North Dakota
Children's Behavioral Health Task Force
September 21, 2018

Meeting Minutes, Approved

Task Force Members Attending: *Chris Jones, Chairperson,* (Executive Director, ND Department of Human Services); *Robin Lang* (Assistant Director, Safe & Healthy Schools, ND Department of Public Instruction); *Kim Mertz, Designee* (Section Chief, Health and Safe Communities, ND Department of Health); and *Lisa Bjergaard* (Director, Division of Juvenile Services, ND Department of Corrections & Rehabilitation.

Members Absent: Erica Thunder, Designee (Judicial Systems Administrator, ND Indian Affairs Commission; and Pam Mack (Director of Program Services, ND Protection & Advocacy Project).

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 10:10 a.m., CT, and welcomed Task Force members and guests to the meeting.

Quorum: A quorum was recorded.

Approval of August 20, 2018 Meeting Minutes: LISA BJERGAARD MADE AND ROBIN LANG SECONDED A MOTION TO APPROVE THE MEETING MINUTES OF AUGUST 20, 2018. MOTION PASSED UNANIMOUSLY. (https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/2018-8-20-ndcbhtf-minutes.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 September 21, 2018, meeting agenda as presented. Greg Gallagher, Task Force Recorder, reported that the November 15, 2018, CBHTF meeting, originally scheduled for 1:00 – 4:00 pm, CT, may need to be rescheduled to the morning, because of a recently scheduled Department of Human Services, Family First meeting. Further discussion was deferred to the end of the agenda-setting section.

Report on CBHTF Chairperson's Meeting with Governor's Office on CBHTF Activities. Chairperson Jones reported that the Governor's Office is working to arrange a meeting to receive an update on the CBHTF's proceedings and recommendations. Chairperson Jones stated that two interim legislative committees demonstrated strong support for behavioral health issues generally and indicated interest in considering the legislative proposals presented by the Department of Human Services at the September 11, 2018, Human Services Committee meeting (https://www.legis.nd.gov/events/2018/09/11/human-services-committee) and the September 12, 2018, Health Services Committee meeting (https://www.legis.nd.gov/events/2018/09/12/health-services-committee). Legislators encouraged the CBHTF to attend to the recommendations specified in the HSRI ND Behavioral Health Systems Study (https://www.nd.gov/dhs/info/pubs/docs/mhsa/2018-4-nd-behavioral-health-system-study-final-report-hsri.pdf). The Governor's Office has expressed its interest in advancing behavioral health initiatives as a higher state priority.

Discussion on Collaboration Between the CBHTF and the Interagency Coordinating Council. Chris Pieske, Region 7 Parent Representative and Chairperson of the Budget Subcommittee of the Interagency Coordinating Council (ICC), presented a summary of the mission and activities of the ICC, at the request of the CBHTF (https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/icc-mission-statement.pdf). The ICC consists of 25 members, of which 8 members are designated as regional parent representatives, consistent with federal law requirements for statewide stakeholder representation. Parent representation is a vital element of sound public policy discussions. North Dakota receives approximately $2.4 Million in federal Individuals with Disabilities Education Act (IDEA), Part C, funds that support overall state Child Find (ages birth through two years), direct services, and other early intervention related activities. Central to Part C activities is the provision of services in the natural home setting and aiding in the transition of the child into later Part B services, generally under the public school system.

Mr. Pieske stated that interim legislative committees have been studying the state's early identification and intervention system, with initial findings indicating that the state's Right Track early intervention system offers a robust means of identifying and supporting at-risk children. The state's system, nevertheless, is showing signs of weakness, resulting from a general under-funding of the program. Part C funding is no longer able to assume the costs of direct services for all children, given the increase in identified individuals. Families who are ineligible for Medicaid Assistance experience a financial stress. Insufficient Part C funds requires the state to adjust its budget to offer some proportional level of support accordingly. It is anticipated, for the first time ever, that the state will expend all its Part C funds before the end of the fiscal year. Right Track offers benefits to many state agencies and services, reducing future state systems' costs through early intervention. The state may need to assess if other state agency programs might partially support Right Track financially to enhance early intervention and prevention efforts.

