

**North Dakota
Children's Behavioral Health Task Force
June 19, 2018**

Meeting Minutes, Approved

Task Force Members Attending: *Chris Jones, Executive Director* (ND Department of Human Services), *Robin Lang* (Assistant Director, Safe & Healthy Schools, ND Department of Public Instruction), *Mylynn Tufte* (ND State Health Officer, ND Department of Health), and *Pam Mack* (Director of Program Services, ND Protection & Advocacy Project).

Task Force Members Absent: *Scott Davis* (Executive Director, ND Indian Affairs Commission) and *Lisa Bjergaard* (Director, Division of Juvenile Services, ND Department of Corrections & Rehabilitation).

Recorder: Greg Gallagher, Program and Research Director, The Consensus Council, Inc.

Call to Order and Welcome: Chairperson Chris Jones called the meeting to order at 8:48 a.m., CT, and welcomed Task Force members and guests to the meeting.

Quorum: With a sufficient number of Task Force members present, a quorum was recorded.

Approval of May 16, 2018 Meeting Minutes: PAM MACK MADE AND ROBIN LANG SECONDED A MOTION TO APPROVE THE MEETING MINUTES OF MAY 16, 2018. MOTION PASSED UNANIMOUSLY.

Acceptance of Agenda. Chairperson Jones announced that the agenda's afternoon session dedicated to legislators' discussions (12:45 p.m.) and linking agency efforts (2:45 p.m.) required rescheduling to the July 16, 2018 meeting to align with legislators' availability. Senator Judy Lee, Chairperson, Interim Health Services Committee, and Representative Kathy Hogan, Chairperson, Interim Human Services Committee, will be present for the July 16 meeting. Any summary reports from the Indian Affairs Commission and the Division of Juvenile Services may also be rescheduled for the July 16 meeting. Task Force members voiced approval for the change in the agenda.

Review of Task Force Responsibilities: Chairperson Jones reviewed the responsibilities of the Children's Behavioral Health Task Force, directing Task Force members to the May 16, 2018 meeting minutes that outlined the Task Force's charge, including:

- a. 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;
- b. Make recommendations to ensure the children's behavioral health services are seamless, effective, and not duplicative;
- c. Identify recommendations and strategies to address gaps or needs in the children's behavioral health system;
- d. Engage stakeholders from across the continuum to assess and develop strategies to address gaps or needs in areas including:
 - (1) Education,

- (2) Juvenile justice,
 - (3) Child welfare,
 - (4) Community,
 - (5) Health; and
- e. Provide a report to the governor and legislative management every six months regarding the status of the task force's efforts.

Chairperson Jones reported that the Task Force is required to submit a written report by July 2018 to the Governor's Office, the Interim Human Services Committee, and the Interim Health Services Committee regarding the activities of the Children's Behavioral Health Task Force, including any forthcoming Task Force proposals for the 2019 Legislative Assembly. Members discussed the importance of generating initial recommendations as early as the July 16, 2018 meeting to facilitate proposing any tentative legislative bill drafts with the Interim Committees by late July 2018. Members reiterated the importance of establishing a relationship with legislators and introducing the broad themes and initiatives under consideration by the Task Force.

Presentation Reviewing the North Dakota Behavioral Health System Study. Chairperson Jones introduced Pam Sagness, Behavioral Health Division Director, ND Department of Human Services, to present an overview of the North Dakota Behavioral Health System Study (NDBHSS: <https://www.nd.gov/dhs/info/pubs/docs/mhsa/2018-4-nd-behavioral-health-system-study-final-report-hsri.pdf>). Chairperson Jones invited Task Force members to integrate questions and discussion throughout the presentation. Ms. Sagness presented a prepared overview of the NDBHSS with extemporaneous narrative: <https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/overview-nd-behavioral-health-system-study-april-2018.pdf>. Ms. Sagness also referenced a presentation provided by Dr. Bevin Croft, Human Services Research Institute, which summarized the NDBHSS findings and recommendations (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/hsri-presentation-behav-health-system-study-4-2018.pdf>).

