Commission on Improving the Status of Children

Commission on Improving the Status of Children

AUGUST 14, 2019

Agenda

1. Welcome and Introductions
2. Consent Agenda
   a. Minutes
   b. Co-Chairs

Agenda

3. Strategic Priority: Mental Health & Substance Abuse
   - Jason Murrey, DMHA—Suicide Prevention

Youth Suicide in Indiana

By: Jason Murrey

Statewide Suicide Prevention Coordinator

Comparison of 2017 through 2018

- 14 Counties reported "*no" suicides*
- 34 Counties reported *"increase" suicides*
- 19 Counties reported *"decrease"* suicides
- 25 Counties reported "*no change*" in suicides

    - no change doesn't include "zero" reporting county

We are in the early stages of collecting data and expect to see an increase in numbers.

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Comparison of 2017 through 2018 (cont.)

- Increase for females 10-14
- Increase for males 15-18 (*decrease for females by 1*)
- Increase for males 19-24 and same for females

Increased overall by *30* from 2017 to 2018

Ages 15-18 (62 compared to 45)

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67 Counties Report at Least 1 Youth Suicide 2017 through 2018

- **Marion – 37/46**
- **Allen – 23/19**
- **Lake – 19/21**
- **Hamilton – 14/15**
- **Vanderburgh – 14/12**
- **St. Joseph – 12/13**
- **Monroe -10/11**
- Porter -8/5
- Hendricks – 8/9
- **Johnson – 6/8**
- Howard/Kosciusko/Jackson-5 (4/6/4)
- Montgomery – 4/3

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DMHA State Level Work

*Facilitate Indiana Suicide Prevention Network Advisory Council (ISPNAC)

*State became a member to the Indiana Suicide Prevention Coalition

*State Agency Collaboration – DOE / DOC (JDAI) / DCS (Training for Transitional Case Managers and Children)
DNR (SP Training for Peer Support) / Excise (SP Training to all officers) / ISDH

*Veteran / Firearm Dealer Working Group – Partnership with IDVA/VA/MFRI/ING – Address lethal means and distribute gun locks.

Developed Indiana State Suicide Prevention Framework

Created Planning tool for creation of coalitions

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Indiana Suicide Prevention Coalition

- Loss Team Training (2 – Trainings)
- Suicide Prevention Training
- Autism and Suicide Conference
- Youth Focused Suicide Prevention Programming
  - Hope Squad
  - Your Life Matters to Us
  - Sources of Strength

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Indiana Suicide Prevention Network Advisory Council

- Volunteers
- Stakeholders from around the state
- Recognized in Law (SB0230 2018)
- Statewide Conference to Provide Funding to Coalitions
- Advises on Suicide Prevention Matters for their Community
- Indiana Suicide Prevention Network (ISPN) was birthed from this organization.

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Indiana Suicide Prevention Network

- Subsidiary of Mental Health America of Indiana
- Contract holder for development of statewide suicide prevention Interactive Website / Technical Assistance for Framework to Plan Development / Curriculum Development for Community Education.
- All to be completed by September 30th

National Suicide Prevention Lifeline

- Consists of Five Crisis Centers
- Covers 37 of 92 counties
- 41% in-state call pick-up
- 70% average pick-up for each call center
- Not funded by the State

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National Suicide Prevention Lifeline (contract)

- Contracted with 4 Crisis Centers ($250,000 ea)
- All Crisis Centers required to submit (submitted) Training; Retention; Recruitment; and Capacity Improvement plans.
- All Crisis Centers have developed on-site self-care activities
- All Crisis Centers have increased recruitment of volunteers
- Increase the number of lines in their facilities
- Taking on more territory (Still being finalized)
- Will double coverage area of life line.
- Qualify for NSPL RFP – 2 Year Sustainability Grant

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CDC State of the State – Sneak Peek

Amount of state funding for suicide prevention	(# states, %)
$0	(11) 24.4%
1-100K	(8) 17.8%
100-249K	(5) 11.1%
250-549K	(10) 22.2%
550K-999M	(4) 8.9%
1M-1.9M	(4) 8.9%
2M-5.9M	(3) 6.7%

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Contact Information

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Statewide Suicide Prevention Coordinator

Division of Mental Health and Addiction

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If you would like to be involved or have suggestions, please reach out!