The ICC defines at-risk children according to federal statute, specifically related to developmental delays, with increased discussion on the pre-qualified inclusion of substance-exposed newborns undergoing policy review. Socio-economic indicators are considered for service eligibility, as illustrated by the work of the Department of Health's Special Health Services programming and the ICC's early intervention providers' subcommittee. Right Track still offers the state's best single source effort for identification and is supported by other agencies, pediatricians, and the public school system. The ICC continues to review the service impact of families experiencing homelessness or other situations. These environmental matters are a particular concern of the ICC.

Mr. Pieske requested that the CBHTF (1) consider how behavioral health programs benefit from the Part C-related programs and whether the behavioral health system might provide some level of financial support for this effort, and (2) consider how parents might be better included into the structure of behavioral health advisory or policy setting committees, such as the CBHTF and other committees, even if changes in statute are required. Mr. Pieske thanked the CBHTF for its invitation to present the work of the ICC. Chairperson Jones thanked Mr. Pieske for his presentation.

Interagency Cooperation on Common Program Goals Identified in the CBHTF Program Service Inventory;

Review North Dakota Behavioral Health System Study, 13 Recommendations: Priorities for CBHTF Platform Statements; and

Review CBHTF Platform Position and Strategy Statements.

Mr. Gallagher provided an overview of the interagency inventory of behavioral health service activities or programs offered by the CBHTF agencies. The Consensus Council compiled the inventory, at the request of the CBHTF, and presented it at the August 20, 2018, CBHTF meeting. Mylynn Tufte had requested that The Consensus Council produce a dedicated inventory of suicide prevention service programs offered by the CBHTF agencies. Mr. Gallagher presented the suicide prevention program inventory, which was queried and compiled from the comprehensive inventory based on agencies' specifically identified suicide prevention activities. Mr. Gallagher stated that the suicide prevention inventory did not include any suicide prevention components that were not *explicitly* stated by agencies, which would require a deeper agency-driven identification effort.

Mr. Gallagher observed that the program service inventory blends into the meeting's remaining agenda items: the HSRI systems study recommendations, the initial draft of CBHTF platform positions and strategies, and potential legislation and interagency agreements.

Chairperson Jones invited members to consider several items in determining future plans: the role of the CBHTF, the HSRI recommendations, the CBHTF service inventory, and the CBHTF platform positions. Members expressed an interest in establishing a coordinating body or cabinet that elevates the interests of children and families, much in line with HSRI Recommendation 1.0 and Section B of the CBHTF platform. Members identified other emergent needs: (1) coordinate early intervention and prevention activities among agencies (e.g., HSRI Recommendation 2.0; 5.0; among others), and (2) involve parents in determining intervention activities and in providing advice and guidance on policies and program delivery (e.g., HSRI Recommendations 1.1; 2.1; 5.0; 9.0; among others). Members also referred to the other initiatives outlined in the CBHTF's platform positions. Members discussed options how to manage the CBHTF platform positions, ensuring that the positions sufficiently encompass the spread of the HSRI recommendations within a measured rollout plan.

Members discussed different models of structuring a coordinating body that can balance advancing children's behavioral health services, honoring the role of families in the effort, and integrating behavioral health planning for children, adults, and the wider community. Coordination ensures efficient programming and secures proper services for both children and adults. One model might place the CBHTF as an established subcommittee within a wider behavioral health steering committee structure. Another model might empower the current CBHTF to coordinate policies and funding across agencies. Another model might establish a new

coordinating committee structure that might replace the CBHTF. Whatever model is selected should secure resources that make children priorities for services.

Members requested that the *CBHTF Platform Position and Strategy Statements* be edited as the CBHTF's plan of action, allowing for further revisions. (https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/cbhtf-platform-positions-and-strategies-draft.pdf).

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

Chairperson Jones introduced Section B, a recommendation regarding the formation of a state-level children's services committee, for the CBHTF's consideration. Members offered the following amendments to the platform's language:

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 ~~committees~~ 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.

