Children's Cabinet

Meeting Minutes
November 19, 2019
Sakakawea Meeting Room
Bismarck, North Dakota

Members in attendance

Susan Gerenz, Superintendent of Public Instruction designee	Rep Lawrence Klemin, Speaker of the House
Maria Neset, Governor's designee	Kimberly Jacobson, Parent/Private Service Provider
Paula Condol, Parent/Private Service Provider	Honorable Lisa Fair McEvers, Justice
Rep Chet Pollert, Chairman – Legislative Management – Presiding Officer	Janell Regimbal, Parent/Private Service Provider
Russell Riehl, Parent/Private Service Provider	Vincent Roehr, Tribal Nations Representative

Task force members not in attendance

Senator David Hogue	Teresa Larsen, Director of the Committee on Protection and Advocacy

Other attendees

Pamela Sagness, Director Behavioral Health Division	Chris Jones, DHS Executive Director
Cory Pedersen, Director Children and Family Services Division	

Representative Chet Pollert, Chair called the meeting to order at 1:00 pm.

Introductions

Overview of the Children's Cabinet Duties:
Overview of SB2313 by Jennifer Clark from Legislative Council
Request by Cabinet to obtain a copy of SB2313 and testimony to review for intent of the bill and insight.

- ✓ SB2313 and testimony attached

Overview of the work completed by the Children's Behavioral Health Task Force (CBHTF) (2017-2018):
Overview provided by Greg Gallagher, CBHTF meeting facilitator

- ✓ Testimony attached

Questions:
Representative Pollert – Is the Children's Cabinet forwarding the work that the CBHTF was assigned?

Greg Gallagher – Yes

Pam Sagness – Presented inventory of different resources across the agency (Link to the CBHTF provided at the end of the meeting minutes). CBHTF didn't move forward because it was limited to Behavioral Health; not broad enough.

Rep. Pollert – Question as to the expiration date.
Jennifer Clark – Clarified expiration date of July 31, 2025.

Pam Sagness – Error in the final edit of the bill. There will most likely will be a change in the expiration date.

Rep. Pollert – Sees it being a lot longer than quarterly. Thinks it will take longer than a year to hit the tasks.

Overview of DHS Efforts to Support Children & Families:
Presentation by Chris Jones – DHS Director

- ✓ Presentation attached

Questions:

Janelle Regimbal - Thoughts and ideas how the legacy fund may be able to play in this prevention shift?
Chris Jones - The amount of dollars coming into DHS is already enough. Not sure how to move them up yet. We need more time to see how to move these things up. As a department we suggested reducing the number of beds in nursing homes so trying to be respectful. Not sure about the legacy fund.

Presentation by Cory Pederson – Director CFS

- ✓ Presentation attached

Presentation by Pam Sagness – Director BHD

Overview of Simle Middle School Behavioral Health Pilot:
Presentation by Russell Riehl –Simle Middle School Principal

- ✓ Presentation attached

Questions:
Rep Klemin: Is there a plan to broaden the scope?

- ✓ Working on a playbook to share with other school districts. Granted 2 years to test the model outside Bismarck Schools.

Vincent Roehr: Is there a Tribal school identified?

- Schools can step forward and say they are interested.

Stakeholder Engagement Discussion:

Topics for next meeting:

- Lutheran Social Services Programs
- Paula Condol's tele-mental health grant
- Juvenile Court
- Police Youth Bureau
- Tribal update
- Early Care and Education
- DPI Updates

Presentation by Susan Gerenz on Youth Exposed to Polysubstances

- ✓ Presentation attached

Public Comment:

Roxane Romanick

- ✓ Comments attached

Links:

Human Services Research Institute (HSRI) - https://www.hsri.org/NDvision-2020

Children's Behavioral Health Taskforce - https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/index.html

Next meeting: Before the end of February

Adjourned: 4:40 p.m.

Sixty-sixth Legislative Assembly of North Dakota
In Regular Session Commencing Thursday, January 3, 2019

SENATE BILL NO. 2313
(Senators J. Lee, Hogan, Poolman)
(Representatives Rohr, Westlind)

AN ACT to create and enact two new subsections to section 50-06-05.1 and two new sections to chapter 50-06 of the North Dakota Century Code, relating to duties of the department of human services, creation of a children's cabinet, and creation of a commission on juvenile justice; to repeal section 50-06-43 of the North Dakota Century Code, relating to the children's behavioral health task force; to provide a report to the legislative management; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 50-06-05.1 of the North Dakota Century Code is created and enacted as follows:

To develop a system of services and supports to provide behavioral health services and supports in the community for children at risk of or identified as having a behavioral health condition and for the families of these children. This system must include early intervention, treatment, and recovery services and supports and must interface with, but not include, child protective services or juvenile court.

SECTION 2. A new subsection to section 50-06-05.1 of the North Dakota Century Code is created and enacted as follows:

To provide resources on mental health awareness and suicide prevention to the behavioral health resource coordinator at each school. The resources must include information on identifying warning signs, risk factors, and the availability of resources in the community.

SECTION 3. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Children's cabinet - Membership - Duties.

1. The children's cabinet is created to assess, guide, and coordinate the care for children across the state's branches of government and the tribal nations.

2. The children's cabinet consists of the following members:

   a. The governor, or the governor's designee;

   b. The chief justice of the supreme court, or the chief justice's designee;

   c. The speaker of the house of representatives, or the speaker's designee;

   d. The president pro tempore of the senate, or the president pro tempore's designee;

   e. The superintendent of public instruction, or the superintendent's designee;

   f. The director of the committee on protection and advocacy, or the director's designee;

   g. A representative of the tribal nations in the state, who is appointed by the governor; and

   h. Four individuals representing parents, private service providers, or other community interests, who are appointed by the governor to serve a term of two years, at the

pleasure of the governor, and who are entitled to reimbursement from the department of human services for travel and lodging at the same rate as provided for state officers and employees.

3. The chairman of legislative management, shall serve as the presiding officer of the cabinet. The cabinet shall meet at least quarterly. Additional meetings may be held at the discretion of the presiding officer.

4. The children's cabinet shall:

   a. Coordinate broad-based leadership across programs, agencies, branches of government, and tribal nations to meet the needs of children;

   b. Develop strategies to address gaps or needs regarding early care and education, medical and behavioral health, community, child welfare, and juvenile justice;

   c. Develop strategies to provide for the full continuum of care in the delivery of services, including promotion, prevention, early identification and intervention, service delivery, and recovery;

   d. Seek to engage cooperation across public and private service providers;

   e. Provide a comprehensive vision for how and where children are best served, attending to children in a respectful and relevant manner;

   f. Seek strategies to provide services to children without consideration of prior engagement with juvenile services;

   g. Provide for the active participation of consumers and providers statewide on advisory committees; and

   h. Receive information and recommendations from the department of human services, department of corrections and rehabilitation, and other state agencies.

5. The department of human services shall provide the children's cabinet with staffing and administrative services.

SECTION 4. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Commission on juvenile justice - Reports.

1. The commission on juvenile justice is composed of:

   a. Three members of the house of representatives, two of whom must be selected by the majority leader of the house of representatives and one of whom must be selected by the minority leader of the house of representatives;

   b. Three members of the senate, two of whom must be selected by the majority leader of the senate and one of whom must be selected by the minority leader of the senate;

   c. The governor, or the governor's designee;

   d. The superintendent of public instruction, or the superintendent's designee;

   e. The executive director of the department of human services, or the executive director's designee;

   f. The director of the department of corrections and rehabilitation's division of juvenile services, or the director's designee;

g. The executive director of the Indian affairs commission, or the executive director's designee;

h. A director of juvenile court services, appointed by the chief justice of the supreme court;

i. A representative from the commission on legal counsel for indigents; and

j. The following members appointed by the governor:

(1) A state's attorney;

(2) A representative of a children's advocacy center; and

(3) A representative of a city police department.