Agenda

3. Strategic Priority: Mental Health & Substance Abuse
   - Dr. Leslie Hulvershorn—Suicide Prevention for Justice-Involved Youth

Agenda

3. Strategic Priority: Mental Health & Substance Abuse
   - Jennifer Tackitt-Dorfmeyer—Update on Mobile Response

Choices Mobile Response

Proposed Pilot Region 9 in Indiana

choices®
COORDINATED CARE SOLUTIONS

Mobile Response

Mobile Response is a focused, time-limited, intensive intervention provided to a youth who is experiencing a mental or behavioral health crisis. Services are tailored to the individual needs of the youth and family.

A crisis may include events that threaten safety or functioning of the youth, family, or the community.

Mobile Response is designed to interrupt a crisis experience and includes face-to-face assessment, brief supportive therapy or counseling, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment, with the goal of symptom reduction, stabilization, establishing support for the parent/caregiver, and restoration to a previous level of functioning.

Mobile Response Data

- Choices operated a Mobile Crisis Response program in a four-county region in central Illinois.
- From July 1, 2015-December 31, 2018, Choices received 6,178 requests for crisis assessment. Of those:
  - 485 (approximately 8%) were cancelled for reasons including the guardian not consenting to the assessment or the crisis resolving prior to arrival of responder
  - 3,595 (63%) resulted in stabilization by conclusion of assessment
  - 1,928 (34%) resulted in psychiatric hospitalization
  - 175 (3%) were recommended for hospitalization, but stabilized in community for reasons including guardian refusal, lack of inpatient bed availability, or hospital ED disagreeing with disposition

Cost Savings

- Mobile Response and related follow-up care reduce the use of higher-cost services, including inpatient hospitalization and residential treatment.
- In Choices' Illinois program, ER diversion savings was $1,775,760.

Goal

MRSS goal is to provide resources and access to care for youth experiencing crises in their homes, schools, and communities.

Mobile Response Proposal

MRSS committee proposes the development of protocols for implementing screening and assessment of youth ages 7-18 residing in Region 9 who are experiencing a mental health or behavioral crisis, who may also be at risk of home or placement instability, or at risk of admission to an inpatient hospital for psychiatric services.

Eligibility

MRSS proposes serving youth in the five-county area of Region 9, including the counties of Boone, Hendricks, Montgomery, Morgan, and Putnam.

This program could be available to all youth within the five-county area, or only youth with Medicaid and/or youth with DCS involvement?

Accessing Mobile Response

MRSS proposes a single point of entry for crisis referrals.

- Crisis agency should maintain a communications system to receive incoming referrals from the established referral source. (If statewide this should be a centralized resource)
- Availability must be 365 days per year, 24 hours per day
- Must consist of a no eject or reject practice. No youth would be declined.
- Dispatch crisis responders to the location of the crisis event
- Assessment will begin within 60-90 minutes of referral with a disposition completed within 4 hours

Available Services

- Responder conducts face-to-face assessment and screening for youth within a 60-90 minute window
  - Evaluation using Crisis Assessment Tool (CAT)
  - Mental status evaluation
  - Evaluation of youth's ability to function and ability of caregiver to maintain youth's safety
  - Assessment of risk of harm
- Status determination
  - If community stabilization is appropriate, complete Crisis Plan and determine available resources
  - If hospitalization is needed, facilitate admission to an inpatient setting

- Post-crisis follow up
  - Connect with youth/family/hospital within 48 hours after screening
  - Facilitate referral and follow up appointments with chosen provider for therapy, case management, or other needed services
  - Optional enrollment in a Care Coordination program
    - *Team approach based on the National Wraparound Initiative's High-Fidelity Wraparound model of care*
    - *Child and Family Team (CFT) establishes a Plan of Care built on strengths and needs, which drives the identification, utilization, and evaluation of services and supports*
    - *Crisis Plan is updated every 90 days or more often, if needed*
    - *CFT is empowered to engage in assessment, intervention planning, and utilization of an array of formal and informal services and supports*

Case Example (Youth Community Stabilization)

Mobile Crisis Responder is dispatched to a local school. An 11-year-old consumer is experiencing severe behavioral challenges in the classroom, including making verbal threats and throwing a book at the teacher. Staff contact the parent for verbal consent for services. The Crisis Assessment Tool and related documentation is completed. Staff provides de-escalation services and the youth is able to return to a healthier level of functioning. Youth remains calm and cooperative and is not determined to be a threat to self or others. Crisis Safety Plan is complete in cooperation with the youth and teacher, with parent participation over the phone. Plan incorporates available strengths and resources with recommendations for services to meet the needs of the youth and family. Staff follows up with youth and family to get connected with their current service provider and to ensure appropriate linkage and referral to other community resources.

