

TESTIMONY

NORTH DAKOTA CHILDREN'S CABINET

Greg Gallagher, Program and Research Director,
The Consensus Council, Inc.
ggallagher@agree.org
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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Authority for the CBHTF was repealed during the 2019 Legislative Session with the passage of Senate Bill 2313, the same legislation that authorized the establishment of the Children's Cabinet.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 Tuft 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.