2. The governor shall designate one of the members of the commission to serve as the presiding officer. The governor's appointees serve at the pleasure of the governor. Excluding ex officio members, the term of a commission member is two years.

3. The commission shall meet at least four times per year at the times and locations designated by the presiding officer. The office of the governor shall provide staffing for the commission.

4. The commission shall:

a. Review chapter 27-20;

b. Gather information concerning issues of child welfare, including education, abuse, and neglect;

c. Receive reports and testimony from individuals, state and local agencies, community-based organizations, and other public and private organizations, in furtherance of the commission's duties;

d. Advise effective intervention, resources, and services for children;

e. Report to and be subject to the oversight of the children's cabinet; and

f. Annually submit to the governor and the legislative management a report with the commission's findings and recommendations which may include a legislative strategy to implement the recommendations.

5. A member of the commission who is not a state employee is entitled to reimbursement for mileage and expenses as provided by law for state officers and employees to be paid by the department of corrections and rehabilitation. A state employee who is a member of the commission is entitled to receive that employee's regular salary and is entitled to reimbursement for mileage and expenses to be paid by the employing agency. A member of the commission who is a member of the legislative assembly is entitled to receive per diem compensation at the rate provided under section 54-35-10 for each day performing official duties of the commission. The legislative council shall pay the per diem compensation and reimbursement for travel and expenses as provided by law for any member of the commission who is a member of the legislative assembly.

SECTION 5. REPEAL. Section 50-06-43 of the North Dakota Century Code is repealed.

SECTION 6. EXPIRATION DATE. Section 3 of this Act is effective through July 31, 2025, and after that date is ineffective.

_____ _____
President of the Senate Speaker of the House

_____ _____
Secretary of the Senate Chief Clerk of the House

This certifies that the within bill originated in the Senate of the Sixty-sixth Legislative Assembly of North Dakota and is known on the records of that body as Senate Bill No. 2313.

Senate Vote:	Yeas 47	Nays 0	Absent 0
House Vote:	Yeas 81	Nays 9	Absent 4

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Secretary of the Senate

Received by the Governor at _____M. on _____, 2019.

Approved at _____M. on _____, 2019.

_____
Governor

Filed in this office this _____day of _____, 2019,

at _____ o'clock _____M.

_____
Secretary of State

TESTIMONY

NORTH DAKOTA CHILDREN'S CABINET

Greg Gallagher, Program and Research Director,
The Consensus Council, Inc.
ggallagher@agree.org
November 19, 2019

Mr. Chairman, Governor Burgum, and members of the North Dakota Children's Cabinet,

I am Greg Gallagher, Program and Research Director at The Consensus Council, Inc., a nonpartisan, nonprofit organization commissioned by its Board to assist agencies, organizations, and communities reach collaborative agreements on important issues of public policy. I am here at the request of the Department of Human Services to provide an overview of the work completed by the Children's Behavioral Health Task Force (CBHTF), during its tenure, spanning 2017-2018, during which time the Consensus Council served as the contracted facilitator for the CBHTF. My comments reflect a general synthesis of the public record covering all meetings, activities, and documentation generated during the time of the CBHTF's official standing. A complete and open record of all CBHTF proceedings and documents is available for general review (https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/index.html).

CBHTF Authority, Membership, Activities

The CBHTF was authorized during the 2017 North Dakota Legislative Session (NDCC 50-06-43), under Senate Bill 2036, and was commissioned to perform the following duties:

1. Assess and guide efforts within the children's behavioral health system to ensure a full behavioral health continuum of care is available in the state;
2. Make recommendations to ensure the children's behavioral health services are seamless, effective, and not duplicative;
3. Identify recommendations and strategies to address gaps or needs in the children's behavioral health system; and
4. Engage stakeholders from across the continuum to assess and develop strategies to address gaps or needs in areas including education, juvenile justice, child welfare, community, and health.

Authority for the CBHTF was repealed during the 2019 Legislative Session with the passage of Senate Bill 2313, the same legislation that authorized the establishment of the Children's Cabinet.

State law prescribed the membership of the CBHTF to include the following officials or their designees:

1. The Superintendent of Public Instruction;
2. The Executive Director of the Department of Human Services;
3. The State Health Officer;
4. The Director of the Department of Corrections and Rehabilitation;
5. The Executive Director of the Indian Affairs Commission; and
6. The Director of the Committee on Protection and Advocacy.

The Executive Director of the Department of Human Services served as the chairman of the CBHTF.

The CBHTF met formally ten times during its tenure. From its initial meeting and proceeding throughout the course of its work, the CBHTF placed a priority on studying strategies that would broaden a wider understanding across the state's network of service agencies and providers of the Institute of Medicine's Continuum of Care model. The continuum of care is a principled approach to providing services within a fully functioning service delivery system, where appropriate attention, programming and funding are dedicated to each of the uniquely critical phases of care, including promotion, prevention, early identification and intervention, service delivery, and recovery. Where any one component of the continuum of care may be either over- or under-emphasized, the system of care becomes unbalanced, inefficient, less effective, or in the extreme, negligent. The CBHTF sought to inventory and assess the functional practice of the continuum of care across the state's service systems, both public and private, encompassing education, juvenile justice, child welfare, community, and health, as the CBHTF's mandate required.

Contemporaneous with the beginning of the CBHTF's work, the Department of Human Services released its much-anticipated *North Dakota Behavioral Health System Study* (NDBHSS), sponsored by the Department and conducted by the Human Services Research Institute (HSRI). This study presented a series of system-wide proposals to improve the reach and effectiveness of the state's behavioral health efforts. The NDBHSS, which effectively validated and updated the findings of previous state studies, stands as a seminal report on the state's behavioral health system, the challenges it faces, and prospective strategies to improve the reach and quality of the state's service system.

The NDBHSS confirmed the CBHTF's observation that the state holds in its possession sufficient independent research to proceed in its work in a coordinated manner across agency lines. The CBHTF received extensive reports on how each of its member agencies structured its

programs to meet the health needs of North Dakota citizens. The CBHTF conducted an inventory of all the CBHTF member agencies, using their biennial reports of programs and activities, to acquire a global understanding of how each agency's activities impact specific groups of people and also how they interact with other agencies' activities. The CBHTF received and considered public comments provided by stakeholder organizations and private citizens, which afforded the opportunity for CBHTF members to probe for information, test ideas, receive unfiltered reactions, and engage in levels of soul searching on what might make a complex system more understandable, transparent, efficient, and humane.

CBHTF Issue Agenda and Position Statements

During the course of the CBHTF's meetings, members identified and considered a series of topics that impact children's behavioral health. The following represents a sampling of these topics:

- Ensuring that all citizens are afforded comparable, culturally appropriate treatment options, regardless of location or jurisdiction, removing any stigma surrounding such options;
- Reinforcing the unique role and relationship the tribal courts hold with the state in properly serving youth adjudicated through tribal courts, including custody arrangements;
- Identifying and resolving tribal and county jurisdictional issues related to social service delivery;
- Assessing the potential development of a permanent, higher-level *Children's Cabinet* to study and enact improvements to the state's service system, ensuring broad outcomes and consumer satisfaction;
- Assessing how to institute a robust continuum of care model within the state's health system, including medical and behavioral healthcare;
- Assessing the application of the continuum of care within the working relationship between the school system and the juvenile services system to better anticipate, forestall, and manage disruptive student behavior triggers before they result in juvenile services referrals;
- Identifying and adopting uniform crisis response measures, including seclusion and restraint practices, that are properly grounded in the continuum of care and remove the prospects of further traumatizing an individual;

- Securing the integrity of family units when certain asset-based service eligibility rules may force the placement of children in foster care in order to receive services;
- Assessing how providers might better support families in designing their own service solutions;
- Incorporating access to safe and stable housing into service system solutions;
- Building greater uniformity between special education and behavioral health practices, referrals, and credentialing;
- Studying how service programs might be better communicated to the public;
- Defining terms and clarifying what behavioral health is (and is not) to better align services across agencies;
- Generalizing access to high-quality, initial screening tools to improve the prospects of receiving appropriate services;
- Communicating well-established research that preventative measures are more economical in the long term and should be funded accordingly;
- Continuing to survey and monitor alcohol, substance use, risk factors, and other health practices among youth to facilitate data-driven decision making;
- Expanding professional development and streamlining professional credentialing across all agencies;
- Increasing the availability of home- and community-based services statewide, especially in rural areas;
- Managing observed increases in the number of students with complex behavioral health issues;
- Expanding an awareness of child maltreatment preventative measures in family and institutional settings;
- Improving early childhood identification and intervention efforts statewide;
- Reconciling discrepancies between the Uniform Juvenile Code and the child protection system regarding certain definitions, evidentiary standards, and determination processes that can unfairly penalize caregivers; and
- Providing system navigators to help individuals find the services they need.