Case Example (Youth Hospitalization)

Mobile Crisis Responder is dispatched to a family home. A 15-year-old consumer is experiencing a behavioral health crisis, including physical aggression and threats of harm self and others. Crisis Assessment Tool is completed, along with other required documentation; hospitalization is deemed appropriate due to the severity of the youth's symptoms. Staff contact area hospitals to facilitate admission for inpatient psychiatric treatment. Once accepted at the hospital, staff coordinates transportation with local EMS or private ambulance company. Staff sends follow up documentation to the treating hospital. Staff remains in contact with hospital staff for the duration of the youth's stay and is kept apprised of pending discharge plans and need for follow up and referral. Staff follows up with youth and guardian to ensure appropriate linkage and referral to community resources.

In both cases, the youth would be eligible for follow-up Care Coordination services to ensure stability in the home environment.

Cost

Initial Assessment	$ 350
Per Diem Rate (enrollment day -> end of 1st month)	$ 31
PMPM Rate	$ 965
Per Diem Rate (over 90 Days)	$ 28
	$ 850.00
Flex Funds Available per Client per Month	$ 100

Assumptions for Budget

- 270 youth should initially be identified to be referred to a pro-active enrollment
- Respond to an average of 60 additional crisis events per month.
- 90% of new responses will be referred to an on-going enrollment.
- For youth in on-going enrollments, estimation that 80% of these youth will transition out of care at the completion of a 90 day enrollment period.
- Responders/coordinators at an average ratio of 14 cases to 1 staff.
- Average approximately 300 clients in care at all times serving all 5 counties.
- $100 per client per month will be made available for flex-spending to help ensure the client stays in the community.
- This would require 36 full-time positions to operate this program
- Total estimated annual cost to serve the above population is $3,250,000.

Contact Us

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Agenda

4. Strategic Priority: Child Safety & Services
   - Angela Smith Grossman—DCS's Kinship Support Services

INDIANA DEPARTMENT OF CHILD SERVICES

Kinship of Indiana Support Services

Children's Commission Meeting

August 14, 2019

Family First Legislation

- **The Family First Prevention Services Act was signed into law as part of the Bipartisan Budget Act on February 9, 2018.** This act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system. The bill aims to **prevent children from entering foster care** by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training. **It also seeks to improve the well-being of children already in foster by incentivizing states to reduce placement of children in congregate care**.

Kinship Navigator Grant Purpose

To assist kinship caregivers in learning about, finding, and using programs and services to meet the needs of the children they are raising and their own needs, and to promote effective partnerships among public and private agencies to ensure kinship caregiver families are served.

Overarching goals within DCS

- To prevent kinship families from entering the child welfare system.
- To increase the number children being placed in kinship care instead of foster care.
- To increase child and adult well-being for those families in kinship arrangements.
- To increase permanency, stability and safety of the child.
- To assist kinship caregivers in learning to advocate for themselves.
- To assist kinship caregivers in identifying and developing stronger support system.
- To decrease re-entry into foster care.

Goals for non-DCS cases

- To connect kinship to public and private services for which they may be eligible
- Improve informal supports available to families raising kin
- Develop outreach materials and effectively reach kinship needing these services
- Partner with communities, schools, private, public and faith based organizations to support kinship needs.
- Build kinship voice in advocacy for improved services and supports in raising family members without DCS intervention.
- Identify gaps that kinship families experience and develop strategies to close them.

Kinship Grant requirements (Indiana)

- Establish a Kinship Placement Coordinator
- Establish guideposts that uniformly prescribe timelines and practices
- Produce and provide trainings for those who work with kinship placements and for individuals who are kinship placements
- Create a website that Kinship Caregivers can access for resource information
- Establish seamless referral process for government benefits
- Develop tools and enhance data collection
- Continuous Quality Improvement
- Availability of DCS Ombudsman
- Collaborate with current 2-1-1 service

Establish a Kinship Placement Coordinator position

This individual will work to create an infrastructure and policies to support to kinship and relative placements.

- ✓ The Kinship Placement Coordinator (Kinship Navigator Manager) position was developed and filled as of January 14, 2019.

Establish guideposts that uniformly prescribe timelines and practices

- ✓ The newly hired Kinship Manager researched best practices and innovations from around the country along with legislative requirements of FFPSA and the grant compliance.
- ✓ Developed a program to pilot within DCS custody cases to increase stability, well being and long term view for kinship families.
- ✓ Hired and trained staff in Region 7 (Delaware, Jay, Grant, Randolph, Wells, Adams, Blackford) to implement pilot kinship navigation program initiated on June 1, 2019.
- ✓ Currently working with Indiana University to design an evaluative process to measure value of wider implementation.