Ms. Sagness presented the four aims of the NDBHSS: (1) conduct an in-depth review of North Dakota's behavioral health system; (2) analyze current utilization and expenditure patterns by payor source; (3) provide actionable recommendations for enhancing the integration, cost-effectiveness and recovery orientation of the system to effectively meet community needs; and (4) establish strategies for implementing recommendations. The NDBHSS incorporated recognized data sources to compile its findings and recommendations, including document research review, stakeholder interviews, and Medicaid claims and state service utilization data. The NDBHSS, completed in April 2018 and previously presented at three interim committee meetings, represents a compilation of a variety of previous reports, including the Schulte Report and the Behavioral Health Stakeholders Group Report. The NDBHSS now represents the most current and complete inventory and study of the state's behavioral health system.

Ms. Sagness stated that the NDBHSS is rooted in a vision of a good and modern behavioral health system, consisting of four core elements: (1) prevent mental health and substance use problems before they occur; (2) identify and intervene early; (3) person-centered, trauma-informed, culturally responsive services, and (4) recovery-oriented services and supports. The report is further informed by the social determinants of health, including education, employment, housing, social support and access to healthcare. Approximately 10% to 20% of health determinants derive

from medical care while social, behavioral, and environmental factors account for 80% to 90% of health outcomes.

The NDBHSS provides more than 65 recommendations across 13 categories, requiring the attention and action of a wide range of entities. No single agency or entity can manage all elements of these issues. The challenge to the state is to organize, coordinate, and keep all elements of these recommendations moving forward. The North Dakota Behavioral Health Planning Council (NDBHPC) is similarly studying the NDBHSS recommendations and preparing a plan to coordinate this work. The Children's Behavioral Health Task Force, which focuses attention on children and youth, represents a subset of this wider effort. The NDBHPC has identified the need to coordinate and manage these recommendations and to bring together the various parties that will ensure a successful deployment.

Ms. Sagness identified core considerations within the NDBHSS that impact our understanding of our state system. Many individuals struggle with undiagnosed and preventable conditions that do not appear in provider data. Individuals many times experience a fragmented service system with siloed medical and mental health care. The current health system allocates the majority share of resources to treatment, at the expense of prevention investments. Residential, inpatient, and other institution-based services prevalently absorb resources compared to prevention and community-based services. The state must find strategies to disinvest from costly institutional services and divert funding to promote population health and prevention, thereby reducing the need for intensive services.

Ms. Sagness referred to the overview notes which presented summary data on the state's standing regarding mental illness, substance use disorder, and suicide. She then proceeded to present an executive summary brief of the NDBHSS, according to service categories specified within the report. These categories include the following:

- (1) community awareness and education;
- (2) prevention and early intervention;
- (3) outpatient treatment, including initiatives, screening, integrated care, services for children and youth, and substance use disorder treatment for adults;
- (4) community-based services, including children, youth, and families, case management, peer support, employment support and community engagement, housing, harm reduction, and community health workers;
- (5) residential treatment and treatment foster care, including residential treatment for children and youth, and treatment foster care;
- (6) crisis services;
- (7) inpatient services;
- (8) long-term care services; and
- (9) services for justice-involved populations.

Mr. Jones observed that treatment and recovery are currently reimbursed while prevention is not comparably reimbursed, producing a situation of conflicting economics: public entities may attempt to advance prevention as part of a social contract, but private entities, which receive reimbursement for treatment and recovery only, may not. Economic incentives may not exist for prevention compared to those for treatment.

Ms. Sagness underscored the gaps that exist in early intervention services, meaning the effort to identify and advance care across all ages of behavioral health needs. Early intervention is not to be restrictively interpreted or equated solely with early age efforts (e.g. children, ages birth to three years). Under continuum of care terms, primary prevention is often a policy-driven effort at the community level. Early intervention is broken into several categories, representing a person-focused effort to provide support services. In areas where service payments are limited, workforce availability is diminished, since lower reimbursement rates deter qualified workers. Prevention and early intervention are oftentimes among the first items removed from legislative funding in favor of more pressing needs. The NDBHSS identified the \$15,000 pre-existing spend for Medicaid as a barrier requiring attention.

The NDBHSS identified outpatient care as a primary issue across the state, including screening, integrated care, services for children and youth, and substance use disorder treatment for adults. There exists a need for more comprehensive continuum of outpatient services for children and youth. There oftentimes exists a system incentive for deeper residential and out-of-state care because of existing policies, such as school-request-placements in place of other measures. There is a lack of infrastructure and coordination to support early childhood mental health. Different program goals can affect direct services to children. Similarly, school-based services were identified as a system gap, where only 5% of all services for persons under age 18 were delivered in a school-based setting and only 0.1% of youth substance use disorder treatment services were delivered in school settings. Only one setting, Beulah, exists for school-based services for substance use treatment services.