The preceding list of issues identified by the CBHTF, although lengthy, is but a partial representation of the many agenda items discussed by the CBHTF members or presented during public comment. The minutes of the CBHTF's meetings present a more detailed review of the content and process of the CBHTF.

As a means of managing and prioritizing its extensive list of agenda items, the CBHTF developed a high-level policy summary, titled *Platform Position and Strategy Statements, December 6, 2018*, developed across five drafts and spanning the tenure of the CBHTF. These statements presented what the CBHTF believed to be the more pressing issues needing resolution (https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/cbhtf-platform-positions-strategies-master-draft-4-clean.pdf). The position and strategy statements, appended to this testimony, consist of a preamble, outlining the purpose and values of the CBHTF, and eleven position statements, each indexed to a set of related findings developed within the NDBHSS. These position statements lay out an agenda for future action by either the CBHTF or other designated agencies, including:

A. Adoption of school seclusion and restraint policy and practices guidelines;
B. Formation of a state-level children's services committee;
C. Suicide prevention;
D. Bullying prevention and intervention;
E. Brain development;
F. Sufficient, sustainable funding;
G. Expanded emergency care resources;
H. Juvenile court rules for maltreatment;
I. State and tribal service collaboration;
J. Early intervention, IDEA Part C; and
K. Substance exposed newborn services.

Please refer to the attached *CBHTF Platform Position and Strategy Statements.* I will present a brief extemporaneous overview of the document.

Summary Observations

From the commencement of its work in April 2018, the CBHTF sought to compile the various issues that affect children and their caregivers. It sought to prioritize what the state might be able to accomplish, both within short-term successes and longer-term investments of effort. It sought to define an aspirational framework of integrated, best-practice, community-wide initiatives, embodying the continuum of care. It sought to build a trusting relationship among the agencies, where everyone would work as partners to advance and advocate for critical policy aims during the 2019 Legislative Assembly, regardless of agency responsibility.

Early on, the CBHTF members determined that the CBHTF, itself, might need to be supplanted with another higher-level leadership organization, which it titled the *Children's*

Commission and which eventually emerged in Enrolled SB 2313 as the *Children's Cabinet.* In effect, the CBHTF wrote itself out of existence. Much of the authorizing language outlining the purpose of the Children's Cabinet in Enrolled SB 2313 finds its origin in the first draft of SB 2313, prepared under the direction of the CBHTF.

The CBHTF proposed this structural change, involving the high-level engagement of all three branches of government, tribal leadership, and wider-community representation, to underscore the importance of addressing the issues of children and youth and their caregivers at the highest levels of state government. The 2019 Legislative Assembly concurred with this assessment, enacting it into law with the Governor's signature. The mandate placed before the Children's Cabinet today is demanding:

Develop a comprehensive vision for how and where children are best served.

Seek to engage cooperation and coordinate broad-based leadership among all parties.

Develop strategies to address gaps or needs.

Provide for the active participation of consumers and providers.

And--to revisit the ever-present theme--develop strategies to provide for the full continuum of care in the delivery of services, including promotion, prevention, early identification and intervention, service delivery, and recovery.

Throughout its work, the CBHTF readily opened its meetings to seek the counsel of the many wise and caring voices of professionals, consumers, and advocates from across this state, who by their lived experiences, wished to share their impressions, ideas, and proposals to improve our state's service system. This is hard work and the need to bring all voices to the table is as important as ever. The CBHTF sought to do so and that may represent its lasting legacy and epitaph.

Mr. Chairman, this completes my testimony. I am available to answer any questions from the Children's Cabinet members.

Children's Behavioral Health Task Force

Platform Position and Strategy Statements
Draft 4.0, Clean

December 6, 2018

Preamble

The Children's Behavioral Health Task Force (CBHTF), pursuant to its statutory responsibility enacted under NDCC 50-06-43, affirms its commitment to provide a voice for advocacy for a good and modern behavioral health system and to develop recommendations, presented herein, that

(1) establish, through either interagency agreement or statute, and
(2) sustain, through either interagency cost savings or legislative appropriations,

behavioral health policy initiatives designed to

(a) eliminate service redundancies and efficiencies,
(b) fill in apparent service gaps,
(c) deploy program and professional best practices; and
(d) promote health and well-being.

These position and strategy statements constitute the CBHTF's position platform, directing future CBHTF activity. Each platform statement consists of

(1) a *position* statement that identifies a need for systemic improvement, and
(2) a *strategy* statement that provides a plan of action.

The CBHTF foresees the combined use of different strategies to achieve the desired aims of each platform statement, including enacting interagency agreements, statutory change, and/or appropriations proposals.

Reference: N.D.C.C. 50-06-43. *North Dakota Behavioral Health Systems Study, 2018* (NDBHSS) Recommendations 1.0; 3.1; 5.1; 6.1; 9.1; 10.2; 11.0; 12.0.

A. Adoption of School Seclusion and Restraint Policy and Practices Guidelines.

Position. The CBHTF identifies the need for the state, local school districts, and schools to adopt student seclusion and restraint policies and practices, including a requirement for all local school districts and schools to adopt and implement effective plans of action. The CBHTF expresses its commitment to advance the adoption and implementation of previously studied seclusion and restraint policies and practices that adapt and incorporate national best-practice standards. These policies and practices move schools forward in securing the safety and wellbeing of students and school staff, ensuring effective yet flexible expressions of best practices, eliminating the prospects of student or staff harm, coordinating data reporting, and reducing unnecessary legal exposure.

The CBHTF affirms the validity of the previous work, conducted by the state Seclusion and Restraint Task Force, to develop these effective best-practice policies and practices The CBHTF seeks to find the most appropriate mechanism that ensures the ultimate adoption and implementation of these policies and practices, including consideration of legislative mandate, established school improvement or compliance rules, or other means of effective adoption.

The CBHTF differs with the assessment of some opponents of any state seclusion and restraint policies and practices who assert, under the pretext of local control, that current federal reporting requirements constitute a sufficient policy response. The CBHTF asserts that clear rules or policies of conduct are required to appropriately manage student behavior and staff interventions, ensuring the safety and security of students and staff and the establishment of a healthy learning environment. The CBHTF is mindful of previous, unsuccessful attempts to achieve a resolution of this matter and the existence of persistent resistance. Nevertheless, the CBHTF perceives a clear need and expresses its commitment to move forward with interim steps to achieve incremental implementation among selective school sites that support such an effort.

As recorded in the CBHTF July 16, 2018, meeting minutes, Chairperson Jones has appointed Pam Mack and Robin Lang to assume the lead to coordinate this task.

Reference: NDBHSS Recommendations 1.3; 2.1; 3.5; 9.8; 13.2.