Produce and provide trainings for those who work with kinship placements and for individuals who are kinship placements

- ✓ Specialized training was created for to Relative Support Staff for the Region 7 program pilot.
- Roll out of the kinship training will occur in Quarter 1 of 2020 after additional data is gathered from the pilot region
- Further training to community partners and providers will be developed with a new Staff Development Specialist that is committed only to foster and kinship care staff development.
- ✓ Engaging resource parents training has been developed and implemented for all Family Case Managers
- In Training modifications scheduled for 2020, higher levels of cultural competence will be incorporated into current foster care trainings that include the specific needs of kinship dynamics.
- Regional staff are meeting with newly contracted providers to develop more robust plans for support groups in all areas of the state to improve the emotional supports to kinship
- DMHA is currently offering “parent cafés” that will be added to the resource guide and portal. Further collaboration is needed to get non DCS kinship connected.
- Brochures are being developed for Kinship to address their needs: Legal brochure, how to get help, statewide resources, etc…

Create a website that Kinship Caregivers can access for resource information

https://www.indianafostercare.org/s/kinship-relative-caregiver-resources

- ✓ The foster care portal has added a kinship module to provide resources and connections to families that includes current resources for financial, educational, childcare, health
- Phase 2 of the Foster Care portal is under development but will include:
  - A phone number and email for kinship caregiver inquires.
  - An inquiry portal for non DCS families to allow them to connect with DCS for prevention services
  - A complaints portal for DCS families to express case specific concerns.
  - An explanation of the kinship navigator pilot, Kinship of Indiana Support Services (KISS) for kinship caregivers to better understand the program, as well as a reference for other states to understand what Indiana is doing.
  - More robust connection to State and local resources. Ideally, kinship caregivers could enter their zip code for connection to local resources.

Establish seamless referral process for government benefits

- The FSSA has an online portal for SNAP, TANF and Medicaid. As part of the kinship navigator model, staff must assist caregivers with applying for these benefits online.

  https://www.in.gov/fssa/4998.htm

- DCS has worked with the Bureau of Child Care to reserve 500 CCDF vouchers for DCS kinship and foster caregivers. Kinship caregivers who qualify, do not have to wait for vouchers.
- FSSA training staff has trained current relative support and foster care staff about the process of applying for public assistance benefits such as SNAP, TANG and Medicaid.

Develop tools and enhance data collection

- ✓ Tools have been developed that include:
  - Family and Services Profile
  - Immediate Needs assessment
  - Child health survey
  - Family Needs Assessment Scale
  - Social Support Survey

IUPUI will be conducting program evaluation over the next 18 months to help Indiana be ready and/or compliant with the requirements of FFPSA.

Continuous Quality Improvement

- A continuous improvement survey is being developed by the DCS Continuous Quality Improvement team in conjunction with the IUPUI.
- The survey will be given at conclusion of services and will be collecting information on how the program was administered, if the families' needs were met and how the program can be improved.
- Kinship Advisory Council convened for the first meeting in July 2019 in collaboration with Casey Family Program and Villages.

Availability of DCS Ombudsman

- The Office of the DCS Ombudsman continues to receive complaints from kinship caregivers. The Ombudsman will investigate complaints that fall within its jurisdiction. When the Ombudsman receives complaints that do not fall into its jurisdiction, he/she forwards the complaints to the Kinship Navigator Manager who works with relevant local staff to resolve the problem.

Collaborate with current 2-1-1 service

- DCS has maintained a partnership with 2-1-1 to provide 24/7 information and support services to callers. The Indiana Kinship Care website lists 2-1-1 in several places for caregivers to refer to when needing help. DCS is working with 2-1-1 to be able to better identify caregivers and to refer those caregivers to the relevant resources and in the absence of known resources to the Kinship Navigator at DCS.