Task Force members inquired into the role of school resource officers (SRO), counselors, school social workers, and school psychologists to support mental health services. Effort might be focused on enhancing school-based mental health services, using a variety of disciplines, given the diversity of capacity and expressions of local control across the state. The level of credentialing varies across the different disciplines. SROs can help identify certain high-risk students, but the use of SROs might also lead to traumatizing certain students. School safety concerns and early identification/intervention efforts are two significantly different matters, requiring care when accessing the right service provider. The state's Education Innovation Summit provided beneficial strategies to integrate behavioral health initiatives; the Task Force might review the findings of the Summit to advance this discussion. It appears that there exists more community support for SROs than behavioral health efforts and this requires messaging to clarify the issues. Each discipline approaches behavioral health matters differently, such as SROs with their justice system training. Cross-training efforts may be required to help optimize the best use of people in a wide range of student needs and circumstances. Each discipline requires a certain style of engagement or professional skill sets, requiring discernment in accessing the right kind of person for the task required. Professional skill sets help define pathways for recruiting the right person for the required service.

Ms. Sagness stated that the NDBHSS reported that oftentimes individuals' and families' only option to access substance use disorder treatment was through residential facilities. The state's system is missing opportunities to intervene early in the community and address substance use problems before they rise to a level of severity that warrants life-disrupting residential treatment.

The NDBHSS observed that there currently exists no widely used trauma screening process across the health and social services sectors. Ms. Sagness reported that the state has initiated

efforts to identify and use a comprehensive trauma screening tool across service sectors, including public and private providers and the justice system. The *Minnesota Traumatic Stress Screen for Children and Adolescents* (TSSCA) has been identified as the preferred tool for voluntary use by providers. The Behavioral Health Division has contracted with outside providers to offer training for the use of the TSSCA as a quick, initial screening tool for identifying trauma-impacted individuals. The training will include an entry-level presentation of trauma care as a means to inform people of the effects and initial identification of trauma, short of more extensive evaluation assessments and treatment. The TSSCA will be state-supported but not state-mandated, allowing individuals to choose their preferred screening tool, yet advancing a state model. The state's training opportunities can be provided to schools, the juvenile court system, and other providers, focusing on the identification of symptoms while encouraging further evaluation assessment leading to a formal diagnosis. The state also provides a clearinghouse website (<https://www.tcty-nd.org>) to connect interested individuals with trained trauma professional providers, optimizing the referral and evaluation process. Schools also use the PowerSchool application to track student attendance and performance indicators, informing staff and leading to possible initial interventions.

Task Force members discussed the status of the Level D schools, especially in Fargo, and the manner in which schools might responsibly assess the value of such a status. It was observed that schools are perceived as community assets, whereas behavioral health institutions oftentimes are not similarly perceived. There exists a lack of alignment in behavioral health practices and services, eligibility, and course of care among institutions, including schools, that requires resolution. Behavioral health professions, including trained clinicians and school personnel, need to be brought into this discussion, defining best practices and seeking systemic solutions.

Robin Lang discussed the structure of schools' Multiple-Tier System of Support (MTSS) and the training that is provided statewide to embed the practices of MTSS throughout all schools (<https://www.nd.gov/dpi/uploads/194/NDMTSSPlaybookWEBversion.pdf>). The MTSS model of structuring student supports has been widely integrated into schools' practices and trainings have been received favorably by school professionals statewide. It often takes schools 3 to 5 years to integrate MTSS practices within their district or school plant operations. Social-emotional student supports have become a critical component of all school practices. The U.S. Department of Education has advocated the adoption of the MTSS across the nation.

Ms. Sagness remarked that MTSS has made a positive impact on certain behavioral health referrals; however, it requires strong leadership within schools to accomplish the aims of MTSS successfully. Ms. Lang stated that expulsion, suspension, and engagement indicators become helpful markers in tracking overall impact for certain students.

Ms. Sagness stated that the NDBHSS observed there is a need for accessible family support and stabilization services in North Dakota. Stakeholders cited a lack of transparency around the process of service approval and delivery that made it difficult for families to understand and navigate the behavioral health system. Ms. Sagness stressed that community-based services throughout the wider community is the core element to focus on. Community-based services offer a means to balance the efforts of prevention, sustaining health, and aiding recovery.