B. Formation of a State-level Children's Services Committee

Position. The CBHTF identifies a need to establish a state-level children's services committee that is dedicated to the collaborative development and implementation of policies and practices that drive coordinated children's services, within the constructs of state law. This children's services committee will (1) ensure the coordinated and efficient provision of continuum-of-care services across all public institutions, and (2) advocate for the wellbeing of children and youth statewide, across all service sectors (e.g., education, social services, health, corrections, and others). This committee encourages an interdisciplinary service focus, addressing, among a variety of children's issues, the state's behavioral health challenges, across the continuum of care and within the context of wider socio-economic service needs.

The CBHTF affirms that the state must establish an inclusive, comprehensive, and sustainable committee that can meaningfully move coordination efforts forward into the future, beyond the ad hoc lifespan of the CBHTF.

Furthermore, the CBHTF affirms that funding should be provided to ensure that these state efforts be sustained and flourish, including the ability of local committees to receive and distribute restricted-purpose grant funding.

Strategy. The CBHTF assumes responsibility to develop a plan of action that advances the establishment of this state coordinating committee, including the development of broad governance interagency agreements, required statutory changes (if any), potential incremental or piloted deployment models, and shared agency resources or state appropriations proposals.

The CBHTF did not assign any primary point of responsibility for this task.

Reference: NDBHSS Recommendations 1.0; 2.0; 3.0; 4.0; 5.0; 6.0; 7.0; 8.0; 9.0; 10.0; 11.0; 12.0; 13.0.

C. **Suicide Prevention.**

Position. The CBHTF endorses a proactive, coordinated, systemic interagency effort to advance suicide prevention programs across all public agencies statewide.

Strategy. The CBHTF supports adjustments within state agency baseline budgets that sustain and expand suicide prevention programs.

Strategy. The CBHTF will consider drafting a resolution of support for the continuation and expansion of the Department of Health's Suicide Prevention program, implementing comprehensive best-practice suicide prevention programs and protocols in schools and healthcare settings.

Strategy. The CBHTF will draft a resolution to support sustaining and expanding suicide prevention programs across all state public and nonpublic agencies.

Strategy. The CBHTF supports the development of best-practices suicide prevention policy guidelines that may be adopted for use by state, regional, and local agencies, including schools, medical facilities, social service agencies, and other interested public and non-public organizations.

Strategy. The CBHTF will compile a list of the various agencies' suicide prevention outreach efforts to assess how collaboration among agencies might improve the combined effect of these efforts across their respective venues.

Mylynn Tufte initiated the proposal to adopt this position statement. The CBHTF has not assigned any primary point of responsibility for this task.

Reference: NDBHSS Recommendations 1.3; 2.1; 2.3; 3.1; 3.3; 4.8; 6.2; 9.8; 10.2; 10.4; 10.5.

D. **Bullying Prevention and Intervention**

Position. The CBHTF identifies a need to (1) evaluate the effectiveness of current school bullying prevention and intervention practices, and (2) assess if school bullying policies might need to be revised to address the impact of technology use on student wellbeing, including social media exposure and media-based bullying.

The CBHTF supports the work of the State Superintendent's Student Advisory Committee to study and provide recommendations to improve the state's bullying prevention and intervention policies and practices.

Strategy. The CBHTF stands prepared to review and provide a supportive response to the Student Advisory Committee's findings and recommendations, contributing an interagency voice to express commendations for the effort and to extend the effect of any recommendations across agencies. The CBHTF will evaluate whether any recommendations in agencies' policies might require additional interagency agreement or legislative action.

Robin Lang, serving as Department of Public Instruction delegate, has expressed willingness to serve as CBHTF liaison to the State Superintendent's Student Advisory Committee. The CBHTF has not assigned any primary point of responsibility for this task.

References: NDBHSS Recommendations 1.3; 2.1; 3.5; 7.2; 7.3; 9.7; 9.8; 10.4; 13.2.

E. **Brain Development**

Position. The CBHTF supports the efforts of the Department of Health to incorporate brain development research findings, including the effects of traumatic brain injury on brain development, into its health promotion and prevention programming. This initiative provides direct application for staff training and client services regarding accident prevention, early intervention monitoring, shaken baby identification, and other activities. The CBHTF anticipates the benefits of this integration of research into prevention measures will produce insights that may provide value to other cross-agency, continuum of care programming.

Strategy. The CBHTF will consider the merits of drafting a resolution of support to accompany the Department of Health's promotional and technical assistance publications, expressing the CBHTF's support for incorporating brain development research and best practices into service delivery.

The CBHTF, with the technical assistance support of the Department of Health, will review and consider expanding the use of this brain development research and its resulting best practices into select cross-agency programs. The CBHTF will compile information identifying how each agency might benefit from this research to improve overall outcomes.

Mylynn Tufte initiated the proposal to adopt this position statement. The CBHTF has not assigned any primary point of responsibility for this task.

Reference: NDBHSS Recommendations 1.3; 2.2; 2.4; 3.0; 4.2; 4.8; 6.2; 8.2; 9.8; 13.2.

F. **Sufficient, Sustainable Funding**

Position. The CBHTF advocates providing quality behavioral health services to all citizens statewide, extending across the complete continuum of care, including prevention. Providing quality behavioral health services across the continuum demands sufficient and sustainable funding, avoiding biennium-to-biennium variations that threaten statewide health indicators. Insufficient funding directly affects the system's ability to provide services across the continuum, oftentimes to the detriment of prevention efforts. The CBHTF commits itself to advocate for the protection and expansion of state appropriations for interagency behavioral health-related programming, covering the continuum of care, with specific attention to securing adequate prevention funding.

The CBHTF is mindful of the Legislative Assembly's constitutional responsibility to set and secure a biennial budget across all public obligations and services, and the Legislature's reluctance to dedicate revenue sources to selective programming targets. Legislators respond best when clear needs are identified and supported with validated data and supportive constituent testimony. Securing and preserving prevention funding requires making a case for prevention's return on investment and then seeking commitments to sustain that level of proportional funding into the future.

Strategy. The CBHTF proposes (1) to develop a case proposal that substantiates the return on investment argument regarding behavioral health programming, and (2) to advance this argument before the Legislative Assembly, referencing case studies and source data. This case proposal will be provided to each agency for voluntary adoption and use during the Legislative Assembly's appropriations hearings.

Strategy. The CBHTF proposes to adopt a resolution advocating for setting and sustaining behavioral health funding levels that support prevention measures.

Strategy. The CBHTF, recognizing the evident need for prevention activities regarding substance use, supports continued funding to eliminate the use of alcohol, tobacco, and other controlled substances among children and youth.

Strategy. The CBHTF commits itself to establish a coordinated service delivery system that secures and sustains essential children's behavioral health services across the continuum of care, evidencing efficiency through collaboration, drawing upon the unique competencies and reach of all dedicated agencies, sharing recognized best-practice policies and resources, and securing financial sufficiency and stability through meaningful legislative appropriations. The CBHTF endorses the practice of agencies readily providing narrative support to other agencies' appropriations requests before the North Dakota Legislative Assembly, which seek funding for initiatives recognized by the CBHTF.

The CBHTF did not assign any primary point of responsibility for this task.

Reference: NDBHSS Recommendations 1.0; 2.0; 3.0; 4.0; 5.0; 6.0; 7.0; 8.0; 9.0; 10.0; 11.0; 12.0; 13.0.

G. **Expanded Emergency Care Resources**

Position. The CBHTF recognizes a critical shortage of financial resources to support clients and/or families during crisis or emergency events, affecting their abilities to secure proper housing arrangements, out-of-home placements, or other supervisory responsibilities.

The CBHTF recognizes that child deprivation protocols, within Children's Protective Services, need to be applicable for infants, young children, and youth alike. Deprived older youth require service options that range from residential care to care coordination to appropriately serve their needs.

Strategy. The CBHTF actively supports any legislative proposals initiated in the 2019 Legislative Assembly that provide sufficient financial resources to support clients and/or families during crisis and emergency events.

Chairperson Jones will serve as primary point of responsibility for this task.

