

PUBLIC COMMENT
ND CHILDREN'S BEHAVIORAL HEALTH TASK FORCE
November 16, 2018

Written comments submitted by
Lutheran Social Services of North Dakota
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A summary of our topline recommendations/requests
(described more fully in the text below)

- Scale impactful resources that presently are not accessible in all areas of the state or at the level needed
 - Flexible approach that allows for services to be structured to best meet the needs of families (ex. allow access to intensive in-home family therapy resources for use where desired at a “lower dose” for those needing earlier intervention rather than just those at imminent risk of out of home placement)
 - Prevention and early intervention available consistently across all areas of the state
 - Recognition that especially where children are involved, involvement with a system (such as child welfare or juvenile justice) should not be needed to access help
 - Recognition that schools for school age children are the center of community and as such need to be places that are open to engaging collaboratively with mental health providers
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Introduction

Lutheran Social Services has been working to develop proactive in-home supports for at-risk families that embody a person-focused early intervention approach to provision of support services. The services we provide are geared specifically to the needs of each family we serve and are intended to both supplement and strengthen the natural supports that are part of each family’s long-term system of care. The majority of our work is not income-dependent (i.e., only available to families of a certain income group) – rather, it is family driven, based on their needs.

We actively engage a wide range of people in this work - from community behavioral health workers (home visitors, peer specialists, facilitators, care coordinators) to credentialed therapists. This broad view of who can and should be delivering early intervention services is a key component of the model we have been developing, and one we hope the State will fully embrace in all of its care systems going forward. Equally important is the commitment to delivering services where families and children are – in homes and in communities.

All of us know that there are many critical junctures in each family’s journey – in each child’s journey. To be truly effective in adopting an early intervention approach, we have to find ways to be authentically and appropriately present at each of those moments.

To better illustrate some of the ideas we would recommend for your consideration, I will describe two major developmental paths that we have identified as opportunities for high impact – early childhood (pre-natal to grade 3), and child and adolescent years (grades 3-12), describe some of our work in each of these life stages (including where it happens), and close with a brief exploration of the promise we see of a seamless behavioral health delivery system that is broadly defined, rooted in communities, centered on families, and able to be delivered effectively and flexibly across the state.

Early intervention in Early Childhood – pre-natal to grade 3 (ages 0-8)

As has been reported to this Task Force previously, the rate of child abuse and maltreatment for young children outstrips that of any other age group. Young children are the population at highest risk of being harmed by abuse and neglect, which we know is often related to challenges that are facing the family unit as a whole (addiction, past trauma, domestic violence).

It is also widely understood that the highest return on investment, of just about any public dollar spent, comes from effort to improve the health, well-being, and life experience of young children. Since 90% of brain development occurs before age 5, doing our absolute best to give young children the best start possible pays dividends. As such, we try to make sure that our work in early childhood encompasses a multi-generational approach.

At LSSND we have been a provider of evidence-based home visiting services, using the **Healthy Families America** model, for close to 20 years (on a limited scale in 4 counties). It is designed to support families, as they become parents, rooted in the belief that early and nurturing relationships are the foundation for life-long, healthy-development. Interactions between Family Support Specialists (i.e., home visitors) and families are designed to promote positive parent-child relationships and healthy attachments through strength-based, family-centered, culturally-sensitive and reflective practices. Healthy Families is specifically designed to support parents who may have histories of childhood trauma, intimate partner violence, poor mental health, and/or substance abuse issues.

About 5 years ago, we had the opportunity to add **child care inclusion specialists** to the Child Care Aware team. This allowed us to offer, for the first time, targeted early intervention behavioral health supports in and through child care settings (two staff serve the entire state).

As the state's child care resource and referral provider for more than 25 years (now known as Child Care Aware), we have had the opportunity to develop a host of **trainings**, in partnership with people across the state. Trainings are made available to child care providers to help them develop their skills as caregivers (who are often in positions to see and support behavioral health needs in children and families before almost anyone else).

In 2015 we opened **About Counseling**, a mental health practice where the majority of therapists specialize in working with children, specifically young children with mental health needs that most often stem from the adverse childhood experiences that have already become part of who they are.

