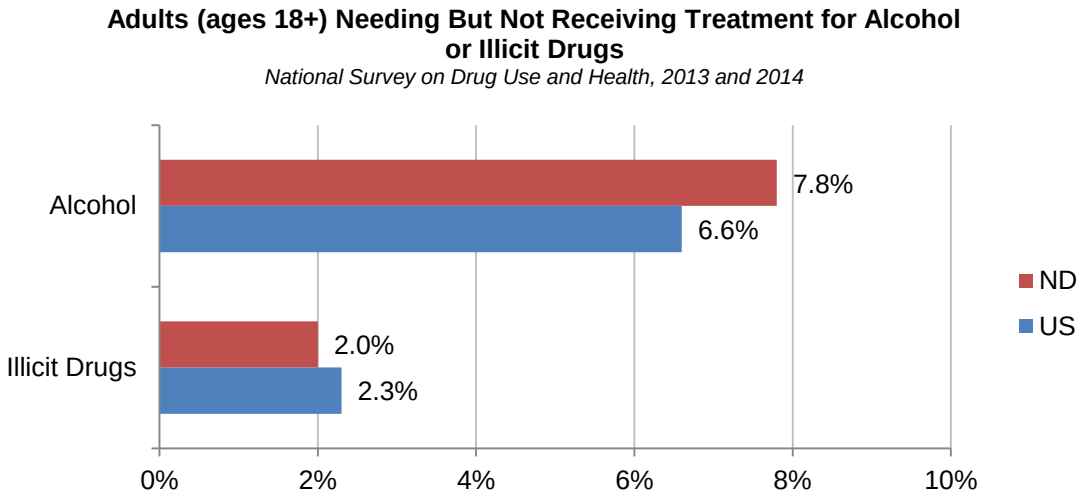
"I know who to go to if I need help for myself or family member(s) who are abusing alcohol or other drugs" - ND Adults

North Dakota Community Readiness Survey, 2015



Approximately eight percent of North Dakotans aged 18 or older report alcohol abuse or dependence. Two percent report illicit drug abuse or dependence.[38] About 2 in 3 (65%) ND adults know who to go to if they need help for themselves or a family member who is abusing alcohol or other drugs.[39] Almost eight percent of ND adults ages 18 or older who need treatment for alcohol did not receive the treatment.[40] At North Dakota Human Service Centers (statewide), an average of 2,082 adults are receiving addiction services in a quarter (3 month period; average of four quarters; April 2015 - March 2016).[41]

[31] Behavioral Risk Factor Surveillance System, 2014; ND adults ages 18+
[32] National Survey on Drug Use and Health, North Dakota, 2013-2014
[33] ND Department of Transportation Crash Summary 2014
[34] ND Uniform Crime Report, 2014
[35] ND Department of Transportation Crash Summary 2014
[36] North Dakota Bureau of Criminal Investigation (NDBCI), 2014
[37] ND Department of Corrections and Rehabilitation, 2014
[38] National Survey on Drug Use and Health, North Dakota, 2013-2014
[39] ND Community Readiness Survey, 2015
[40] National Survey on Drug Use and Health, North Dakota, 2013-2014
[41] Unduplicated count of youth and adult mental health clients and addiction clients - Jan-March 2016


Adults (ages 18+) Needing But Not Receiving Treatment for Alcohol or Illicit Drugs
National Survey on Drug Use and Health, 2013 and 2014
Alcohol
Illicit Drugs
7.8%
6.6%
2.0%
2.3%
0%
2%
4%
6%
8%
10%
ND
US

North Dakota Behavioral Health System Review

By defining and reviewing resources across the Institute of Medicine's Continuum of Care model, the state is beginning to develop and ensure the full continuum of services are available in the state. When components of the system are missing, individuals with behavioral health needs are either under-treated or over-treated, which limits positive outcomes for the individual, family and larger community. It is vital that an individual's behavioral health need is identified early, assessed accurately, and the best-possible, least-restrictive services (directly matching the need) are available and provided. Simplistically, an individual with a behavioral health need should receive the right services at the right time in the right dose.

Another vital component of ensuring a full continuum of care is partnership and collaboration. Movement throughout the continuum should be seamless and fluid. Because an individual's behavioral health needs cannot be disconnected, services and stakeholders should not be disconnected. Supportive, healthy communities are needed to support overall health. This includes involvement and collaboration among a variety of sectors: primary care, education, criminal justice, behavioral health services (public & private), medical services, social services, etc.