Reference: NDBHSS Recommendations 1.3; 3.3; 4.0; 5.2; 5.3; 5.4; 6.0; 9.8; 10.5.

H. **Juvenile Court Rules for Maltreatment**

Position. The CBHTF recognizes that current juvenile court definitions and rules for the management of child maltreatment, including the current registry or index of identified abusers, might introduce circular penalties that can inappropriately impact children and destroy an adult's prospects for

restitution and recovery. The CBHTF affirms the need to propose measured changes to current deficient practices.

Strategy. Whereas, the Uniform Juvenile Care Act presumes that any youth found by the courts to have committed a delinquent act is determined to be in need of treatment and rehabilitation, the CBHTF seeks to apply this principle to parents of deprived children, where evidence or presumed deprivation by a parent similarly establishes a determination of the parents' need for treatment, rehabilitation, and support.

Position. The CBHTF recognizes the need for states attorneys to acquire additional training on NDCC 27-20, regarding the appropriate disposition of a deprived child and the ability of parents to receive training and treatment, something often sought by case workers but not readily supported by states attorneys. This training is designed to mitigate the historical use of NDCC 27-14, which defines the abuse of the child in exclusive terms of criminality and, instead, redirects efforts to family rehabilitation.

Strategy. The CBHTF supports providing training to states attorneys to optimize the ability of parents of deprived children to receive or be compelled to receive the training and treatment they need and deserve to secure the viability of the family unit. The CBHTF supports surveying states attorneys to determine the prevalence of criminal case management and the prospects for beneficial training. The CBHTF will reach out to the state's Courts Improvement Project to offer behavioral health technical assistance that might reinforce the Project's work.

Position. The current standards for building a child maltreatment case, based on clear and convincing versus preponderance levels of evidence, introduce difficulties for child protection professionals and raise the prospects of doing harm to children. Professionals are unnecessarily required to become experts in drafting affidavits to document a credible case navigating the technicalities of troublesome legal distinctions.

Strategy. The CBHTF supports the lowering of the evidentiary standard for child maltreatment cases, effectively replacing the clear and convincing standard with the preponderance standard. The CBHTF supports this change to provide greater options for rehabilitative care to families.

As recorded in the CBHTF July 16, 2018, meeting minutes, Chairperson Jones has appointed Lisa Bjergaard to assume the lead in coordinating this task.

Reference: NDBHSS Recommendations 1.3; 2.1; 3.5; 4.1; 4.3; 4.8; 5.2; 6.0; 10.4.

I. State and Tribal Service Collaboration

Position. The CBHTF recognizes the importance of exchanging appropriate client service information across jurisdictions (e.g., state, tribe, regional human service centers, counties, cities) to improve access to service programs.

Strategy. The CBHTF will evaluate if any changes in agencies' policies, regarding the exchange of client information and shared reporting, might require additional interagency cooperative agreements or legislative action.

Position. The CBHTF recognizes the role that the Tribal-State Taxation Committee plays in studying the management of alcohol and tobacco tax collections and distributions and the effect that such tax management has on behavioral health services and outcomes. The structure of tribal and state taxation agreements contributes to the responsible collection and use of tax revenue, especially taxes collected from alcohol and tobacco. There exist long-standing conversations among state and tribal leaders concerning how to manage tax revenues to improve community health outcomes. This study addressed tribal-state issues, including government-to-government relations, health, human services, education, corrections, and issues related to the promotion of economic development.

Strategy. The CBHTF will review current tribal-state taxation agreements to determine if the interests of behavior health, including prevention and treatment, might be advanced by amending any agreement provisions. The CBHTF may reach out to tribal-state taxation committees to provide technical assistance and to raise awareness how tax collection and use policies can impact health and behavioral health outcomes.

Position. The CBHTF recognizes the importance of updating older Title IV-E agreements, which are currently undergoing revision, to improve foster care services, including data management and sharing.

Position. The CBHTF supports the reinstatement and work of the Tribal and State Court Affairs Committee, which has endorsed a memorandum of agreement on Drug Courts and which impacts the identification and disposition of individuals with behavioral health needs.

Strategy. The CBHTF will extend an offer to provide technical assistance and support to the committees working on memoranda of agreement regarding Title IV-E and the courts. The CBHTF seeks to optimize the effect and reach of interagency agreements that ultimately drive the constructive collaboration among the various agencies.

Erica Thunder initiated the proposal to adopt this position statement. The CBHTF has not assigned any primary point of responsibility for this task.

Reference: NDBHSS Recommendations 1.0; 3.1; 4.1; 5.1; 8.2; 9.0; 10.2; 10.4; 10.5; 11.0; 13.1.

J. Early Intervention, IDEA Part C

Position. The CBHTF recognizes the need to promote strong IDEA Part C early intervention programs, ages birth to three years, and to secure a comprehensive statewide Child Find system. High quality early intervention attends to the unique needs of each child, including the child's social and emotional health.

Strategy. The CBHTF will reach out to the Interagency Coordinating Council, which provides guidance on IDEA Part B and Part C services, to begin discussions regarding current early intervention efforts and what might be required to further enhance these programs.

The CBHTF did not assign any primary point of responsibility for this task.

Reference: NDBHSS Recommendations 1.0; 2.0; 3.0; 4.1; 5.0; 9.1; 9.9; 10.2.

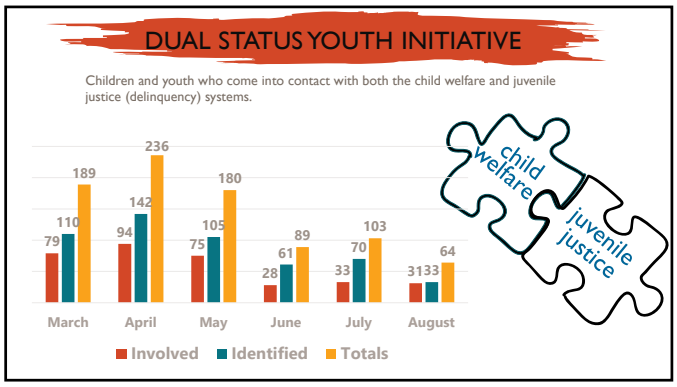
K. Substance Exposed Newborn Services

Position. The CBHTF acknowledges the need to provide and sustain high quality service supports for all newborns and infants who have experienced substance exposure. The CBHTF further recognizes the need to attend to the behavioral health needs of other family members, as well. The CBHTF expresses its appreciation for the valued research and proposals on substance exposed newborns developed in the previous biennium by the Substance Exposed Newborns Task Force. The CBHTF affirms the validity of the Task Force's completed work plan, which, although proposed, was never enacted or funded.

Strategy. The CBHTF assumes responsibility to review and update the findings and proposed work plan of the Substance Exposed Newborn Task Force, and to bring forth its recommendations for final, successful resolution.

Pam Sagness initiated the proposal to adopt this position statement. The CBHTF has not assigned any primary point of responsibility for this task.

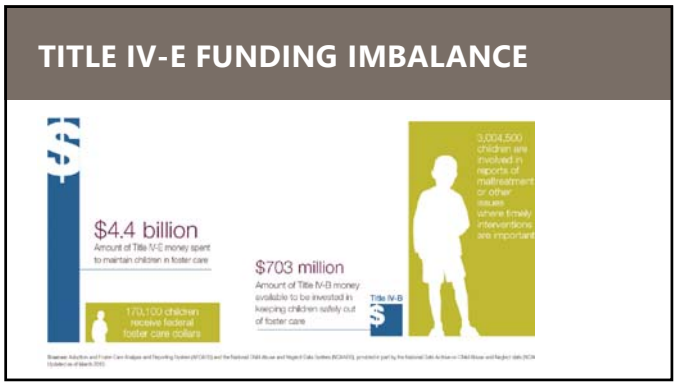
Reference: NDBHSS Recommendations 1.3; 2.0; 3.0; 4.3; 5.1; 5.2; 8.2; 9.8.