LISA BJERGAARD MADE AND ROBIN LANG SECONDED A MOTION TO ADOPT SECTION B WITHIN THE CBHTF PLATFORM POSITIONS AND STRATEGY STATEMENTS, AS AMENDED, EXPRESSING THE INTENT OF THE CBHTF TO ADOPT THE FORMATION OF A GOVERNING STRUCTURE, VEHICLE, OR ORGANIZATIONAL BODY THAT ADVANCES THE COLLABORATIVE PLANNING OF CHILDREN'S BEHAVIORAL HEALTH ISSUES, ENGAGING MULTIPLE STATE AGENCIES AND OTHER ORGANIZATIONS.

THE MOTION PASSED UNANIMOUSLY.

Mr. Gallagher presented an overview of the remaining CBHTF Platform Positions and Strategy Statements. The CBHTF had requested that Mr. Gallagher draft a preamble to the platform statements, underscoring the CBHTF's statutory mission and purpose of the platform. Mr. Gallagher identified where certain text embellishments clarified the CBHTF's strategies, including the insertion of designated lead Task Force members for certain platform statements. Mr. Gallagher offered to cross-reference each platform statement to those HSRI recommendations that are applicable to the statement's purpose, grounding the legitimacy of each platform statement to a researched recommendation.

Preamble: Platform Position and Strategy Statements

Chairperson Jones introduced the Preamble, a summary statement of the CBHTF's statutory mandate and the expressed need for platform statements, for the CBHTF's consideration. Chairperson Jones requested the following amendments to the preamble's language:

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.

Chairperson Jones requested that the amendment be deferred to the October 2018 CBHTF meeting for consideration. Members concurred.

Section A: Adoption of School Seclusion and Restraint Policy and Practices Guidelines

Chairperson Jones introduced Section A, a recommendation regarding the adoption of school seclusion and restraint policy and practices guidelines, for the CBHTF's consideration.

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.

CHAIRPERSON JONES REQUESTED THE ADOPTION OF SECTION A, REGARDING THE ADOPTION OF SCHOOL SECLUSION AND RESTRAINT POLICY AND PRACTICES GUIDELINES.

THE MOTION PASSED UNANIMOUSLY.

Section C: Suicide Prevention

Chairperson Jones introduced Section C, a recommendation regarding collaborative support for suicide prevention programming, for the CBHTF's consideration.

Members expressed a willingness for agencies to provide support for other agencies' appropriations requests before the Legislative Assembly. Members requested that this statement be inserted in a separate section of the platform statements, perhaps within Section F, regarding sufficient and sustainable funding. Mr. Gallagher stated that he would amend Section F accordingly.

Members discussed how to advance the adoption of suicide prevention policy statements for schools and other institutions statewide, advocating for a systemic solution. Members requested that Mr. Gallagher draft an amendment to incorporate a systemic solution to the adoption of suicide prevention policies across agencies, for consideration at the October 2018 CBHTF meeting. The proposed amendment language follows:

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

Members deferred further action on Section C until the October 2018 CBHTF meeting.

Section D: Bullying Prevention and Intervention

Chairperson Jones introduced Section D, a recommendation regarding bullying prevention and intervention, for the CBHTF's consideration.

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.

CHAIRPERSON JONES REQUESTED THE ADOPTION OF SECTION D, REGARDING BULLYING PREVENTION AND INTERVENTION.

THE MOTION PASSED UNANIMOUSLY.

Section E: Brain Development

Chairperson Jones introduced Section E, a recommendation regarding brain development, for the CBHTF's consideration.

E. Brain Development

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

Strategy. The CBHTF will consider the merits of drafting a resolution of support to accompany the Department of Health's promotional and technical assistance publications, expressing

the CBHTF's support for incorporating brain development research and best practices into service delivery.

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

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

CHAIRPERSON JONES REQUESTED THE ADOPTION OF SECTION E, REGARDING BRAIN DEVELOPMENT.

THE MOTION PASSED UNANIMOUSLY.

Section F: Sufficient, Sustainable Funding

Chairperson Jones introduced Section F, a recommendation regarding sufficient, sustainable funding.

Members expressed their intention that agencies cooperatively provide support for other agencies' appropriations requests before the Legislative Assembly, when these requests support the advancement of CBHTF policies, programs, and practices. Members requested that Mr. Gallagher draft an amendment to Section F to underscore this intent.

