

**North Dakota
Children's Behavioral Health Task Force
August 20, 2018**

Meeting Minutes, Approved

Task Force Members Attending: *Chris Jones, Chairperson*, (Executive Director, ND Department of Human Services); *Erica Thunder, Designee* (Judicial Systems Administrator, ND Indian Affairs Commission); *Robin Lang* (Assistant Director, Safe & Healthy Schools, ND Department of Public Instruction); *Mylynn Tufte* (ND State Health Officer, ND Department of Health); *Lisa Bjergaard* (Director, Division of Juvenile Services, ND Department of Corrections & Rehabilitation); and *Pam Mack* (Director of Program Services, ND Protection & Advocacy Project).

Pamela Sagness, Designee Assistant to Chairperson Jones (Behavioral Health Division Director, ND Department of Human Services).

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

Call to Order and Welcome: Chris Jones, Chairperson, called the meeting to order at 1:04 p.m., CT, and welcomed Task Force members and guests to the meeting.

Quorum: With all members present, a quorum was recorded.

Approval of July 16, 2018 Meeting Minutes: LISA BJERGAARD MADE AND PAM MACK SECONDED A MOTION TO APPROVE THE MEETING MINUTES OF JULY 16, 2018. MOTION PASSED UNANIMOUSLY. (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/2018-7-16-ndcbhtv-minutes-final.pdf>).

Review of Task Force Responsibilities: Chairperson Jones reviewed the responsibilities of the Children's Behavioral Health Task Force, 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.

Acceptance of Agenda. Chairperson Jones reviewed and accepted the August 20, 2018, meeting agenda as presented.

Report on CBHTF Presentations Before Interim Legislative Committees. Chairperson Jones invited Pam Sagness, Behavioral Health Division Director, Department of Human Services, to report on her presentation of CBHTF's proceedings before the July 26, 2018, Interim Health Services Committee and the July 27, 2018, Interim Human Services Committee. Ms. Sagness reported that her presentations provided a summary of (1) the mandated July report of CBHTF activities and (2) the first-draft initiatives developed by the CBHTF during its July 16, 2018, meeting (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/setting-cbhtf-priorities.pdf>). Ms. Sagness stated that legislators generally responded favorably to the report and expressed satisfaction with the overall progress evidenced by the CBHTF, despite its delayed startup. Legislators recommended that the CBHTF cooperate closely with the Interagency Coordinating Council to ensure a more seamless analysis of issues and coordination of forthcoming recommendations. Ms. Sagness stated that Roxane Romanick had submitted separate testimony to the Committees encouraging the promotion of (1) a strong Part C Early Intervention system and a comprehensive Child Find system, enhancing a focus on social-emotional health, and (2) a quality system to provide supports for infants who have experienced substance exposure, as well as their family members.

Committee members discussed the need to reach out to the Interagency Coordinating Council to assess the focus and direction of their activities and to determine how the CBHTF and the ICC might work cooperatively on selected initiatives.

Report on the Survey of Interagency Behavioral Health Services. Chairperson Jones invited Greg Gallagher, Program and Research Director, The Consensus Council, Inc., to report on the status of the CBHTF's survey of behavioral health programs. Mr. Gallagher provided a summary of prior CBHTF discussions leading up to the development of the current *Inventory of Behavioral Health Service Programs* (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/inventory-of-services-consensus-council.pdf>). Mr. Gallagher stated that the CBHTF had identified the purposes of the inventory to include: (1) compile an inventory of children's behavioral health services, including programs, policies, and practices, provided by public agencies; (2) allow for the analysis of perceived service gaps, redundancies, inefficiencies, best practices, and emergent priorities; and (3) allow for the development of integrated program service responses to improve the state's system of children's behavioral health. Mr. Gallagher identified the parameters used to develop the inventory, including, (1) restricting the inventory to only CBHTF agencies; (2) not replicating findings generated by the HSRI state systems study; (3) focusing on higher level agency programs, broadly defined; (4) including programs spanning institutional through program components; (5) attending to the needs of all individuals, yet highlighting services for children and youth; and (6) providing a clear title and purpose statement. Mr. Gallagher stated that the original 17 program elements originally identified by the CBHTF were reduced to 9 to better manage the discovery process. The Consensus Council used each agency's 2015-2017 Biennial Report and other sources to generate the inventory.

Mr. Gallagher stated that the inventory provides a comprehensive accounting of the agencies' various behavioral health program efforts, spanning activities as diverse as direct client services, professional development, administrative program compliance monitoring, quality assurance standards, and other related activities. The inventory supports the development of the CBHTF's initiatives, addressing its previously stated interests: (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 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. Mr. Gallagher presented the resulting inventory (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/master-nd-behavioral-health-services-programs-inventory.pdf>).