Non DCS families

- All current initiatives are starting in DCS but their design will translate to other families who need short term support.
- Resource guides exist but packets are not enough. Parenting kin is a hard and often unexpected role for these individuals.
- Community Partners can and could serve these families but resources are limited.
- At the finalization of materials for kinship, more outreach will be scheduled that mimics other community fair activities, foster care recruitment models and identifies target community engagement that outlines ways to support families

Opportunities

- Valuable resources do exist in most communities but connectivity to kinship is not robust.
- Eligibility requirements of many public aid programs reduce access to kinship (counting income of relatives that are no bio parents in eligibility)
- Community Partners would be a good point of access for many kin families but not well understood by communities.
- There are not enough affordable legal services across the state to support kinship families in establishing legal custody arrangements for non DCS families
- Support groups exist, but struggle with starting and stopping based on uneven participation and there is no one repository for when and where these are offered to identify needs or improvements

Agenda

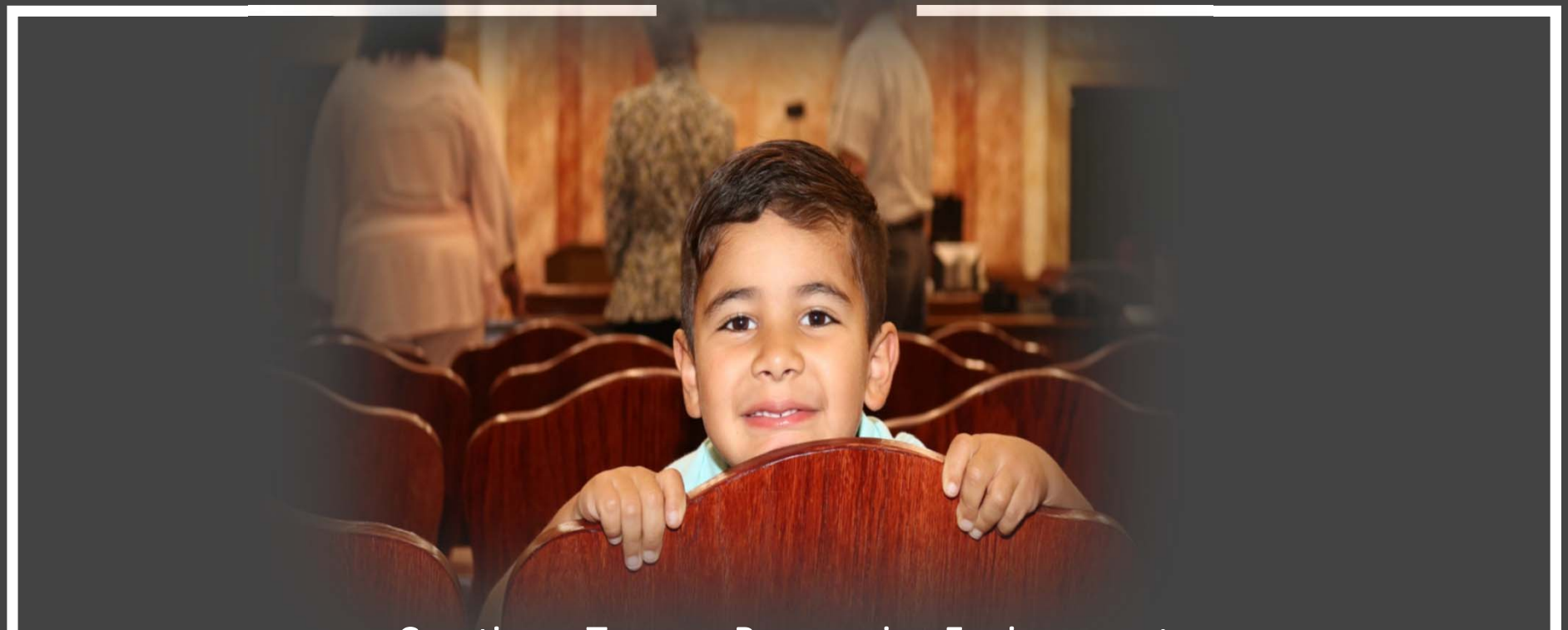
4. Strategic Priority: Child Safety and Services
   - New Objective on Kinship Care

Agenda

5. Strategic Priority: Educational Outcomes
   - Brenda Graves-Croom and Tashi Teuschler—Positive Discipline Guide Revisited