When reviewing services and systems in place across the continuum of care, there are a few additional considerations that were taken into account in this assessment. In order to create sustainable and effective change, it is not sufficient to merely identify that a particular service is or is not available. It is vital to look deeper into why services are not available and if they are available, whether they are effective.

- **Funding or reimbursement:** If there is not funding or resources to support a service, or there is no reimbursement for the service, the service will likely not exist.
- I**nfrastructure, including agencies/organizations, workforce, and oversight bodies:** In order for a service to be available and sustainable, there are several layers of infrastructure that are needed. There needs to be an agency or organization through which the service is provided, a workforce to provide the service, and an oversight body to ensure quality, health and safety.
- **Best practices:** Best practices exist and should be utilized in the provision of all behavioral health services across the state. Services must continuous evaluate effectiveness.

Promotion/Prevention

The field of prevention science, well known for advancing the health of people at risk for illnesses such as cancer, diabetes, and heart disease, has also produced effective strategies for the behavioral health fields. Prevention is a cost-effective and common-sense way to avoid the consequences of behavioral health disorders. Prevention efforts are effective when approaches are comprehensive, address risk and protective factors, and focus on a community's unique challenges. All promotion and prevention efforts should recognize and

> The majority of ND adults (90.6%) agree that preventing alcohol and other drug use among youth is important. And, almost three in four (71.6%) agree that alcohol and other drug prevention programs are a good investment because they save lives and money.
>
> *2015 ND Community Readiness Survey*

address the interrelated impact of behavioral health on overall well-being. Investing one dollar in prevention can yield ten dollars of savings in health costs, criminal and juvenile justice costs, educational costs and lost productivity.[42]

Stakeholder Feedback

In general stakeholders valued the importance of promotion and prevention. However, often stakeholders were not aware of prevention efforts occurring in the state or what evidence-based promotion and prevention services should look like. Stakeholders see situations everyday where individuals end up needing more advanced care than would have been necessary if prevention and early intervention services were available.

Currently in the state, substance abuse prevention services are primarily funded through federal grants and have guidelines that direct what funds can be spent on. Mental health promotion and mental illness prevention is a fairly new field of which best practices are still being identified.

Identified Gaps and Needs

- Workforce and best practices are still being identified, as mental health promotion and mental illness prevention are new to the state.
- Limited resources supporting mental health promotion and mental illness prevention efforts.
- There is no credentialing process in the state for prevention professionals.
- Overall, promotion and prevention tends to not be valued as a priority.

Early Intervention

A systematic approach within systems for the early identification of behavioral health disorders is critical. Research suggests that investing in early intervention services can contribute to a reduction in health care costs and help ensure the improved health and well-being of individuals. When integrated into primary health care systems, school settings, and community-based programs, screening can lead to early interventions that can prevent problems from arising.

> Almost half (48.9%) of ND adults agree that there are leaders in their community who are interested in reducing access and abuse of alcohol and other drugs
>
> *2015 ND Community Readiness Survey*

Stakeholder Feedback

Stakeholders identify the importance of early intervention services and at the same time identify some pretty significant gaps in the early intervention services available in the state for children and adults across all behavioral health needs (mental illness and substance abuse). Because of this gap, individuals who develop a behavioral health condition often end up needing more intensive and expensive services because the early intervention services in the continuum of care are not available. And, if the services are available they are not consistent across populations and locations. Stakeholders identified that a lack funding/reimbursement and workforce may limit the availability of early intervention services. Also, stakeholders identified the need for coordination and collaboration between systems (primary care, education, long-

[42] Institute of Medicine and National Research Council's Preventing Mental, Emotional, and Behavioral Disorders Among Young People report – 2009

term care, early childhood development, law enforcement, criminal justice, public and private providers and other systems).

Identified Gaps and Needs

- In general, gaps in collaboration and integration with the education system, including early childhood and childcare systems exist.
- There is a need to identify the primary workforce (including credentials) responsible for implementing evidence-based screening efforts.
- There is not a consistent, universal screening utilized in the state.
- At this time, it was identified that funding is a limitation in the widespread implementation of screenings and early intervention programs.
- Where screenings are occurring in the state, often there are issues with an efficient referral process to further assessment and/or treatment services.
- In general, the current process of conducting assessments is not efficient or effective and this often delays the provision of services.