Members stated that the inventory provides a sense of the broad scope of behavioral health services currently available across the state, yet its breadth may indicate a need to provide a more uniform definition of *behavioral health* to reconcile some apparent disconnections among agency programs. Members observed that the inventory was helpful and informative, expanding an awareness of the interagency nature of behavioral health. Members identified a possible need to further refine the inventory to distinguish among activities focused on clients, providers, resources, or organized programs, thereby providing a more unified presentation. Members observed that the inventory offered a first step in addressing gaps and redundancies, clarifying what initiatives might be most important to address.

Public Comments. Chairperson Jones requested the CBHTF amend its agenda to allow for the inclusion of public comments, prior to the CBHTF moving forward with consideration of statewide behavioral health initiatives. Members unanimously agreed to amending the agenda to allow for public comment.

Jennifer Faul, Chief Operating Officer, Prairie St. John's, a licensed and accredited psychiatric and addiction treatment center in Fargo, ND, encouraged the CBHTF to address previously studied need indicators and systemic gaps, including identified social determinants for youth by region (e.g., school engagement, work, pregnancies), and service discrepancies that exist between urban and remote, rural settings statewide. Ms. Faul stated that individuals in urban settings have a 1:300 provider/client ratio while rural settings have a 1:10,000 provider/client ratio. Ms. Faul identified the need to enhance tele-health services to mitigate those disparities introduced by considerable distances between clients (i.e. students) and providers. Transportation barriers constitute a significant factor in individuals not accessing direct services, as reported in the recent HSRI statewide systems study and the previous Schulte study. Ms. Faul pointed to the New Town, ND, school district as an example where tele-health services have enhanced the quality of care. This effort provides a replicable model for other rural settings statewide, where local school staff can support the direct services provided by certified staff via tele-health. Such arrangements will expand the availability of licensed addiction counselors across the state, especially in the southwest quadrant, further enhancing both mental health and chemical dependency treatment services. Mr. Jones thanked Ms. Faul for her testimony.

Rebecca Matthews, a Bismarck resident with four children and currently employed as a parent mentor for the Bismarck Early Childhood Education Program, an ages 0-3 early intervention and education program, provided testimony on early intervention. Ms. Matthews holds an occupational therapy degree with experience in in-patient psychiatry programs. Ms. Matthews shared her experience, as a parent of a special needs child who was determined not eligible to receive public early intervention services, despite an identified need for such services. Ms. Matthews stated that service needs begin with birth or pre-natal identification. Early intervention screenings, such as those provided in Right Track, need to be expanded. Program administration requirements, which produce burdensome siloed barriers for parents, need to be removed. Research identifies the benefits of early intervention and parent education in aiding a child's wellbeing, including health, language, communication, cognitive, and social-emotional development. Early intervention and education programs provide longer term benefits impacting education, child welfare, behavioral health (mental health and addictions), developmental

disabilities, and corrections systems. Parents need help in navigating the public systems' silos, even as parents themselves may need behavioral health assistance.

Ms. Matthews recommended that the CBHTF focus on several initiatives, including (1) improve Child Find activities, ages 0-3, with coordinated screening efforts, such as Right Track; (2) embed infant mental health specialists and training into current Part C programs, without creating yet another program structure; (3) invest in the treatment of substance exposed infants and early intervention efforts that are provided by current infant development specialists and based on family service plans; (4) provide additional funding for technical assistance grants to support behavioral health programs; and (5) conduct longer term tracking of children through youth and adulthood, mapping and supporting their development. Programs need to attend to the needs of parents, who themselves have behavioral health needs. Programs should consider recovery coaches to aid certain parents in their addiction recovery efforts. Despite the many community programs that exist, gaps still persist. Navigators are needed to guide parents, finding those programs that are most appropriate. Voluntary programs will oftentimes see parents exiting programs prematurely because of difficulties in program scheduling and delivery. This is especially prevalent among Native American parents. Parents must ultimately make decisions regarding their children's care. Programs need to honor the core role of parents and support parents in making good, informed decisions that address their child's needs. Mr. Jones thanked Ms. Matthews for her testimony.

Jennifer Faul provided supplemental testimony, referencing the research of Dr. Jeff Duncan-Andradi, Associate Professor of Raza Studies and Education Administration and Interdisciplinary Studies, San Francisco State University, and Founder of the Roses in Concrete Community School, Oakland, CA, that reports the key influence of schools on children and youth. This research shows that schools, sometimes more than parents, exert the primary influence on the long-term benefits to children. Mr. Jones thanked Ms. Faul.

