

**North Dakota
Children's Behavioral Health Task Force
May 4, 2018**

Meeting Minutes, Approved

Task Force Members Attending: *Chris Jones* (Executive Director, ND Department of Human Services), *Scott Davis* (Executive Director, 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).

Recorders: Rose Stoller, Executive Director, and Greg Gallagher, Program and Research Director, The Consensus Council, Inc.

Call to Order and Welcome: Chairperson Chris Jones called the meeting to order at 10:09 a.m. and welcomed Task Force members and guests to the meeting.

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

Approval of April 2, 2018 Meeting Minutes: MYLYNN TUFTE MADE AND SCOTT DAVIS SECONDED A MOTION TO APPROVE THE MEETING MINUTES OF APRIL 2, 2018. MOTION PASSED UNANIMOUSLY.

Review of Task Force Responsibilities: Chairperson Jones reviewed the responsibilities of the Children's Behavioral Health Task Force. He directed Task Force members to the April 2, 2018 meeting minutes that outlined the Task Force's charge, including:

- a. Assess and guide efforts within the children's behavioral health system to ensure a full behavioral health continuum of care is available in the state;
- b. Make recommendations to ensure the children's behavioral health services are seamless, effective, and not duplicative;
- c. Identify recommendations and strategies to address gaps or needs in the children's behavioral health system;
- d. Engage stakeholders from across the continuum to assess and develop strategies to address gaps or needs in areas including:
 - (1) Education;
 - (2) Juvenile justice;
 - (3) Child welfare;
 - (4) Community; and
 - (5) Health; and
- e. Provide a report to the governor and the legislative management every six months regarding the status of the task force's efforts. (RECORDER NOTE: Next report is due July 1, 2018)

Presentation on an Overview of the Division of Juvenile Services. Chairperson Jones amended the order of presentations on the agenda to better accommodate a required change in scheduling. He introduced Lisa Bjergaard, Director of Juvenile Services, ND Department of Corrections and Rehabilitation (DOCR) to lead the presentation on an overview of the Division of Juvenile Services. Chairperson Jones invited Task Force members to integrate questions and discussion throughout the presentation. Ms. Bjergaard provided introductory comments and introduced Cory Peterson, Director of Juvenile Court, Unit 3, to present an overview of the Juvenile Services within DOCR. Mr. Peterson presented a prepared program with extemporaneous narrative (<http://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/overview-juvenile-justice-system-2018.pdf>).

Mr. Peterson reported that the Juvenile Court (JC) system oversees proceedings and services to delinquent, unruly, and deprived children. The JC system is comprised of 8 judicial districts, 4 court administrative units, 11 juvenile offices, 34 JC officers, and 6 juvenile drug courts. The JC system manages approximately 8,000 referrals annually with an average probation caseload of 45 clients per JC officer. He identified the newly released *2017 North Dakota Juvenile Court Annual Report* as a primary summary of the JC mission, activities, and impact data (<http://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/2017-juvenile-court-annual-report.pdf>).

Mr. Peterson presented referral protocols for any youth managed within the JC system. Any youth cited by police are referred directly to the JC. The JC's rules, policies, and manuals drive the course of all referrals, investigations, detentions, petitions, and disposition decisions. Children suspected of being in danger can be removed by the JC for protective care. Most referrals involve disorderly conduct, unruly or runaway cases, abuse/neglect of children, alcohol and drug events, theft, and criminal mischief. The JC follows the principles of balanced and restorative justice, promoting public safety, holding offenders accountable, and increasing the capacity of juveniles to contribute productively to their communities, by addressing the unique characteristics and needs of each individual.

Most referrals involve misdemeanor cases. ND arrest rates are higher than most other states, since ND law enforcement uses arrests as a means to direct offenders into services quickly. There is a need to identify potential referrals prior to arrest, improving the likelihood of successful intervention. Maltreatment offenses, including child abuse and neglect, have increased 43% in the past five years, closely tracking adult arrest rates for alcohol and drug abuse.

The JC system emphasizes diverting youth from the court system and toward the Police Youth Bureau and other diversion programs around the state, thereby improving outcomes. The JC provides accountability classes for certain referrals involving theft, drug and alcohol use. The severity of a charge or a first-time-status determine the course of any diversion strategy. Peer mentoring and youth trackers, recognized successful interventions, are currently difficult to access in some areas of the state. Case management is integral to all referral services. Oftentimes, certain critical services are under-funded and pilot programs are prematurely terminated. School support services and engaged school resource officers are pivotal; the state needs to assess its current services and direct support services to schools, where the prospect of impacting youth is greatest. Services such as after school programs, Boys and Girl Clubs, extracurricular events, and community schools, offer models upon which to build. For many youth, any strategy based on punishment is less likely to improve prospects for change than direct supports introduced early.

