Testimony
Judicial Process Committee
Representative Shirley Meyer, Chairman
December 14, 2009

Chairman Meyer and members of the Judicial Process Committee, I am Dr. Andy McLean, Medical Director of the North Dakota Department of Human Services. As you are aware, the legislative intent of the Chapter 25 commitment procedures is as follows:

1. Provide prompt evaluation and treatment of persons with serious mental disorders or chemical dependency.
2. Safeguard individual rights.
3. Provide continuity of care for persons with serious mental disorders or chemical dependency.
4. Encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures.
5. Encourage, whenever appropriate, that services be provided within the community.

My understanding of the focus of this committee's requested testimony lies in five areas:

1. The concern regarding uniformity of commitment procedures throughout the state.
2. The appropriateness of detention sites while awaiting hospitalization or evaluation.
3. The timeliness of evaluation.
4. The limited availability of psychiatric services in the state (as relates to above, as well as overall behavioral health services access).
5. The availability of treatment beds in private facilities.

Regarding uniformity of commitment procedures, in my experience, there are differences from county to county for a number of reasons. There are differences in resources, differences in philosophy, differences in expertise, etc.

1. Potential solutions to uniformity issues:
   a) Simplification of commitment forms. Currently there are multiple and duplicative forms that contribute to lack of uniformity in procedures. This can be accomplished with input from stakeholders and through legal processes.
   b) Department of Human Services staff have engaged in meetings and consultation with judges and attorneys regarding commitment rules and will continue to do so.

   The Department holds summits for regional human service center "screeners" to review current issues. Our last summit included staff from the Department of Corrections and Rehabilitation. We also encourage regions to develop community provider meetings to discuss capacity and procedural issues. Department staff have been active members of those meetings.

   Regarding appropriateness of detention and timeliness of evaluation: Obviously safety is a primary issue. Jails are only to be utilized in an emergency. While transportation can be an issue in frontier areas, my colleagues from the ND Psychiatric Society will report that this issue is rarely a concern. I would also defer to that group to discuss the issue of private psychiatric beds, as well as funding issues affecting placement.

Last legislative session, language change was approved to underscore the recognition that face to face screening for public facility admission should be done, but that exceptions may need to take place, particularly in more rural areas. Some have reported a concern regarding limited numbers of mental health professionals to do screening. One oversight last legislative session, in our attempt to fully recognize Licensed Addiction Counselors as expert in addiction commitment definitions, was section: **25-03.1-23. Petition for continuing treatment orders.**

"A petition for an order authorizing continuing treatment must contain a statement setting forth the reasons for the determination that the patient continues to be a person requiring treatment; a statement describing the treatment program provided to the patient and the results of that treatment; and a clinical estimate as to how long further treatment will be required. The petition must be accompanied by a certificate executed by a physician, psychiatrist, or psychologist."

We would recommend the latter sentence read "by a physician, psychiatrist, psychologist, or licensed addiction counselor, within their respective areas of expertise."

2. & 3. Potential solutions include:

a) The use of tele-behavioral health technology for initial evaluation. Technology and IT security needs to be in place, but with adequate computer/camera access, this could be accomplished almost anywhere and anytime.

4. Access: Regardless of specialist prescriber numbers, the vast majority of psychotropic medication prescribing will continue to be done by primary care providers. In addition to telepsychiatry, the Department of Human Services is committed to the concept of primary care-behavioral health care interface. We have developed a pilot with a Federally Qualified Health Center (FQHC), and certain private providers are doing the same.

This concludes my written testimony. I would be happy to answer any questions.