Treatment

Treatment is the use of any planned, intentional intervention in the health, behavioral and personal or family life of an individual suffering from a behavioral health disorder designed to enable the affected individual to achieve and maintain physical, mental health and a maximum functional ability. Individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs.

Stakeholder Feedback

The primary focus of the previously completed behavioral health assessments have been the behavioral health treatment system and services. Multiple needs and recommendations have been identified through these processes. As discussions about treatment services occurred in meetings with stakeholders, multiple facets of the system were identified. From the initial assessment process identifying an individual's true behavioral health need to the identification and availability of appropriate services and supports.

Assessment and treatment services are not necessarily consistent across the state or across systems (mental health or substance abuse). For example, services provided for individuals with a substance use disorder usually are therapy or treatment. However, individuals with a serious mental illness typically receive medication and case management services. Stakeholders identify a lack of individualized treatment and a lack of integrated care services available for consumers.

Other concerns noted were a lack of a centralized "bed count" system to ensure efficient access to open beds and transportation to inpatient facilities. Stakeholders also expressed a lack of transportation for individuals needing treatment services, at times, causing crisis beds to be utilized for housing when transportation is not available.

Another piece identified throughout most stakeholder meetings was limited services throughout the state. The service limitations reported differed by region whether workforce issues,

timeliness to access services or the availability of effective services. Stakeholders were generally not aware of the priority populations or proposed changes in the public service delivery system.

Lastly, because all substance use disorder programs are required to be licensed, there is the ability to identify the levels of services available in various areas of the state to identify gaps. Stakeholders expressed a lack of available information regarding mental health providers.

Identified Gaps and Needs

- There is a need to reduce the criminalization of behavioral health disorders. Also, reimbursement is not available for BH services for individuals in jails.
- As the field is moving to understand the chronic nature of behavioral health conditions, it has been identified that there are many limitations in the availability of community-based services (including housing, transportation, employment) to allow individuals choice of services in the least restrictive environment and to support individuals throughout their life.
- In general, behavioral health services in the state are not integrated in service provision. Also, limited collaboration or communication with community or health organizations, including the utilization and exchange of data. Also related to this integration, it was identified that when individuals change to a different level of care in service provision, the transition is often not fluid or seamless.
- Oftentimes the services available in a community are not widely known. Changes in services or processes are not always communicated widely to stakeholders and the general public.
- As has been identified in previous studies and assessments, there are gaps and needs in the behavioral health workforce. However, this limitation is not exclusively related to the number of providers. There are other considerations in this need, including the limitations in utilization of evidence-based practices among the current workforce. Also, there is a need for a single registry for mental health providers.
- Comprehensive care coordination is lacking across the system for individuals with a behavioral health condition. This includes a need for workforce capacity building about effective care coordination.
- There is a continued need for role clarification between the public and private behavioral health service systems to ensure the variety of treatment services are available to individuals.

Recovery

Recovery is the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The process of recovery is highly personal and occurs via many pathways. The Substance Abuse and Mental Health Services Administration (SAMHSA) has delineated four major dimensions that support a life in recovery: (1) Health—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being; (2) Home—having a stable and safe place to live; (3) Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or

creative endeavors, and the independence, income, and resources to participate in society; and (4) Community—having relationships and social networks that provide support, friendship, love, and hope.

Stakeholder Feedback

Stakeholders identified limited recovery supports, including community-based services, peer support, supported employment and supported housing. Funding/reimbursement was identified as a barrier as well as a sustainable workforce and infrastructure.

Identified Gaps and Needs

- Workforce limitations (number of trained providers in evidence-based recovery services)
- Limited evidence-based services, and the infrastructure to support these services, available in the state, including sober living environments and other community-based services and supports (including housing, transportation, employment)
- Limited payment to support evidence-based recovery services

Summary and Recommendations

It is acknowledged that the foundational recommendations in this assessment require the involvement and collaboration of a variety of stakeholders. No one system can address these issues. Also, many stakeholder groups have identified service needs, communication barriers and data gaps. It is important to continue engaging stakeholder groups in order to identify more specific recommendations once infrastructure concerns have been addressed.