Engage youth early by infusing services directly, without interfering with their core individualized curriculum. Highly impacted referrals will require more resources and care.

Mr. Peterson presented an overview of the JC intake-through-determination process. The JC system uses a variety of screening tools to assess the overall status of a referral and weigh the best prospective strategy for success. Accessing appropriate, high-quality screening tools, such as the popular YASI tool, covering various purposes, is a high priority across the state. The JC system will soon begin the use of a trauma screening tool. It is difficult to compare status data across state lines because states use different referral categories (e.g., “unruly youth” is not recognized in neighboring states). Members observed that there exists a difference in data collected with the state and tribal systems, requiring further attention.

Within probation and case management, the JC system focuses on building strong relationships, based on accountability and structure, rather than over-management or micro-management of referrals. Data indicate that 78% of referrals demonstrate high behavioral health needs and 88% of referrals’ parents demonstrate behavioral health needs, showing a clear spiraling effect across generations. The JC system attends to dual status youth needs as a priority in the long-term prospects for successful treatment. In order for agencies to better collaborate on intervention supports, data systems may require an improved means of exchanging information.

Members stated the need to use data as a primary means to influence legislators to upfront-fund prevention measures. The state must assess how best to fund prevention-to-recovery efforts in a balanced, equitable manner. The state’s limited budget will demand a thoughtful means of funding overall priorities. When a typical referral youth indicates a three-year delay in learning goals, the role of identification and prevention becomes clear. Intervention efforts must better grasp referral youths’ motivations and the efficacy of relational and development service models. While certain youth may require a corrections model to realign their cognitive and behavioral needs, the vast majority of youth respond best to care provided closest to home. Capturing how to place a human face on the complexity of this issue will determine the degree of attention and funding this effort receives.

Mr. Peterson distributed the *North Dakota Juvenile Court—Statewide Intake Matrix*, which presented the protocol for referral interventions for diversion, informal adjustment, and formal petition determinations for each of the identified referral categories, including unruly, infraction/misdemeanor, felony drug or property, and felony against persons (<http://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/nd-juvenile-court-statewide-intake-matrix.pdf>). Mr. Peterson completed his presentation and Ms. Bjergaard provided closing remarks.

Chairperson Jones thanked Ms. Bjergaard and Mr. Peterson for their presentations and the Task Force members’ questions and discussions. Chairperson Jones closed the agenda item and called a break for lunch.

Presentation on an Overview of Behavioral Health Services. Chairperson Jones reconvened the Task Force meeting following the scheduled lunch break and introduced Pam Sagness, Director of the Behavioral Health Division, ND Department of Human Services (DHS) to lead the presentation on an overview of the Behavioral Health Services. Chairperson Jones invited Task Force members to integrate questions and discussion throughout the presentation. Ms. Sagness presented a

prepared program with extemporaneous narrative
(<http://www.nd.gov/dhs/services/mentalhealth/children-bh-taskforce/docs/2018-5-presentation-nd-behavioral-health-services.pdf>).

Ms. Sagness stated that there exists no single definition for mental health or behavioral health; however, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides an operative definition to guide meaningful discussion. SAMHSA presents behavioral health (mental health) as a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health involves preventing and treating depression and anxiety, preventing and treating substance abuse or other addictions, supporting recovery, creating healthy communities, and promoting overall well-being. The recently released *North Dakota Behavioral Health System Study, Final Report, April 2018*, (NDBHSS) prepared by the Human Services Research Institute (HSRI) for the DHS as part of the North Dakota Comprehensive Behavioral Health Systems Analysis contract, presents a comprehensive overview of the state's behavioral health system (<http://www.nd.gov/dhs/info/pubs/docs/mhsa/2018-4-nd-behavioral-health-system-study-final-report-hsri.pdf>).

Ms. Sagness referenced a SAMHSA statement indicating by 2020 mental health and substance use disorders will surpass all physical diseases as a major cause of disability worldwide. North Dakota, through the State Epidemiological Outcomes Workgroup, identifies, analyzes, and communicates key substance abuse and related behavioral health data to guide programs, policies and practices (www.prevention.nd.gov/data). Additionally, Substance Use North Dakota (SUND) compiles and provides critical data regarding substance use across the state (<https://sund.nd.gov/#/>).

Ms. Sagness reported that annual Youth Risk Behavior Survey data indicate alcohol use represents the highest percentage of substance use statewide, at 59.2% reported lifetime use among high school students. Survey results show students demonstrate a significant misperception of how frequently peers binge drink compared to actual binge drinking rates. Adult opioid overdose deaths have risen steadily in North Dakota over the past four years, with no reported youth deaths. The NDBHSS states that North Dakota fares well on most indicators of physical and behavioral health, except regarding alcohol use, where the state ranks much higher than the national average in excessive drinking and alcohol-related motor vehicle crash deaths. Ms. Sagness presented prevalence data regarding the proportion of foster care children and youth who indicate adverse childhood trauma, the age of youth alcohol initiation, high school student depression survey data, suicide rates, among other issues. Overall, the state's highest prevention priorities include underage drinking, adult binge drinking, and prescription drug/opioid abuse.