Ms. Sagness stated that the NDBHSS observed it is difficult to assess the need for residential treatment and treatment foster care when the current array of community-based services is

insufficient. It is hard to know the true needs of the community when only certain elements of care are emphasized, to the detriment or exclusion of other elements. There are often missed opportunities for diverting relatively lower-need populations from the system entirely, which would create more capacity for those with higher needs. Similarly, as evidenced by the caregiver substance abuse data, it is important to attend to the needs of families and those who care for family members. Some children and youth are underserved while others are receiving services at higher levels than is needed. Stakeholders expressed concern that some residential treatment facilities cherry pick individuals with lower levels of need. It appears difficult to find appropriate placements for children and youth in the state, particularly those youth with the most complex needs. Certain highly interrelated services result in the overlapping of services for some children and youth. When some children return from treatment foster care services and re-enter a family environment where there are unmet behavioral health needs among parents and caregivers, there exists a high risk for triggering a cycle of relapse and re-treatment in the health system. The NDBHSS identified crisis services for children and youth as particularly lacking statewide. Within the juvenile court system, attention must be given to avoid the relapse effect, oftentimes within high-risk family situations.

Ms. Sagness observed that the NDBHSS and its 13 core recommendations offers a list of areas for attention. Her report to the CBHTF offers a context for these recommendations, offering a way to understand the direction and priorities the state might take. The NDBHSS states that North Dakota shows a strong commitment to values of person-centeredness, cultural competency and trauma-informed approaches, principles that should be at the heart of any effort to coordinate an improve behavioral health services. The report also identifies a need for greater engagement and partnerships with American Indians in the design and delivery of behavioral health services.

Task Force members observed that the NDBHSS points to the need to redesign the behavioral health system itself, allowing for or moving resources to other continuum of care components which will better serve a wider population. Members questioned whether the state has sufficiently structured a support system for certain age groups, especially for children ages birth through six, to optimize overall health prospects. It is important to not re-invent what might be working; instead, it would be wise to seek better alignment and coordination among those agencies and entities that are working in these areas. Members raised the prospect of reassessing the intent of the Children's Behavioral Health Task Force, including perhaps renaming itself, to better position the Task Force as an active coordinator of interagency activity across a wider age span or community focus.

Task Force members expressed support for the findings and recommendations of the NDBHSS. Members stated that there needs to be a commitment to coordinate behavioral health services across all agencies and entities. The CBHTF must assess how behavioral health is interwoven throughout the various programs and services of every agency. Members recognized the current interest of certain legislators and committees in behavioral health issues, which may enhance the prospects of the Task Force successfully advancing proposals for action. To design an effective behavioral health system, programs and funding need to be commensurate to the expressed needs. Certain school funding, especially dedicated federal programs, allows schools to adopt a variety of behavioral health initiatives; however, the field is oftentimes stymied by uncertainty over which initiatives might be most effective. All agencies need to build high-quality training as a central component to designing an effective statewide system.

Chairperson Jones thanked Ms. Sagness for her presentation and called a break.

Presentation Previewing a Service Delivery Survey, Classification System. Chairperson Jones introduced Greg Gallagher, Program and Research Director, The Consensus Council, to present an overview of a possible service delivery survey to be used by Task Force members and their agencies to inventory the current system of behavioral health services across agencies. Chairperson Jones invited Task Force members to integrate questions and discussion throughout the presentation.

Prior to beginning his presentation, Mr. Gallagher informed the Task Force that an abstracted summary of the NDBHSS, compiled by The Consensus Council in April 2018, had been forwarded to members prior to the June 19, 2018, meeting. (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/nd-behav-health-system-study-abstracted-summary.pdf>). This abstracted summary provides a high-level review of the NDBHSS findings and recommendations and reflects much of the material presented by Ms. Sagness in her earlier presentation. The Consensus Council provided this document to support the Task Force's study and deliberations.

Mr. Gallagher distributed a list of criteria, generated by Task Force members in previous Task Force meetings and compiled by The Consensus Council, that might provide the framework for a survey of agency services (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/service-inventory-elements.pdf>). Mr. Gallagher stated that the Task Force had expressed a desire to conduct an inventory of behavioral health-related programs and services provided by all agencies represented on the Task Force. The purpose for this survey included:

1. To compile an inventory of children's behavioral health services, including programs, policies and practices, provided by public agencies and nonpublic providers;
2. To allow for the analysis of perceived service gaps, redundancies, inefficiencies, best practices, and emergent priorities; and
3. To allow for the development of integrated program service responses to improve the state's system of children's behavioral health.