DUAL STATUS YOUTH INITIATIVE
Children and youth who come into contact with both the child welfare and juvenile justice (delinquency) systems.
79
110
189
94
142
236
75
105
180
28
61
89
33
70
103
31
33
64
March
April
May
June
July
August
Involved
Identified
Totals
child welfare
juvenile justice

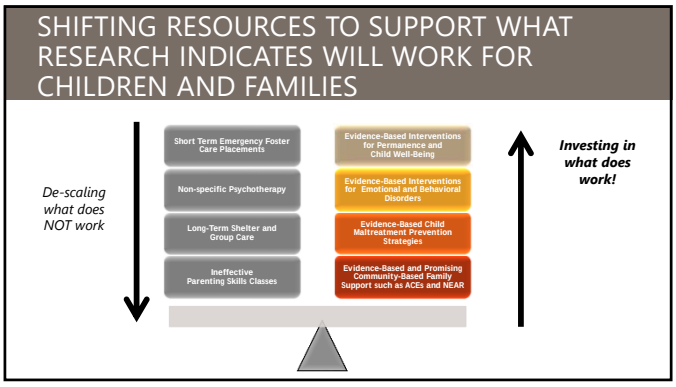
1

FAMILY FIRST PREVENTION SERVICES ACT (PL 115-132)
Cory Pedersen, NDDHS Child and Family Services
NORTH Dakota | Human Services
Be Legendary.

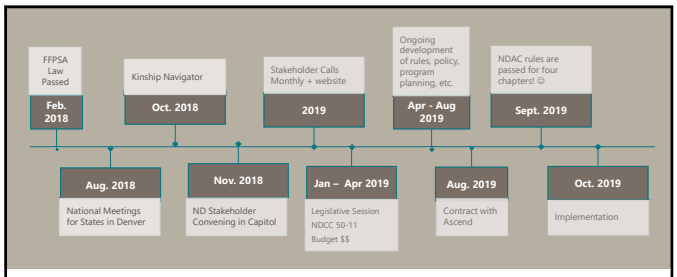
2


TITLE IV-E FUNDING IMBALANCE
$4.4 billion
Amount of Title IV-E money spent to maintain children in foster care
170,100 children receive federal foster care dollars
$703 million
Amount of Title IV-B money available to be invested in keeping children safely out of foster care
Title IV-B
3,004,500 children are involved in reports of maltreatment or other issues where timely interventions are important

3


SHIFTING RESOURCES TO SUPPORT WHAT RESEARCH INDICATES WILL WORK FOR CHILDREN AND FAMILIES
De-scaling what does NOT work
Short Term Emergency Foster Care Placements
Non-specific Psychotherapy
Long-Term Shelter and Group Care
Ineffective Parenting Skills Classes
Evidence-Based Interventions for Permanence and Child Well-Being
Evidence-Based Interventions for Emotional and Behavioral Disorders
Evidence-Based Child Maltreatment Prevention Strategies
Evidence-Based and Promising Community-Based Family Support such as ACEs and NEAR
Investing in what does work!

4

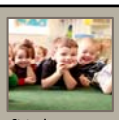


NORTH DAKOTA OVERVIEW

NORTH Dakota Be Legendary. | Human Services

5

John H. Chafee Foster Care Independence Program (Sec. 50753)



State plan requirement under Title IV-B to describe activities:

To reduce the length of time to permanency for children under age 5 and

Address the developmental needs of all vulnerable children under age 5 who receive services (Sec. 50772)

Title IV-E Adoption Assistance "delink" and the savings and reinvestments (Sec. 50782)

Reauthorized a number of Title IV-B programs through FY2021 (Sec. 50752)

Title IV-B, Subpart 1,

Promoting Safe and Stable Families Program (Title IV-B, Subpart 2),

Funding reservations for supporting monthly caseworker visits, and

Court Improvement Program Grants

✓ Done in February 2019

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6

✓ In discussion

Title IV-E reimbursement for a child who has been placed with a parent in a licensed residential family-based **treatment facility for substance abuse.** (Sec. 50712)

✓ On Hold - Pending

Reimbursement for 50% of the state's expenditures on **kinship navigator** programs (Sec. 50713)

✓ Done

Title IV-B track and prevent child maltreatment **fatalities**. (Sec. 50732)

✓ Done

States are required to have procedures for **criminal records child abuse and neglect index checks** on any adult working in group care settings where foster children are placed. (Sec. 50745)

Effective October 2019

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7

✓ Finalized Law, Rule, Policy & Forms

Family Licensing will mirror the national model standards per NDAC 75-03-14 (Sec. 50731)

✓ Pending

Reimbursement for 50% of the state's expenditures on prevention program that are well supported evidence based per the prevention plan (Sec. 50711)

✓ Finalized Rule and Application

Offer Supervised Independent Living for 18+ foster children in ND via NDAC 75-03-41(Sec. 50741)

✓ Finalized Rule & Application

Offer licensure for Qualified Residential Treatment Facility per NDAC 75-03-40 (Sec. 50745)

Effective October 2019

NORTH Dakota Be Legendary. | Human Services

8

DIFFERENCE OF RCCF VS QRTP

RCCF Resident Characteristics

- Previous/history
- Family setting is not secured
- A safe bed in a group home/facility
- Placement was infinite amount of time, no length of stay requirements
- No specific treatment/service requirements
- Most youth manage full day of school in the community without disruption/intervention, etc.

QRTP Resident Characteristics:

- Current/future
- Use CANS domain criteria
- Several areas of need of treatment/intervention

9

NEW ~ QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)

- ✔ Licensed and accredited
- ✔ Trauma informed treatment model
- ✔ Registered or licensed nursing and other clinical staff onsite
- ✔ Level of care assessment
- ✔ 60 day review hearings
- ✔ Full family engagement
- ✔ Aftercare supports for 6 months

10

WHAT IS THE CANS?

- ✔ Child and Adolescent Needs and Strengths assessment
- ✔ Developed for children's services to support decision making
  - Level of care and strengths-based service planning
  - To facilitate quality improvement initiatives
  - To allow for the monitoring of outcomes of services
- ✔ Each item suggests different pathways for service planning
- ✔ 4 levels for each item with anchored definitions to translate into action levels

Praed Foundation is a public charitable foundation committed to improving the wellbeing of all through the use of personalized, timely, and effective interventions

11

Simle Behavior Systems Explained

1

Philosophy

Students should be in class to receive instruction to improve learning. The focus on student behavior should be teaching the appropriate behavior and rewarding/reinforcing the behavior we want to see by providing specific feedback to the student. When a student is behaving in a manner that is impacting the learning of others, it is important to intervene quickly and provide re-teaching.

Students will be re-directed and re-taught correct behaviors. If a student does not correct the behavior and it is impacting other student's learning, they may be issued an SIR or Student Incident Report. This is written by the classroom teacher and the student must take a copy home for his/her parent to sign. If teachers do not receive this copy back, they will be calling parents to make them aware of the incident.

Teams are dedicated to providing a productive and active learning environment for all students. Our goal is not only for students to find success at Simle, and eventually Legacy High School, but also beyond school. We want to give them the tools to succeed in our always-changing world.

2

SPARTANS

What is MTSS?
MTSS stands for Multi-Tiered Systems of Support. It is a tiered structure for schools to systemize both academic and behavior intervention, prevention, and supports. The main focus is to provide students with what they need.

MTSS structure for ALL

How Simle Middle School is supporting all students

Why MTSS?
Simle chooses to use and implement the MTSS structure to increase academic time, create positive culture for staff and students, and it allows us to use a positive approach to student behavior.

3

All schools can implement MTSS with little cost. Strong leaders create change in the school system.

Teams of teachers, administrators, and other support staff work together to systemize interventions.

The focus shifts from consequences to re-teaching and providing supports for students to be successful.