The following recommendations have been identified as vital foundational pieces on which further efforts can continue to be made and be sustained:

- Continuous collection, analysis and utilization of comprehensive behavioral health data.
- Development of a formal Children's Behavioral Health Leadership group.
- Support substance use disorder early intervention services.
- Mental health promotion and early identification of mental illness.
- Continue to support public service delivery system changes relating to core services and population.
- Recognition of behavioral health conditions as a chronic disease.

Through the process of identifying these recommendations, some special considerations and populations came to light, which need further attention. Federal funding availability often directs the behavioral health services available and are an important resource in considering avenues to fill gaps in the state's behavioral health system. However, resources need to be considered in the application for federal funding and the management of these federal funds. Also, as mentioned in various ways throughout this assessment, the silos present at various levels (funding, services, providers, etc.) greatly impact the effectiveness of the behavioral health

system as a whole. True integration must be a key consideration throughout all behavioral health system efforts.

To be effective, all behavioral health services must be person-centered, where services are centered on the needs and desires of the individual. It is important to note throughout the system review there was recognition the need for consideration of special populations. The following special populations have been identified as needing further identification of needs: early childhood, transition-age youth, 18-25 year olds not in higher education, tribal members, military service members and family, older North Dakotans, persons with disabilities and individuals in jail.

Continuous Collection, Analysis and Utilization of Comprehensive Behavioral Health Data

Behavioral health epidemiological data and service data should be collected, monitored and communicated regularly to guide system and program decisions. In order for this to happen, authority and resources would need to be established. Individual agencies and programs typically track and monitor their own data. However, currently the data is not compiled to provide a picture of the broader behavioral health system.

Overall, it is recommended that a priority be placed on the utilization of comprehensive data to guide further work in the behavioral health field. Specifically, it is recommended that authority and resources be identified to require and/or incentivize data submission by programs, support the ongoing collection and analysis of the data, and communicate the data/results to stakeholders, decision-makers, and the general public.

Development of a Formal Children's Behavioral Health Leadership Group

Many systems and agencies play a role in the children's behavioral health system across the continuum of care. Partnership and collaboration across these systems is vital to ensure a seamless and effective system of care for children where services are streamlined and not duplicated. Stakeholders report there is currently no primary, coordinated infrastructure, authority or leadership to guide the work of children's behavioral health across systems.

It is recommended that a formal, sustainable leadership group is established to assess and guide efforts within the children's behavioral health system. It is recommended this group brings together the key stakeholders, including those from the following fields (among others): education, social services, behavioral health, criminal justice, medical, advocacy, etc. As arose through stakeholder discussions, it is recommended the primary items this leadership group should address are screening, early intervention services, assessment processes, transitions and coordination between services, with the ultimate goal of supporting the full continuum for children.

Support Substance Use Disorder Early Intervention Services

The early intervention services section of the continuum of care is one area that has pretty significant gaps and because of this impacts all areas of the system. It is recommended to review resources in order to ensure the evidence-based program, Screening, Brief Intervention

and Referral to Treatment (SBIRT), is provided in a consistent manner across the state. The first step should include ensuring reimbursement options for this service.

Another area where early intervention services for substance use disorders can be enhanced in the state is by expanding the required alcohol and drug education for all first offenders of alcohol-related offenses. An important consideration in this is ensuring an oversight body is established.

Finally, another area where early intervention services can be enhanced (and simultaneously fulfills a part of the first recommendation for continuous data collection and analysis) is to analyze the Department of Transportation driving under the influence data to identify individuals who may be in need of early intervention and potentially treatment services. The review of this data would also assist in ensuring the screening, assessment and treatment services provided to this high-risk population are effective.

Mental Health Promotion and Early Identification of Mental Illness

In order to enhance the health promotion services available in the state, it is recommended that resources are dedicated to developing healthy communities to support individuals' behavioral health. The goal of these efforts would be to create an environment supportive of mental health and reducing the stigma of mental illness.

Continuing with the goal of improving the early intervention services within the state's behavioral health system, it is recommended to support the implementation of consistent screenings for at-risk populations. In order to develop a plan to implement consistent screenings, collaborations with a variety of organizations and disciplines will be vital, from the education system to long-term care.