Mr. Gallagher stated that the Task Force had not yet defined the scope of any survey. Previous Task Force discussions on any survey's scope ranged from a high-level survey, capturing the core mission and service programs across agencies, to a detailed inventory of service protocols and practices, such as inventorying different screening tools. Based on member comments, Mr. Gallagher compiled a list of 17 criteria that might be used for a survey, dependent on a final designated purpose. The term "service" was adopted as an operational, generic means of capturing relevant criteria to help guide Task Force discussions. These service criteria included: service title; service focus; lead provider; collaborating providers; target population; service eligibility; continuum of care phase; service intensity; service duration; service cost; service cost category; projected impact; service funding source; required provider credentials; service site; identified service gaps; and identified service impediments. Mr. Gallagher encouraged the Task Force to determine the preferred breadth or scope of services to be compiled by the survey. An option open to the Task Force might be to begin with a high-level program survey and then to conduct more granular surveys, such as screening tools or case management protocols, if such a need arises.

Members observed that the list of service criteria captured well the content of previous Task Force discussions, yet its extensive length underscored the need to limit the scope of the survey. Members expressed an interest in better understanding the state's community-based service supports or direct services and selecting criteria that would provide for this discovery. Members also indicated an unwillingness to replicate any survey activity already conducted by the NDBHSS. Previous survey efforts have included (1) the Governor's Prevention Advisory Council which prepared a road map of programs and funding across agencies as a means to identify substance abuse service redundancies and gaps, and (2) the "Judy Lee Document," a biennial survey, spanning three legislative sessions, of risk behavior programs to monitor activity across agencies. The proposed CBHTF survey requires a clear title and purpose statement. The survey should inventory agency service programs for *all* individuals yet highlight services for children and youth. Some service criteria might include: title, age, purpose, type of service, eligibility, governance control, funding source, geographic region, intended outcome, agency responsible, and who conducts the service.

Mr. Gallagher will redesign the survey criteria and reach out to Task Force members to complete the process of collecting and compiling survey results by the end of July 2018.

Reviewing Past Legislative Initiatives. Mr. Gallagher distributed three documents, produced by the North Dakota Legislative Council, that presented historical overviews of state legislative mental/behavioral health initiatives. One document, *History of Behavioral Health Services in North Dakota, November 2015*, provided a summary of major behavioral health initiatives since statehood (<https://www.legis.nd.gov/files/resource/committee-memorandum/17.9129.01000.pdf>). A second document, *Recommendations Provided to the Interim Human Services Committee, May 2016*, provided a summary of policy recommendations by issue category (<https://www.legis.nd.gov/files/resource/committee-memorandum/17.9323.02000.pdf>). A third document, *Categories of Recommendations Provided to the Interim Human Services Committee—Behavioral Health Needs Study, May 2016*, provides an index of policy recommendations by topic and subcategory (<https://www.legis.nd.gov/files/resource/committee-memorandum/17.9350.01000.pdf>).

Reviewing Agency Program Initiatives. Chairperson Jones introduced a general discussion on behavioral health initiatives administered by each of the represented Task Force agencies.

Mylynn Tufte, ND State Health Officer, ND Department of Health, distributed copies of the *North Dakota Department of Health, Biennial Report, 2015-17* (<https://www.ndhealth.gov/publications/bienrpt/BiennialReport2015-2017.pdf?v=3>), and directed attention to pages 29-34, regarding Title V/Maternal and Child Health Block Grant, Women's Health, Suicide Prevention, Worksite Wellness, Crisis Response, and Main Street Initiative activities. Ms. Tufte discussed statewide community health needs assessments. The biennial report provides a comprehensive presentation of statewide health activities. The Department of Health also works closely with local public health units statewide regarding client services and standards.