4

A world of change

Simle is partnering with Sanford Health to create a continuum of supports to address behavioral health. Simle will work to create a model that can be replicated by any school system. Simle is able to do this because of the MTSS structure and proactive approach that has been implemented for the past four years.

5

MTSS B Vision:

Positive behavior is the **key to school success**.

We believe a student must understand what it takes to be successful at school; it takes organization, curiosity, responsibility, and a willingness to be kind to all.

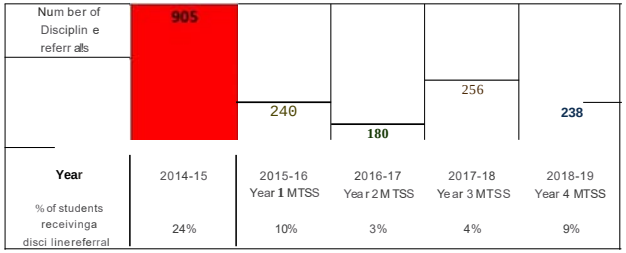
Spartan 5 **ROCKS**: I will be **Responsible**, **Organized**, **ur10** , and **Kind**, and **Successful.**

6

How did we get here?

Teachers were involved in the creation of our MTSS systems from the beginning. For the past four years, Simle has attended ND's Fargo MTSS conference to build and sustain our system. Because teachers helped create this and wanted it, we have been able to be consistent in our dellivery to students. Our MTSS Behavior work has become embedded into our culture.

7



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Since impl ementing MTSS, Siml,e con tinues to see adecrease in behavior ref er r alls.There was an increase in 1 7-1 8 due to high risk students whi c h prompted the need for more support, leading to S1mle'smental health grant. SImle administration saw a need f or o u t s i d e resources to assist students and familles with behavioral heaUh. The percentage of student s continues to 1ncr e a se as we are seei n g more use of vapes at school, and students avoiding class due to anxiety or other mental health needs.

8

Why the drastic drop?

After one year of MTSS implementation, Simle declined their behavior referrals by over 600. They continued to see a decrease into year two and a rise in year three. This is the result of consistent tier 1 and tier 2 behavior responses. We believe students must be taught the behaviors we expect to see in our school. Teachers spend the first month of school continuously teaching our expectations for different areas of the building. They then recognize student positive behaviors by reinforcing the behavior with sparklers. The sparklers are part of our Positive Behavior Intervention Support (PBIS). All students are taught, expected to perform, and then positively reinforced when they show these behaviors.

If students struggle to perform behaviors, we identify the student quickly, target why they are not performing (they do not know how or they are choosing not to) and then assign an appropriate interventi:on to get a better result. Things a student may experience is a Check-In/ Check-Out system in which an adult is providing extra positive reinforcement, Check and Connect, where a student meets with a counselor once a week to create goals and work to reach them, or a student may work more closely with a teacher mentor. Each intervention depends on the needs of the student. We consider all of these tier 2 interventions. If a student is still struggling even with this amount of support, they would then be a candidate for our Spartan Center.

The Spartan Center is run by one teacher with the assistance of building aides. Students may be assigned to the Spartan Center for one class or multiple classes. It is a more intense support as we consider it a tier 3 approach. With each tier having different options, we are able to serve students better than we have before implementing MTSS.

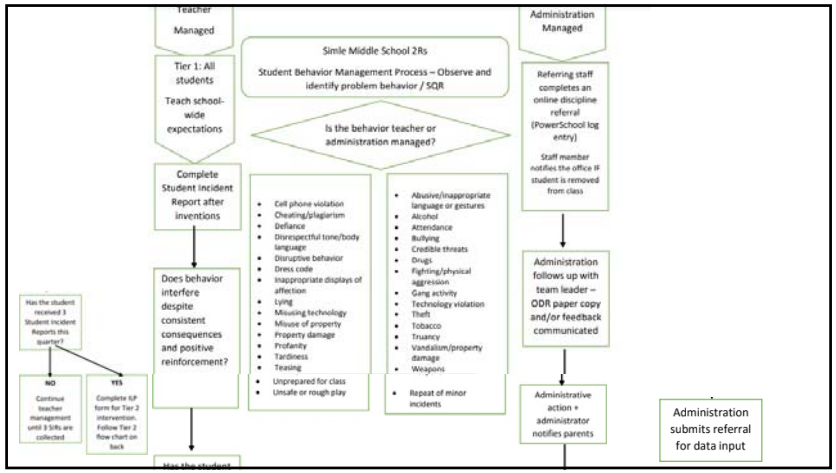
9

Responsible	Organized	Curious	Kind	Successful
The ability to take ownership of my actions and understand the result	Being prepared and having a plan for anything that happens	The desire to know more about myself and my world	Being accepting, caring, and grateful to others and myself	Working hard, solving problems and feeling accomplished with my choices

Before School	• Stay in designated area and keep it clean • Gather materials for the day • Use kind words and actions • Prepare my mind for a successful day • Remove headgear
After School	• Know and follow your exit plan • Take home necessary materials • Explore after school clubs/activities • Use kind words and actions • Celebrate my successes of the day
Hallways	• Walk and stay to the right (stairs also) • Take the shortest route and be prepared for the next class • Use kind words and actions when addressed by adults • Arrive to class on time
Cafeteria (Lunch)	• Keep all areas clean • Decide what I am going to eat and form a line • Sit with different people/Invite people to sit with me • Greet the staff, say please and thank you

10

11



12

Spartan Center Tier 3

Our Spartan Center provides a w r ap-ar ou nd approach to a student. We are wanting students to develop a strong relationship with the Spartan Center teacher while gaining supports for academics and finding more social or emot iona l success by going into the community to volunteer.

One area that our Spartan Center lacks is in-depth mental health support. The students that reach the Spartan Center, generally have more needs than our school can provide. This is where some of the funds would be spent.

13

What does our system look like?

Tier 1	Tier 2	Tier 3
• Weekly Teach-to's • Breakfast cart • Flex days • Home base circles • No transition bells • Behavi or and academic flow charts • Second Steps • Boys to Men • Girls to Women • Mentoring • Physical Education for all kids, all year. • Behavior Grades • Yoga • TAG (Training And Games) before school option • Students advocating for themselves to switch classes/teachers as they see fit • Sparkler System/PSIS	• Taekwondo • Reading class/science/SS • Tutors- assigned to tutor room • Check In/Check out • Check & Connect program with counselors/social worker • Re storat ive Justice • Small Group Counseling • Extra PE for some students • Boys group: Zones of Regulation • Girls group: Self-confidence and friendship skills • Mentoring	• Spartan Center • Volunteer work through Spartan Center

14

Tier 1	Tier 2	Tier 3
• AP/teacher swap • Coaching and office days for Admin • SMS Rocks sessions for all teachers - occurs every three weeks • Commitment to keeping kids in school and limiting OSS/Citations. • MANDT Training • Assessing and Reporting Behaviors • Avid Path training/ Summer Institute	• Mental Health First Aid Training • SEL building team • Special ed teachers working with Safe & Civil Schools (Tough kid, Social thinking)	• District resource

For staff...

15

Our community resources

- Restorative Justice (Lutheran Social Services/United Way)
- Taekwondo
- Volunteer trips through our Spartan Center
- Behavioral Health work
  - Department of Human Services Behavioral Health Division
  - Sanford Health
- Fuel Up to Play 60 - Midwest Dairy
- Mental Health Technology Transfer Center
- Juvenile Court
- Police Youth Bureau

16

What is restorative justice?

17

What do we use Restorative work for?