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.

CHAIRPERSON JONES REQUESTED THE ADOPTION OF SECTION F, REGARDING SUFFICIENT, SUSTAINABLE FUNDING.

THE MOTION PASSED UNANIMOUSLY.

Section G: Expanded Emergency Care Resources

Chairperson Jones introduced Section G, a recommendation regarding expanding emergency care resources.

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.

Chairperson Jones recommended that the CBHTF hold Section G revisions for a future meeting. Members concurred.

Section H: Juvenile Court Rules for Maltreatment

Chairperson Jones introduced Section H, a recommendation regarding juvenile court rules for maltreatment.

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.

CHAIRPERSON JONES REQUESTED THE ADOPTION OF SECTION H, REGARDING JUVENILE COURT RULES FOR MALTREATMENT.

THE MOTION PASSED UNANIMOUSLY.

Section I: Expanded Emergency Care Resources

Chairperson Jones introduced Section I, a recommendation regarding state and tribal service collaboration.

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.

Members discussed holding Section I revisions for a future meeting, allowing an opportunity for Erica Thunder, Designee for the ND Indian Affairs Commission, to engage in the discussion of Section I.

LISA BJERGAARD MOVED AND ROBIN LANG SECONDED THAT THE CBHTF DEFER FURTHER DISCUSSION OF SECTION I UNTIL THE OCTOBER 2018 CBHTF MEETING.

THE MOTION PASSED UNANIMOUSLY.

Section J: Early Intervention, Part C.

Chairperson Jones introduced Section J, a recommendation regarding early intervention, IDEA Part C.

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.

CHAIRPERSON JONES REQUESTED THE ADOPTION OF SECTION J, REGARDING EARLY INTERVENTION, IDEA PART C.

THE MOTION PASSED UNANIMOUSLY.

Section K: Substance Exposed Newborn Services

Chairperson Jones introduced Section K, a recommendation regarding substance exposed newborn services.

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.

LISA BJERGAARD MOVED AND ROBIN LANG SECONDED THE ADOPTION OF SECTION K, REGARDING SUBSTANCE EXPOSED NEWBORN SERVICES.

THE MOTION PASSED UNANIMOUSLY.

Mr. Gallagher recommended that the CBHTF Platform Position and Strategy Statements include references to those HSRI system study recommendations which align with the platform statements' purpose, providing validation of CBHTF activity against the HSRI system study. CBHTF members concurred.

Chairperson Jones instructed Mr. Gallagher to complete the amendments to the CBHTF Platform Position and Strategy Statements, including HSRI system study references, and to distribute the resulting draft to CBHTF members for their review.

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

- Tuesday, October 16, 2018, 1:00 – 4:00 p.m., CT, in the Missouri River Room, State Capitol; and
- Thursday, November 15, 2018, 9:00 a.m. – 12:00 p.m., CT, in the Sakakawea Room, State Capitol, pending the confirmation of room availability. At the request of the Chair, the meeting's time has been adjusted to accommodate a Family First conference.

Members recommended that the October 16, 2018, CBHTF meeting agenda include:

1. Amend CBHTF Platform Position and Strategy Statements deferred for future consideration: Preamble; Section C (suicide prevention); Section F (sufficient, sustainable funding); Section G (expanded emergency care resources); and Section I (state and tribal service collaboration).
2. Review how each CBHTF Platform Position and Strategy Statement aligns with respective HSRI system study recommendations.
3. Design an organizational body structure that accomplishes the goals of Section B of the CBHTF Platform Position and Strategy Statements.
4. Consider the role of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and Medicaid in supporting children's behavioral health services.

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 reviewed the status of the issues within the Issue Bin:

> 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 interested members of the public to provide comments for the Task Force.

Carlotta McCleary, Executive Director for North Dakota Federation for Families for Children's Mental Health and Executive Director for Mental Health America—North Dakota, provided written testimony, presented here in its entirety (https://www.nd.gov/dhs/services/mentalhealth/children-bh-

taskforce/docs/Carlotta%20McCleary%20Testimony%209-21-2018.pdf). Chairperson Jones thanked Ms. McCleary for her testimony.