Continue to Support Public Service Delivery System Changes Relating to Core Services and Population

In the effort to enhance services available to support an individual's behavioral health, it is recommended to continue role clarification between the public and private behavioral health service delivery systems. The public service delivery system's primary role as chronic disease management, regional intervention services and 24-hour crisis services has been identified. It is also recommended that the public service delivery system continue to enhance building awareness of these service changes. This may include increased communication to general public and stakeholders, holding regional meetings and providing information to consumers.

Recognition of Behavioral Health Conditions as a Chronic Disease

With the recognition of behavioral health conditions as chronic disease, it is vital that the services available follow chronic disease management principles. Aligning with these principles, it is recommended that access to community-based recovery supports are increased. These recovery supports include supported employment, supported living (including sober living), and recovery coaches (including peer support). It is also recommended to reduce barriers to accessing already available recovery supports.

Appendix A

Resource Links

REPORTS

- Interim Human Services Committee testimony: www.legis.nd.gov/assembly/64-2015/committees/interim/human-services-committee
- Schulte Consulting, LLC Behavioral Health Planning Final Report July 22, 2014: http://storage.cloversites.com/behavioralhealthsteeringcommittee/documents/ND%20Final%20Report.pdf
- North Dakota Behavioral Health Stakeholders Group Reports
  - Building Stronger Behavioral Health Services in North Dakota: Framing Key Issues and Answers – 7/18/2014: https://ruralhealth.und.edu/projects/nd-behavioral-health/pdf/building-stronger-behavioral-health-services-nd-summary-report.pdf
  - November 17, 2015 Summary Reports: https://ruralhealth.und.edu/projects/nd-behavioral-health/pdf/summary-report-nov-2015.pdf
  - Behavioral Health Stakeholder Survey, June 2016

DATA

- United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, & Inter-University Consortium for Political and Social Research. National survey on drug use and health. Retrieved from www.samhsa.gov/data/population-data-nsduh
- North Dakota Office of Attorney General, Bureau of Criminal Investigation. Crime in North Dakota. Retrieved from www.ag.nd.gov/Reports/BCIReports/CrimeHomicide/Crime14.pdf
- North Dakota Department of Transportation. North Dakota Crash Summary. Retrieved from www.dot.nd.gov/divisions/safety/docs/crash-summary.pdf
- Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System Survey data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention. Youth Risk Behavior Survey. Retrieved from www.cdc.gov/healthyyouth/data/yrbs/index.htm and www.nd.gov/dpi/SchoolStaff/SafeHealthy/YRBS/
- WYSAC (2016). North Dakota Community Readiness Survey, 2015 by Nelson, N., Harnisch, B., Anatchkova, B. & Canen, E. L. (WYSAC Technical Report No. SRC-1601). Laramie: Wyoming Survey & Analysis Center, University of Wyoming. https://prevention.nd.gov/sites/default/files/North%20Dakota%20Community%20Readiness%20Report%20Final%2003292016.pdf
- Department of Human Services, Behavioral Health Division. (2015). North Dakota epidemiological profile: Alcohol, tobacco and illicit drug prevalence, root causes, and consequences in North Dakota. Bismarck, ND. https://prevention.nd.gov/sites/default/files/pdf/2015-epi-profile.pdf

Appendix B

Description of a Good and Modern Addictions and Mental Health Service System[43] – Excerpts

Draft – April 18, 2011

As outlined in this brief, a modern behavioral health 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 behavioral health service system is **accountable**, **organized**, **controls costs and improves quality**, is **accessible**, **equitable**, and **effective**. It is a public health asset that improves the lives of Americans and lengthens their lifespan.

The vision for a good and modern behavioral health system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a "good" and "modern" system of care is to provide a full range of high quality services to meet the range of age, gender, cultural and other needs presented. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidenced-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. A good system should also promote healthy behaviors and lifestyles, a primary driver of health outcomes.

CORE STRUCTURES AND COMPETENCIES FOR A MODERN SYSTEM

1. **Workforce**. The modern system must have experienced and competent organizations and staff. Recruitment and retention efforts will need to be enhanced, especially to increase the available pool of culturally, ethnically and racially diverse practitioners. Providers will need to embrace team-based care and collaboration with other systems as a way of doing business. Licensure requirements need to evolve and certification requirements need to be strengthened for those professions that do not currently require formal licensure. The workforce must also develop an improved ability to use technology to provide, manage and monitor quality care.