Kim Osadchuk, Director, Burleigh County Social Services, stated that county social service offices periodically receive petitions, initiated by parents, for a transfer of child custody from the parents to the county in order for the child to receive behavioral health services, including addiction treatment. When the county receives custody, the child then can be placed into services. This illustrates a troubling situation where parents feel they must transfer custody of their child to the county in order for the child to receive needed behavioral health services. This situation places county social service workers in an untenable situation. The circumstances surrounding this situation should be studied and addressed. Mr. Jones thanked Ms. Osadchuk for her comments.

Setting CBHTF Priorities and Draft Legislative Proposals and Interagency Agreements.

Chairperson Jones reinstated the current Order, returning to the established agenda, and recommended the joining of two agenda items, (1) setting priorities and (2) drafting proposals, to expedite proceedings. Members consented to this amendment to the agenda.

Mr. Gallagher placed before the CBHTF information requested by the CBHTF during its July 16, 2018, meeting regarding the origin and governance of the Children's Services Coordinating Committee, authorized in 1987 under NDCC 54-56-01 and subsequently repealed in 2017 under S.L. 2017, ch.373, §4. The CBHTF discussed during its July 2018 meeting whether the CSCC might offer a model to coordinate both state-level and regional service activities. Mr. Gallagher provided a summary history of the CSCC (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/csccl-background-history-archives.pdf>) and the governance agreement that established the structure for the CSCC (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/csccl-interagency-agreement-original.pdf>). Mr. Gallagher reported that, in a

2004 Attorney's General opinion (2004-L-37; <https://attorneygeneral.nd.gov/sites/ag/files/Legal-Opinions/2004-L-37.pdf>), regional CSCCs could no longer act under the name or authorization of the state CSCC once the state CSCC lost its funding and ceased its operation; however, regional CSCCs, now operating under different titles, may retain their nonprofit corporation or tribal status. Under this opinion, local or regional coordinated efforts may continue to operate, but may not refer to themselves under the title or authorization of the CSCC, whose funding was discontinued in 2004 and whose legal status was repealed in 2017.

Chairperson Jones invited members to review and amend the list of CBHTF priorities generated at the July 16, 2018, CBHTF meeting (<https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/setting-cbhtf-priorities.pdf>).

Members reiterated their intent to develop a list of CBHTF platform statements 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 eliminate service redundancies and efficiencies, fill in apparent service gaps, and deploy program and professional best practices.

Chairperson Jones opened discussion for the CBHTF to amend the list of platform statements initially developed during the July 16, 2018 CBHTF meeting, and to specify action steps for each platform statement, including any necessary bill drafts or interagency agreements.

Ms. Sagness stated that the CBHTF list of initiatives, drafted in July, was presented to both the Interim Health Services Committee and the Interim Human Services Committee, in anticipation of CBHTF submitting any bill draft recommendations at the Committees' mid-September meetings. Ms. Sagness also reminded members of a separate effort of the Substance Exposed Newborns Task Force, conducted during the previous biennium, whose recommendations did not receive approval in the subsequent legislative session. Ms. Sagness recommended that the CBHTF adopt two additional CBHTF initiatives: (1) the previous Substance Exposed Newborns Task Force's proposals, including its completed work plan, which was never enacted or funded, and (2) the Romanick proposal, concerning the expansion of early intervention Child Find, Infant Development, and substance exposed newborns' services. Any final CBHTF proposals may be brought forward to the Interim Health Services Committee, the Governor's Office, as a selected CBHTF agency's initiative, or as a combined initiative of all CBHTF agencies.

Members proceeded to develop a second-draft document that constitutes the CBHTF's position platform, directing future CBHTF activity. Each platform statement consists of (1) a CBHTF *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, or appropriations proposals.

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 policy and practices guidelines, 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 guidelines that adapt and incorporate national best-practice standards. These guidelines 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 guidelines. The CBHTF seeks to find the most appropriate mechanism that ensures the ultimate adoption and implementation of these guidelines, including consideration of incremental competitive deployment grants, 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 guidelines 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 guidelines of conduct are required to appropriately manage student behavior and staff interventions, ensuring the safety and security of students 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.

Strategy. The CBHTF recommends that funding be sought during the 2019 Legislative Assembly to provide competitive grants to select school districts or schools who voluntarily (1) adopt and implement comprehensive seclusion and restraint policies and practices, incorporating those best practices that are either specified within the Seclusion and Restraint Task Force's guidelines or are documented by some equivalent policies, and (2) provide sufficient assurances and action plans to ensure the establishment of safe and appropriate student behavior management and staff intervention policies and practices.