We are actively working to expand the About Counseling practice to include **community-based skills and rehab supports for children and families**. This in-community support can be targeted to children not yet identified by the "system" (school, juvenile justice or child protection) as being a "system" kid (IEP, out of home placement, juvenile court). Rather, we connect with them early and help build resilience and coping skills that can change the child's behavior trajectory. We know that the younger the child, the more likely that their mental health needs actually show up as aggression, anger, and other behaviors that are challenging in social settings (like schools and child care centers), and which many times lead system actors to take actions that have the opposite effect on the child the system is seeking to help.

In addition to community-based skills supports, we also see an opportunity for the Child Care Aware team to bring a more formalized **training/certification in early childhood mental health practices** to child care providers across the state, by building on the existing training and support infrastructure. To do this North Dakota should consider becoming a member of organizations such as The Alliance

(<https://www.allianceaimh.org/members-of-the-alliance/>) so that individuals in North Dakota can receive and be recognized for receiving their Infant and Early Childhood Mental Health endorsements. And we need to work together to develop content for early childhood mental health practices that can be delivered in an on-the-job format, which we know is effective for child care providers. Currently there are approximately 29 infant mental health state associations and two international associations. North Dakota should be added to this list of those who use competency guidelines for promoting infant mental health.

Early intervention in Childhood and Adolescence – grades 3-12 (ages 8-18)

While a child's earliest years are scientifically proven to be a time of tremendous development and growth, research has also identified adolescence as another critical time in a child's development. It is in adolescence that the parts of the brain that govern judgment and decision making are developing. And it is precisely at this stage of development that many children and families find themselves at a new stage of struggle, as the challenges they face ramp up in complexity and severity. It is this knowledge that has driven our commitment to supporting families at this stage of development.

During adolescence, early intervention often happens at the earliest possible stage of "system" interaction – first contact, first incident. If a child is having their first engagement with the juvenile justice system (often because of a behavior that happened in school or when a parent is overwhelmed with no idea of where to turn so calls law enforcement), we have a range of **diversionary and restorative justice approaches** that we deliver at the request of the juvenile court system, to help keep those kids from going deeper into the system (ex. Youth Court, accountability conferences). Why does this matter? Because the first interaction is often the fork in the road where intentional, appropriate intervention can be most effective.

In addition to individual justice system diversion work, we have an active initiative to help train entire school systems (building by building, team by team), in how to see, interpret, and respond to challenging in-school behaviors differently – using **principles of restorative practice**. The premise is that, like with young children, the outward behaviors displayed by these children are related to their stage of development, but that the "normal" behaviors of the teen years can be morphed into something beyond normal when a child has experienced trauma or adversity that they aren't equipped to deal with, or when they have a mental health issue that hasn't yet been diagnosed or identified. Using Restorative Practices provides school personnel with structured communication processes and strategies they can utilize to repair harm and deal with conflict in ways that strengthen relationships and forge connections rather than drive students away from schools and relationships that can help.

Beyond the school setting, we have experimented with group work for children of incarcerated parents, and for kids who are struggling with social skills. We have a robust practice with teens and their families both through **DIVERT**, a successful family based diversion program in northeastern ND, and **Abound Counseling**, where we serve both kids in the foster care system and those living at home with their families. And we provide **intensive in-home counseling** statewide to kids who are justice-system involved, still living with their families, and at high risk of out of home placement (through Juvenile Court).

We recently added **therapeutic foster care** to our foster care practice (we had previously focused on foster care services for refugee children who came to the U.S. without a parent or an adult caregiver) and offer **residential psychiatric treatment** to kids at Luther Hall (on any given day, up to 16 boys and girls, ages 10-17).

All of these interactions give us a window into families' lives – the challenges they face, and how they struggle to know how best to rise to meet them. And **it helps us know with certainty that there are definitely critical points in each person's life where intentional, appropriate intervention can make a lifelong difference.** This opportunity to get involved before a person reaches crisis is the cornerstone of our work – it is the challenge we have taken upon ourselves, and I believe it is the challenge this task force has set before itself as well. Proactive supports for at risk families allow us to be prioritize services like therapeutic foster care and residential treatment for kids with the most significant, most complex needs, while applying less intense, less costly interventions at critical transition times for more families.

We simply know too much to be satisfied with crisis-level responses being our preferred option any more.