Currently, funding is not available through federal sources to study other mental or behavioral health issues. The press oftentimes inadequately covers stories related to behavioral health, emphasizing the issues of concern without reporting those areas related to successful prevention, treatment, and recovery efforts.

Committee members discussed the different practices and tools related to initial screenings and more involved diagnostic assessments. Ms. Sagness stated screenings provide a means to identify symptoms that might lead to additional, more time-intensive diagnostic assessments. Not all trauma requires the use of an assessment, given the resilience of most children and youth. Screenings, sometimes administered by non-credentialed individuals, provide a more straightforward and routine means of determining the standing of a child or youth, ensuring

ongoing monitoring and more appropriate intervention responses. An increased use of informal screenings may aid early identification and referral to qualified professionals, including the Treatment Collaborative of Traumatic Youth (<https://www.tcty-nd.org>), who can proceed with possible treatment services. This effort requires collaboration among agencies and service providers. More trauma training opportunities are being offered to addiction counselors, other mental health clinicians, social service staff, among others. The DHS is preparing a Frequently Asked Questions (FAQ) document to offer guidance to statewide service professionals and referring agencies.

Ms. Sagness presented the core values of the state children's behavioral health system: community-based, family-driven, youth-guided, and culturally and linguistically competent. The system is built on certain key principles, including multi-system collaboration, service integration, least restrictive environment, resist criminalizing outcomes, and providing a broad array of services and supports (i.e., accessible and timely, quality and effective outcomes, tailored to youth and family, and strengths-based). The state endorses the behavioral health continuum of care model, issued by the Institute of Medicine Continuum of Care, which includes promotion, prevention, treatment, and recovery.

Research reports the need to attend to shared risk and protective factors, where mental illness factors are significantly impacted by the presence of substance use disorders factors. Providing certain developmental supports helps to promote client resilience and the prospects of success. Community-based prevention efforts offer a means to collaborate and optimize impact on children, youth, and families.

Members noted that the state's county social services and regional human service agencies increasingly collaborate to improve identification and referral services. The Vera Institute in New York, a non-profit organization to advance community reforms and resilience work, offers a model for community systems development (<https://www.vera.org>). The state has historically underfunded prevention and promotion efforts, dedicating resources largely to treatment. Agencies can work together, based on shared values and improved collaboration of practices, to build resilience among children, youth, and families. An opportunity exists to resurrect the substance exposed newborns task force, originally proposed during the 2015 Legislative Assembly in SB 2367. The state must emphasize early intervention and identification to look for those first symptoms that might lead to concerted monitoring, assessment, and referral to services. Children and youth require dedicated substance use disorder treatment programs that are more appropriate to their personal development.

Members identified a need to better align education and behavioral health efforts. The state needs to pursue an integrated systems approach to advancing behavioral health, built on best practices, mindful of school and workforce needs, resilience-focused, non-punitive, collaborative in nature, community-based, inclusive of tele-behavioral health delivery, supportive of a continuum of care model, and sufficiently funded.

Ms. Sagness completed her report. Chairperson Jones thanked Ms. Sagness for her presentation and the Task Force members for their questions and comments.

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

- Wednesday, May 16, 2018: 12:00 Noon – 4:00 p.m.: Focus on education and building connections among the various topics presented and discussed thus far by the Task Force;
- Tuesday, June 19, 2018: 10:00 a.m. – 2:00 p.m.: Focus on social services, child welfare and tribal services, including jurisdictional issues; and
- Monday, July 16, 2018: 10:00 a.m. – 2:00 p.m.: Focus on home- and community-based services; health, wellness (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 the primary and secondary payors.

Public Comment: Chairperson Jones invited any public members to provide comments for the Task Force. Carlotta McCleary, representing North Dakota Federation of Families, announced that Children’s Mental Health Awareness Week, titled Green Ribbon Awareness Week, was being observed May 7-13, 2018, statewide. Ms. McCleary distributed a handout that presented a statement recognizing the need for the wider community to support children with emotional, behavioral, and mental health challenges and their families. Green ribbons have been tied around all trees surrounding the State Capitol Mall in recognition of Green Ribbon Awareness Week. Chairperson Jones thanked Ms. McCleary for her presentation.

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.

PAM MACK MADE AND ROBIN LANG SECONDED A MOTION TO ADJOURN. THE MOTION TO ADJOURN PASSED UNANIMOUSLY.

The meeting was adjourned at 2:08 p.m. CT.

Respectfully submitted,

Greg Gallagher
Consensus Council, Inc.