Fights

Language toward others

Citable offenses & non-citable

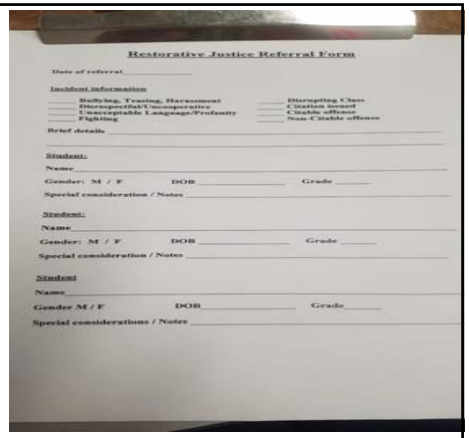
Bus drivers & students

Any situation where the environment was harmed or another person

Home base circles

New student circles

Restorative meetings

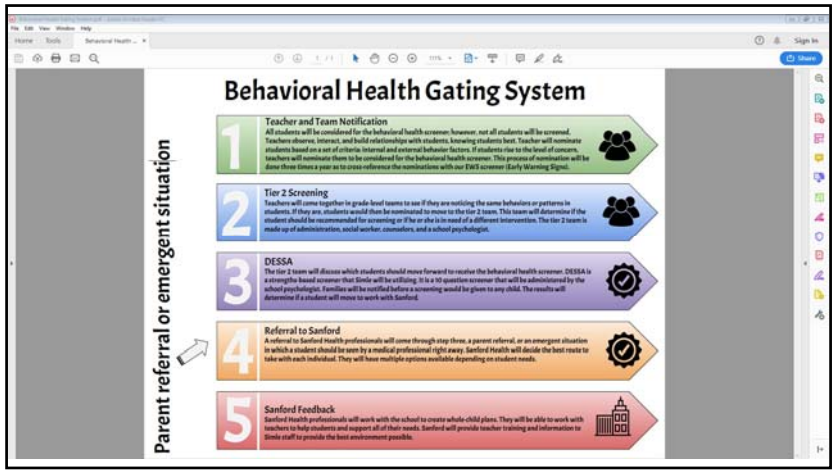


18

Simle's restorative feedback

- **88.50% of the 261 surveyed reported that they felt the process created a safer school environment**
- **82.38% of the 261 surveyed reported that they felt they had a greater commitment to the school as a result of participating in the conferencing process.**
- **88.50% of the 261 surveyed felt the process helps to hold people accountable for their actions**
- **76.81% of the 69 (new students) surveyed reported that they felt more comfortable in their school from participating in a restorative process (New Student Circles).**
- **39 out of 47 students (82.98%) with citable offenses were alternately held accountable by participating in a restorative process and did not receive citations.**

19



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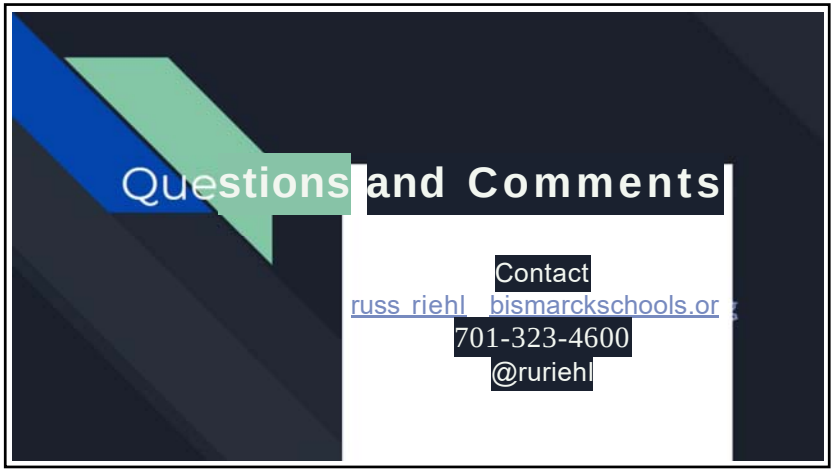

Questions and Comments
Contact
russ_riehl_bismarckschools.org
701-323-4600
@ruriehl

21

WORKING WITH YOUTH EXPOSED TO POLYSUBSTANCES

SUSAN M. GERENZ, M.Ed.
Special Education Regional Coordinator
North Dakota Department of Public Instruction
sgerenz@nd.gov
(701) 328-2277

1

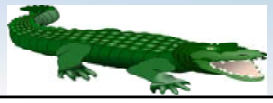
Polysubstance use may include, but is not limited to, combinations of:

- ❖ nicotine
- ❖ alcohol
- ❖ marijuana
- ❖ opiates
- ❖ methamphetamine
- ❖ cocaine
- ❖ heroin
- ❖ synthetics

2

Exposure to Poly-substances during pregnancy/infancy or extreme stress, neglect, abuse, and/or trauma changes the developing brain of the child.

- The brain stem is over-activated: leading to magnified fear and/or anger response.
- The cerebellum & limbic system is under-activated: leading to withering of emotional control.
- The cortex is under-activated: leading to diminished learning, memory, and higher order thinking.
- Downshifting- under threat and stress, the brain shuts down layer by layer-
  - "Go Reptilian!"



3

Polysubstance Use Affects More Than Pregnancy

- Egg
- Sperm
- In-utero
- Environmental Exposure
- Lifestyle & Parenting
- Nutrition
- Medical
- Dietary
- Attachment
- Self-Regulation
- Executive Functioning
- Developmental Skills

4

Effects on Brain and Central Nervous System Development:

- Disruption in migration of cells-movement along branches
- Shorter dendrites-difficulty carrying information
- Reduced myelin insulating the neurons-slower information processing and less white matter
- Impaired cell survival

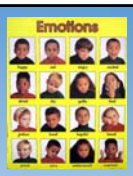
5

Observations of Children in Psychiatric Residential Treatment who are likely polysubstance exposed

1. Non-categorical delays: across many life domains
2. Autism-like symptoms: communication, socialization, behavior
3. Psychotic symptoms: disorganized thinking, personality changes, limited insight, social impairments
4. Childhood schizophrenia symptoms: auditory/visual hallucinations, paranoia, delusions, bizarre behavior
5. "Children with no skin!"
6. "FAS on steroids!"

6

Polysubstance Exposure Impacts:



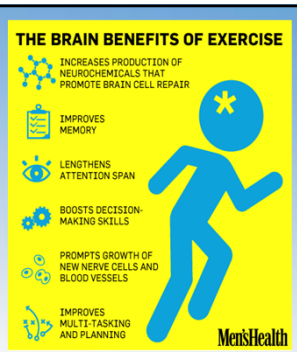
- Working Memory and Information processing
  - Provide extra processing time
  - Offer visual cues/multisensory learning
- Face-emotion labeling
  - Requires direct instruction, repetition & overlearning
  - Prerequisite for empathy skills
- Focus/attention in emotional situations
  - Use coping/calming techniques before presenting verbal information or directives

7

POLYSUBSTANCE EXPOSURE IS CHARACTERIZED BY LONG RANGE UNDER-CONNECTIVITY

- Impacts integration of skills important for language, social skills, and sensory-motor.
- Impacts frontal lobe executive functions:
  - Working memory
  - Planning and organization
  - Self-regulation
  - Perspective taking
  - Empathy and compassion

8



- HOOK UPS
- CROSS LATERAL MARCH
- RHYTHMIC CLAPPING
- JUMPING JACKS
- FULL BODY BREATHING
- WALKING OUTSIDE
- SWINGING ON SWINGS
- RIDING BIKE
- DANCING
- CLIMBING STAIRS
- PLAYING CATCH OR FRISBEE

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Processing Coping Skills are designed to help you work through thoughts and feelings you have about challenging situations. Some suggestions:

- Make a coping box
- Write poetry
- Use a journal
- Use a feelings thermometer
- Create a playlist to listen to

copingskillsforkids.com

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SOCIAL EMOTIONAL LEARNING COMPETENCIES NDMTSS

http://www.ndmtss.org/wp-content/uploads/2019/06/39545-6-1-18-Compiled-NDMTSS-SEL-Scales.pdf

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CLOSING THOUGHTS

"This isn't something else on the plate; this *is* our plate. Once you get the plate established, everything else flourishes."

Rennie Center on Education Research & Policy

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