Robin Lang, Assistant Director, Safe & Healthy Schools, ND Department of Public Instruction, discussed the programs administered by the Department of Public Instruction, especially those activities conducted in close cooperation with the Department of Health, specifically prevention and early intervention activities. Alcohol and suicide prevention programs and health screenings,

including vision, dental, and chronic disease, are long-standing school-based services. Increasingly, tele-health has emerged as an important tool. Multi-Tiered System of Supports, as previously discussed, represents a critical element of student support. The state's Youth Risk Behavior Survey is recognized as a primary means of monitoring student health indicators. The Department and the Education Standards and Practices Board track licensing and credentialing to analyze emerging gaps, especially with out-of-state teachers. The state's academic content standards establish a base for academic preparation in all disciplines, including health and physical education, with local school districts assuming responsibility for assuring compliance. Early childhood programs, ages 3-5, and English language programs have grown across the state. Title IV funding, supporting behavioral health programming and training, allows for program growth in critical areas. Foster care and homeless support programs are present statewide. ND Insights, the state's data collection tool, provides schools with actionable data for student supports. Tribal schools participate in many programs provided through the state's Regional Education Associations.

Ms. Sagness referenced the NDBHSS presentation and Legislative Council reports as illustrations of the long-standing work of the Behavioral Health Division's activities.

Pam Mack, Director of Program Services, ND Protection & Advocacy Project, discussed the advocacy and protective service elements of behavioral health. Protection and Advocacy works with matters concerning the criminal justice system, the State Hospital, abuse/neglect and exploitation investigations, seeking funding payments from insurers, and other matters.

Identifying Emergent Issues. Mr. Gallagher observed, based on Task Force scheduling, that the Task Force faces a July report to the Governor's Office, the Interim Human Services Committee, and the Interim Health Services Committee. The Task Force had previously expressed its intent to prepare policy proposals for the Interim Committees in anticipation of the 2019 Legislative Assembly. Chairperson Jones expressed an interest in proceeding incrementally across the broad range of behavioral health priorities. Priority issues might best be approached on the merits of improving the most prominent statewide behavioral health needs, regardless of the age of service recipients. Priorities for behavioral health values might include stopping the criminalization of behavioral health, meeting people where they are rather than forcing them to go to service centers, removing obstacles to services (e.g., transportation), repositioning services statewide across different agencies and locations, adopting a community and schools concept for service delivery, redesigning the social service system, linking agencies to provide better service, and making services accessible in an administratively simple manner. Perhaps the state might consider embedding services and resources into schools to reach more children and youth. The state needs to focus on the best return for investment by optimizing resources. The service community needs to meet children and youth where they are and find ways to better support families and caretakers.

Members expressed an interest in crafting policy recommendations that enhance well-rounded services and remedy funding concerns. Issues such as seclusion/restraint or bullying management practices require meaningful policy solutions and the proper training of professionals. Attention should be given to family economic and social stressors that affect children and youth. Policy proposals will need to accommodate certain governance restrictions, such as school districts' local control, since such restrictions may affect program effectiveness and consistency statewide. Past experience with statewide behavioral health training and substance abuse and bullying

prevention efforts illustrate the variance that can occur in the scope and quality of service offerings. Policies that support community- and school-based programming may provide a primary means of addressing a wide array of needs. The scope of services provided to children have been determined or influenced by reimbursement practices and funding, such as Medicaid and insurance plans, rather than the services being determined by the expressed needs of children and youth. Policies should try to fill the gaps that reimbursement practices create. It may be advisable for the Task Force to adopt recommendations that equitably touch each of the continuum of care levels to ensure that the state's statewide system remains supportive of every level of care for all the state's citizens. If schools become a focus for activity, then attention should be centered on those areas where schools' current competencies are the weakest. Policies might move to restrict cherry-picking students or conditions. The Task Force might benefit from addressing community-based services as a central theme for service design and delivery.

Members raised an interest in hearing from additional state agencies not included in the Task Force's membership, such as the North Dakota Extension Service, to better complete an assessment of state capacity. Members also expressed an interest in better balancing the continuum of care model, especially advancing promotion, prevention, and early intervention issues against the current concentration of effort and funding on treatment. A balanced continuum of care model would attend to the often-under-emphasized matters of health and wellbeing. Members also observed that the Task Force faces the reality of needing to address unmet needs in treatment and recovery areas, raising a struggle in where to determine priorities when the needs are great and varied.

Members expressed a means to move forward by

- (1) endorsing the principled adoption of the continuum of care model for the design and delivery of services, acknowledging the wide and varied needs of the state's population and committing to attend to the unique aspects of each level of the continuum;
- (2) adopting a longer-term, incremental plan to identify and address statewide behavioral health policy and practice improvements across all levels of the continuum of care; and
- (3) proceeding within the constraints of approaching reporting and legislative deadlines to propose those initiatives that will advance key improvements in as many levels of the continuum of care as is practicable.