For consideration: Areas where focused attention could have a big impact

As you have heard in testimony provided by others at previous meetings, for this type of work to continue, public and private payer systems need to **recognize and value prevention and early intervention services** as being both effective and high value, making them eligible for payment as a valid, needed aspect of good care. Without established payment sources, the best that providers like LSSND can do is apply for philanthropic support and “pilot” projects that allow us to serve families in the way we know works, and in the way we know they want to be served, but that are neither able to be delivered at scale nor become sustainable for the long term.

While changes in insurance over the last few years have certainly improved access to traditional mental health services, delivered either in person or via video, there are still significant barriers to being able to deliver in-home mental health services. Today **intensive in-home therapy work** is available only to families who are at imminent risk of out of home placement – families who are admittedly in crisis and running out of options quickly. These same services can and should be available to families before that point of crisis, but at a dosage level appropriate for their need. Greater flexibility applied to service delivery systems is needed in order for families to be optimally served.

We know that intensive in home supports, like the work of home visiting for families of infants and toddlers, can be some of the most impactful work we can do. For people to live and be well, they have to **develop skills to navigate their environment.** Not the relatively safe, controlled environments that characterize treatment and therapeutic settings. It is the most compelling reason for making sure as much work as possible in behavioral health is home and community based. The skills one learns in good, sound behavioral health treatment need to be honed and developed in real life settings, amidst the realities that trigger behaviors, breakdowns, and substance abuse.

This also speaks to the importance of **solidifying the role of skills integration and community-based rehab services** for people with behavioral health needs. As noted in my opening comments, creating more opportunities to engage a wider workforce in the work of building better behavioral health for children and families is essential to our ultimate ability to do what we know needs to be done.

Restorative practices (ex, re-integration circles, victim empathy seminars) are currently not considered part of the traditional behavioral health system. But our experience is that this type of focused, respectful relationship re-building is highly impactful and is in fact, foundational to healing and better wellbeing. Strong relationships and a sense of belonging and personal agency are protective factors that lead to greater personal and familial resilience, which we often think of as a “vaccine against adversity”.

Delivery of restorative practices can happen just about anywhere, by a wide range of people (professional and paraprofessional, volunteer and paid). It is cost effective. And it makes a difference. But, without a tacit recognition of the value of healing past harm and of re-building broken relationships as being essential to a person's ultimate health and well-being, the work cannot and will not happen in any consistent fashion.

In many situations, the action that needs to happen is quite simply an expansion of investment in infrastructure that already exists. As an example, **Child Care Inclusion Specialists** deliver direct support to child care providers when they find themselves caring for a child who is struggling to succeed in the child care setting due to "challenging" behaviors. The child care providers, most of whom have VERY limited access to professional support resources to figure out how best to serve kids with special needs, call one of the two inclusion specialists at Child Care Aware and ask for advice. The inclusion specialist assesses the situation as described by the child care provider and then, more often than not, connects with the child's family as well. The inclusion specialist is often the very first person that a family has an opportunity to interact with, who has specific training in helping them better understand and address their child's challenging behaviors, which we often find to be, the earliest signs of behavioral health needs that if left unaddressed will almost certainly manifest themselves later in school and other settings.

The inclusion specialists help the child care provider develop alternative approaches for use in the child care setting and helps connect the family with resources that may allow them to get help for their child early -- before they face their first negative consequence (which is most often, expulsion from the child care setting).

Child Care Inclusion is a powerful early intervention, delivered locally, and it keeps the child and the family firmly at the center of the entire interaction. The initial identification of need comes from a local community provider – the child care center – and the plan to change the child's trajectory is centered on community. There are many more things we could do to help connect families to effective services – parent cafes as peer support, home visiting resources, mental health professionals trained in early childhood mental health, etc. - but the framework is there. We know this works. We know this model works. And it works regardless of zipcode, family income, or child's age.

It is our opinion, as an organization that has served children and families across the state of North Dakota for almost 100 years, for this task force, and any successor body, to achieve success, it is imperative to look around and identify existing system architecture that works, and then invest in it more fully. Identify effective practices and delivery systems and find ways to scale them to serve more areas of the state. Essentially, building out the system of care by investing in components that are proven to work in our state, with, not against, our unique geographic and demographic challenges.

There will always be new pieces of the puzzle we need to find and put in place. But they will be most effective if they can be part of a system architecture whose structural strength will, in the end, result in each individual component being stronger and more effective because it is part of a cohesive whole.