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

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

Position. The CBHTF identifies a need to establish a standing state-level children's services committee that is (1) supported by similarly structured regional children services committees and (2) dedicated to the collaborative development and implementation of policies and practices that drive coordinated children's services, within the constructs of state law. These children's services committees 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 and regionally, across all service sectors (e.g., education, social services, health, corrections, and others). This committee structure 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 a sustainable, standing committee structure, both at the state and regional levels, that can meaningfully move coordination efforts forward into the future, beyond the ad hoc lifespan of the CBHTF.

The CBHTF envisions a standing structure that might replicate the design and purpose of the former Children’s Services Coordinating Committee, provided for under N.D.C.C. 54-56-01 and subsequently repealed. Such a combined state- and regional-level committee structure balances the interests of ensuring uniform service accessibility and accommodating unique local program implementation.

Furthermore, the CBHTF affirms that funding should be provided to ensure that these state and regional 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 and regional coordination structure, 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.

C. Suicide Prevention.

Position. The CBHTF supports the Department of Health’s budget adjustments within the Department’s baseline budget to sustain and expand its Suicide Prevention program.

Strategy. The CBHTF will consider the merits of drafting a resolution of support for the continuation and expansion of the Department of Health’s Suicide Prevention program.

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.

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.

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

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.

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

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.

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

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 will evaluate if any changes in agencies' policies or appropriation levels might require additional interagency agreement or legislative action.

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

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.

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.

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.

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.

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.

Chairperson Jones instructed Greg Gallagher to complete the formatting and drafting of the CBHTF position and strategy platform and to distribute the resulting draft to Task Force members for their review. Chairperson Jones stated that he would meet with the Governor's Office to provide an update on Task Force activities, including its position platform, and to inquire into the Governor's interest in providing any further guidance or comments to the CBHTF, as the CBHTF moves into its next phase.

Finalize Agenda for Next Meeting, Requests for Supplemental Reports and Presentations. Chairperson Jones announced the scheduled dates for forthcoming meetings.

- Friday, September 21, 2018, 10:00 a.m. – 1:00 p.m., CT, in the Sakakawea Room, State Capitol;

- Tuesday, October 16, 2018, 1:00 – 4:00 p.m., CT, in the Missouri River Room, State Capitol; and
- Thursday, November 15, 2018, 1:00 – 4:00 p.m., CT, in the Sakakawea Room, State Capitol.

Members recommended that the September 21, 2018, CBHTF meeting agenda include (1) a report on Chairperson Jones' meeting with the Governor's Office regarding CBHTF activities and future plans; (2) a structured review of any outstanding issues within the Issue Bin that may be considered by the CBHTF; (3) identify any cross-agency efforts, taken from the services inventory, that may apply to any of the initiatives adopted by the CBHTF; (4) amending and completing strategy statements for all identified CBHTF initiatives; and (5) discussions with a representative of the Interagency Coordinating Council regarding early intervention priorities. Chairperson Jones instructed the Consensus Council to prepare a manageable agenda to meet these objectives, considering also any outstanding issues from the CBHTF's issue bin. Members identified several issues within the Issue Bin (listed below) that might be removed from further discussion, since the service inventory provided a means to account for their objectives.

Prospective 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 any members of the public to provide comments for the Task Force.

Heather Simonich, Operations Director, PATH ND, a private nonprofit child and family services agency in Fargo, ND, testified to the importance of providing support to families and the role they play in the health care of their children. It is important for the service system to be creative in reaching and effectively supporting clients. It becomes difficult, however, for outpatient providers to be creative and attentive to client needs when current payment-for-services policies obstruct care, especially payment for services when a parent's presence may not be appropriate for the treatment of a child. Current private insurer and Medicaid rules require that behavioral health payments be contingent on the presence by both the parent and child at the time of a service session. Some care plans are better served by allowing the child or parent to be assisted separately; however, current payment practices do not allow payment for such service sessions. This constitutes a backward understanding of client care and represents a potential burden to providers.

Ms. Simonich stated that the state's current inability to enact a meaningful seclusion and restraint policy applicable across all schools is unacceptable and inexcusable. It is contradictory for the state to claim it has trauma-sensitive programs within schools when schools cannot evidence any policies on seclusion and restraint. It is inconsistent to fall back on the old argument of not supporting state-level safety policies because of local control while not providing fundamental safety assurances in its place. Teachers and administrators are requesting services. This is one area where the state can make a meaningful difference. Ms. Simonich commended the efforts of schools to introduce additional staff and programs to assist children.

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.

ERICA THUNDER MADE AND LISA BJERGAARD SECONDED A MOTION TO ADJOURN.

Chairperson Jones declared the meeting adjourned at 4:01 p.m. CT.

Respectfully submitted,
Greg Gallagher
Consensus Council, Inc.