

Children’s Behavioral Health Task Force
Platform Position and Strategy Statements
Draft 2.0

September 21, 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 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, and
- (c) deploy program and professional best practices.

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 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.

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

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 organizational body 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 and the recommendations contained within the HSRI North Dakota Behavioral Health Systems Study. These~~ This children’s services committee’s organizational body 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~~ organizational body 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 organizational body 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~~ coordinating organizational body, 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 entertains the prospects of establishing a relationship with any other state behavioral health organization to gain further efficiencies without diminishing the charge of the CBHTF to advocate for and advance the best interests of children's behavioral health needs.

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 the ~~Department of Health's budget~~ adjustments within the Department of Health'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.

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 Tufté 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 Tuftte 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 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.

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.

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.