   Four critical efforts loom large: (1) redeployment of the shrinking professional workforce to positions of consultation and oversight; (2) augmentation of the existing workforce to include trained family, youth and peer supports as part of the paid workforce; (3) a more concerted pre-professional training effort to prepare new frontline and professional providers for the modern delivery system that is consumer- and family-driven, youth-guided, recovery/resiliency-oriented and evidence-based; and (4) a robust continuing training effort to develop, enhance, and sustain providers' capacity to access, interpret, and apply performance data and research findings on an ongoing basis to improve care.

[43] Description of a Good and Modern Addictions and Mental Health Service System, Draft – April 18, 2011; http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

2. **Empowered Health Care Consumers**. Health care consumers/families need information and tools to allow them to promote and reinforce their role as the center of the health care system. At a minimum, this will include a system that supports health literacy, shared decision making, and strategies for individuals and families to direct their own care. Shared decision making should become the standard of care for all treatment services. Participant direction of services allows individuals and their caregivers (when appropriate) to choose, supervise and in some instances, purchase the effective supports they need rather than relying on professionals to manage these supports. Health care consumers and families will also need access to user-friendly information on the effectiveness of available services in order that they may truly make informed health care decisions.

3. **Information Technology**. To achieve optimum individualized care, a modern health system should include a structure in which all holistic outcomes, measures and indicators of health are collected, stored and shared with the individual and all of those providers who are associated with care of the individual. To that end, interoperable, integrated electronic health records will be necessary, as will community-wide indicators of behavioral health disorders. Additionally, appropriate security mechanisms and informed consent should drive this system while taking into account protection of individual rights and support to ensure appropriate linkages to services.

PRINCIPLES

These principles should apply to the provision of behavioral health services and cross the lifespan of individuals who need and use these services.

- Preventing and treating behavioral health disorders is integral to overall health.
- Services shown to be effective must be available to address current health and behavioral health disparities and be relevant to, and respond to, the diverse cultures and languages of individuals and families.
- A wide range of effective services and supports should be available based on a range of acuity, disability, engagement levels and consumer preferences. The consumer's resilience and recovery goals in their individualized service plan should dictate the services provided.
- The system should use information and science to deliver services. Services should be provided in convenient locations in order to reduce barriers, identify needs as early as possible, and engage individuals in care as early and as easily as possible.
- Wherever possible, the health system should support shared decision making with adult consumers, with youth and with families.
- Effective care management that promotes independence and resilience is key to coordinating health and specialty care.
- Service delivery must achieve high quality standards and results as well as outcomes that are measurable and are measured.
- Technology will be an important tool in delivering services. This includes telehealth, web-based applications and personal digital assistants that assist individuals in their recovery. Increased use of technology will expand access to and coordinate care rather than always relying on location-based service delivery.
- Services that are proven effective or show promise of working will be funded and should be brought to scale; ineffective services and treatments that have not shown promise will not be funded.

4. **Funding and Payment Strategies**. In the public sector, individuals/families/youth with complex mental and substance use disorders receive services funded by federal, state, county and local funds. These multiple funding sources often result in a maze of eligibility, program and reporting specifications that create funding silos featuring complicated administrative requirements. If services are to be integrated, then dollars must be also intertwined. In the same way that Medicaid will be required to streamline eligibility and

enrollment, the good and modern system must either blend or braid funds in support of comprehensive service provision for consumers, youth and families.

5. **Quality and Performance Management**. Quality improvement through the use of outcomes and performance measures is a cornerstone of the Affordable Care Act. A renewed focus on quality will also help payers link performance improvement with payment while moving away from the current incentives to provide more care without evidence of improved outcomes.

6. **Sustainable Practice Improvement**. Key to a modern behavioral health system will be an ethic of—and standard operating procedures for—continuous practice improvement to incorporate new evidence and to ensure more accountability, with a focus on "practice-based evidence" as well as evidence-based practice. Standards being developed by national organizations can guide providers (agencies, group practices and individual practitioners) in their efforts to reshape their practice and to sustain changes over time.

7. **Continued Partnerships**. While the good and modern system focuses on the need for better integration of primary care and behavioral health, this does not supplant the continued need to work with other systems that serve individuals with behavioral health disorders. Links between the good and modern system and the child welfare, criminal and juvenile justice, education and aging systems are more critical than ever.