Linda Reineke, Prevent Child Abuse North Dakota, a statewide non-profit organization centered on prevention and education matters, provided written and extemporaneous testimony regarding the North Dakota Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. Ms. Reineke provided a written outline with supporting written narrative of her comments for the MIECHV program (Part 1: https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/Prevent%20Child%20Abuse%20ND%20Testimony%20Part%201%20-%209-21-2018.pdf and Part 2: https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/Prevent%20Child%20Abuse%20ND%20Testimony%20Part%202%20-%209-21-2018.pdf). Ms. Reineki provided a separate written general description of the home visiting conducted within MIECHV (Part 3: https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/Prevent%20Child%20Abuse%20ND%20Testimony%20Part%203%20-%209-21-2018.pdf). Ms. Reineke entered into testimony an additional written summary of Early Head Start home-visiting practices (Part 4: https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/Prevent%20Child%20Abuse%20ND%20Testimony%20Part%204%20-%209-21-2018.pdf). Ms. Reineke presented a Connecticut-based study on the effects of home-visiting on child maltreatment prevention (Part 5: https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/Prevent%20Child%20Abuse%20ND%20Testimony%20Part%205%20-%209-21-2018.pdf).

Ms. Reineke provided an overview of the MIECHV Innovation Grant, centered on awareness, prevention, and intervention of trauma situations, based on best practices. This program trains outreach professionals to better understand adverse childhood experiences (trauma) and expand prevention measures, using, in part, ACE Interface materials. This training involves culturally sensitive empowerment to enhance best practices. NDSU acts as program evaluator for this program. Chairperson Jones thanked Ms. Reineke for her testimony.

Elizabeth Pihlaja, Prevent Child Abuse North Dakota, presented a written summary of the Handle with Care Program, 2017-2018 (Part 6: https://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/Prevent%20Child%20Abuse%20ND%20Testimony%20Part%206%20-%209-21-2018.pdf). Handle with Care provides wrap-around services for identified children and families, currently implemented in the Mandan Public School District, West Fargo Public School District, with other school districts considering the adoption of the program, as well. Chairperson Jones thanked Ms. Pihlaja for her testimony.

Vicki Peterson, a Family Consultant for Family Voices of North Dakota, a member of the IDEA Advisory Committee, a member of the the Autism Task Force, and a parent of a child with autism, provided testimony on seclusion and restraint policies in North Dakota. Ms. Peterson asserted the need for the state to establish strong, effective policies and practices regarding seclusion and restraint in all settings, especially within schools. Ms. Peterson stated that she recently has worked with approximately ten families who have experienced sometimes dangerous instances of their children being subjected to extreme restraint procedures in schools. Some students have evidenced bruising, bumps to the head, concussion symptoms, among other injuries. Some families have never received an incident report or any evidence that the schools have active seclusion and restraint policies. Some parents characterized that school administrators have stated that parents can only expect “Chevy vs. a Cadillac” support. One parent reported restraints that have been applied repeatedly, sometimes for as long as over 40 minutes. Ms. Peterson stated that these instances represent a perhaps larger number of instances that go without reporting.

Parents fear retaliation from schools and are hesitant to move forward with reporting these incidents. The state must attend to instituting meaningful seclusion and restraint policies. Chairperson Jones thanked Ms. Peterson for her testimony.

Rebecca Matthews provided background information regarding early childhood intervention and home visitation services. Many parents struggle to find support services for their child's or family's traumas when they themselves are suffering. Many parents do not have advocates to support them, especially when they themselves are vulnerable. Ms. Matthews encouraged the CBHTF to assume a family perspective when providing services: think of all the family members, because each member is a person in need. Chairperson Jones thanked Ms. Matthews for her testimony.

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.

ROBIN LANG MADE AND LISA BJERGAARD SECONDED A MOTION TO ADJOURN.

THE MOTION PASSED UNANIMOUSLY.

Chairperson Jones declared the meeting adjourned at 1:35 p.m. CT.

Respectfully submitted,
Greg Gallagher
Consensus Council, Inc.