Setting the July 16 Agenda. Mr. Gallagher proposed, based on previous Task Force comments, that the July 16, 2018, meeting agenda include the following items: (1) facilitating an approximate two-hour discussion with Senator Judy Lee and Representative Kathy Hogan regarding possible legislative proposals arising from the NDBHSS recommendations; (2) prioritizing Task Force initiatives for inclusion in reports to the Interim Human Services Committee and the Interim Health Services Committee in late July 2018; (3) prioritizing any policy initiatives and/or supplemental budget requests across agencies; (4) providing guidance to the CBHTF Chairperson regarding the content of Task Force reports to the Governor's Office, the Interim Human Services Committee, and the Interim Health Services Committee; and (5) identifying additional reports from other agencies or organizations that might support the Task Force's work across the continuum of care levels. Task Force members expressed support for the proposed agenda.

- Agenda Issue Bin for Forthcoming Meetings. Issues identified by the Task Force for consideration at forthcoming meetings include home-, school-, and community-based services; social services; child welfare and tribal services, including jurisdictional issues;

health and wellness checks (including EPSDT, screenings); health integration; peer, family and community supports; complex, fragile medical needs; how the behavioral health and developmental disabilities systems are or are not connected; and a review of primary and secondary payors in the behavioral health system.

Public Comment. Chairperson Jones invited members of the public to provide comments to the Task Force.

Gayle Klopp, Co-Executive Director for Administration and Operations, Charles Hall Youth Services, operating three youth services homes in Bismarck, identified a gap in the state's continuum of care, regarding psychiatric care for adolescents statewide. Sanford Medical Center and the State Hospital have closed their respective adolescent psychiatric units and St. Alexius Medical Center may soon be closing its unit as well. These closing have produced significant gaps in psychiatric care for children and youth. Within Charles Hall Youth Services, approximately 80% of youth behavioral health needs can be served; however, approximately 20% of youth require more appropriate, intensive care that is becoming increasingly difficult to access. The Dakota Boys and Girls Ranch, Bismarck, a recognized psychiatric treatment center for youth, can provide certain high-need services, however, the required certificate of need process, which might take up to six weeks to process, makes the referral and treatment effort unnecessarily cumbersome. Mr. Klopp stated there exists a need to review and improve the speed of the certificate of need process to make these transitions minimal. Chairperson Jones thanked Mr. Klopp for his comments.

Roxanne Romanick, a private citizen invested in the birth-to-three-years early intervention system where she has worked for many years, reminded the Task Force of its need to attend to the needs of early childhood intervention. Ms. Romanick observed that the opioid epidemic is beginning to emerge in the overt needs of young substance-exposed children, perhaps contributing to student behavior and school safety concerns. Attention should be given to the birth-to-age-three population, with assistance of the current Part C programs and behavioral health programs to support these children and their families. It might serve the state well to provide supports around addiction treatment and recovery for the parents, using professionals within the birth-to-age-three system who are experienced in these matters. Hospital Neo-natal Intensive Care Units (NICU) and other health professionals are aware of this crisis. In recent years, the definition of which children are eligible for birth-to-age-three services has been restricted, effectively underserving some deserving children and families. These tightened eligibility rules, set entirely by the state on its own criteria, need to be reassessed and reversed to serve a wider group of deserving children and families. This opportunity rests entirely with the state, which can ease and correct this eligibility restriction. Ms. Romanick recommended that the Task Force move to correct this situation, beginning first by reaching out to the health care professionals who work in this area, such as Dr. Anna Tobias, Sanford Health. Ms. Romanick also encouraged the Task Force to review the work of inclusion specialists, supported through approximately \$400,000 in state general fund grants through Child Care Aware. This work is grounded in child development and behavioral health and should be reviewed and expanded, including additional funding. It supports technical assistance specialists to help people statewide. The key rests with early intervention and universal design. Foundation programs, such as schools' Multi-Tiered System of Support, provide a means to assist children and youth in all settings. Chairperson Jones thanked Ms. Romanick for her comments.

Adjournment. Having completed the meeting's agenda and hearing no further comments from the Task Force, Chairperson Jones entertained a motion to adjourn the Task Force meeting.

MYLYNN TUFTE MADE AND ROBIN LANG SECONDED A MOTION TO ADJOURN.

Chairperson Jones declared the meeting adjourned at 12:55 p.m., CT.

Respectfully submitted,

Greg Gallagher
The Consensus Council
Task Force Recorder