Agenda

6. Strategic Priority: Juvenile Justice and Cross-System Youth
   - Judge Charles Pratt—Trauma Audit

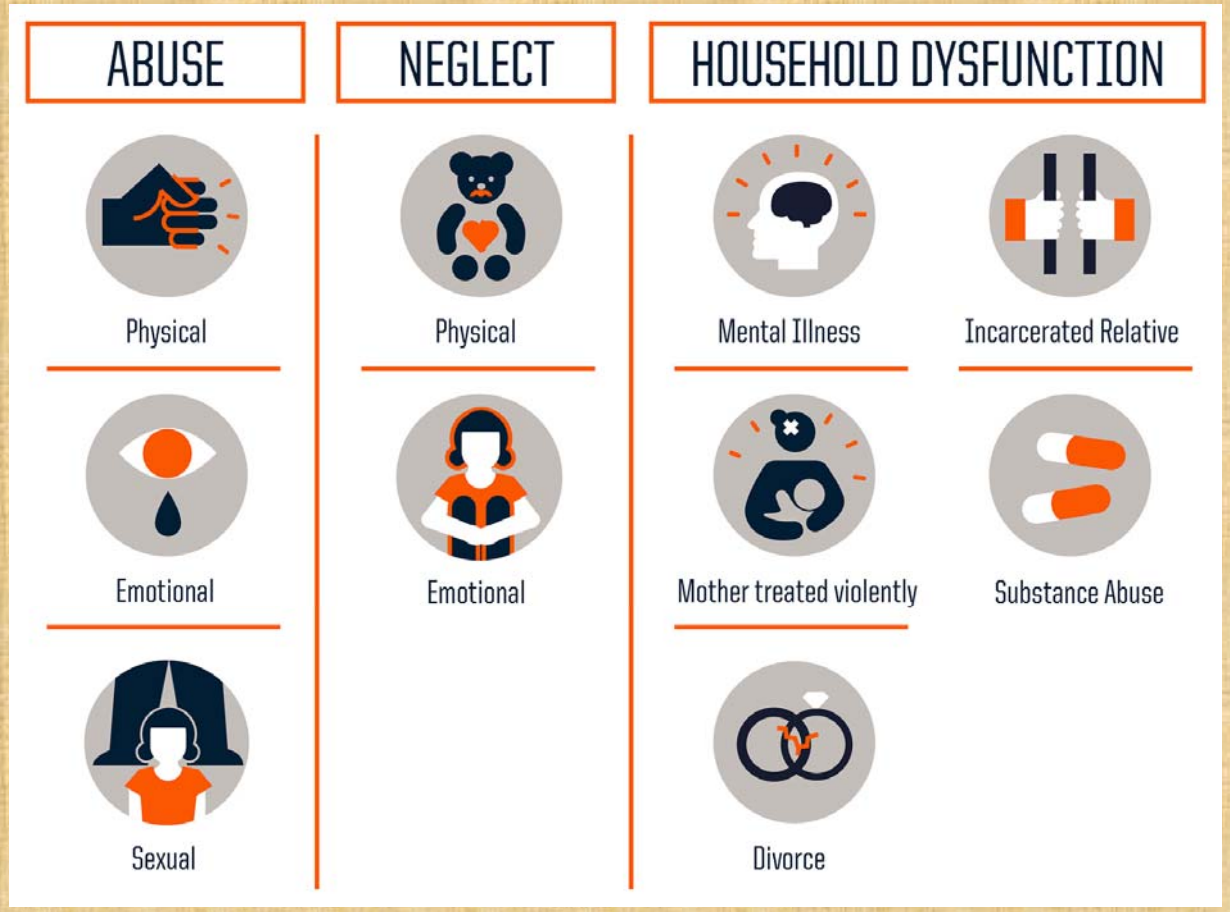


Creating a Trauma-Responsive Environment

A Look at One Court through the Lens of a Trauma Audit


ACEs
health
development
ACE
people
resilience
community
childhood
experience
disease
study
Brain
three
stress
adults
social
resilient
affects
competencies
categories
neurobiology
wellbeing
problems
new
one
mental
work
Resilience
foundation
bounce
support
action
drinking
toxic
higher
number
dose-response
complex
public
outcomes
relationship
associated
sensitive
pattern
process
school
correlated
increases
everyone
develop
Puberty
diabetes
high
Three
prevention
periods
Childhood
likely
levels
dose
stressors
Middle
family
executive
become
welcome
likelihood
letters/numbers
interpret
less
predict
scores
great
effects
times
care
reducing
two
gained
processes
trauma
Families
brain
insight
adapt
respond
whole
suicide
reduce
together
plus
live
cues
understanding
place
back
function
original
also
important
abilities
understand
ways
time
kind
biological
Community
Study
developmental
functioning
positive
highly
trajectory
occurs
Adolescence
discovery
difficult
risks
score
first
symbols
Individuals
adaptive
affected
common
helps
communities
learning
life
drug
period
world
rely
building
lives

The ACEs = Adverse Childhood Experiences



The Impact of ACE's

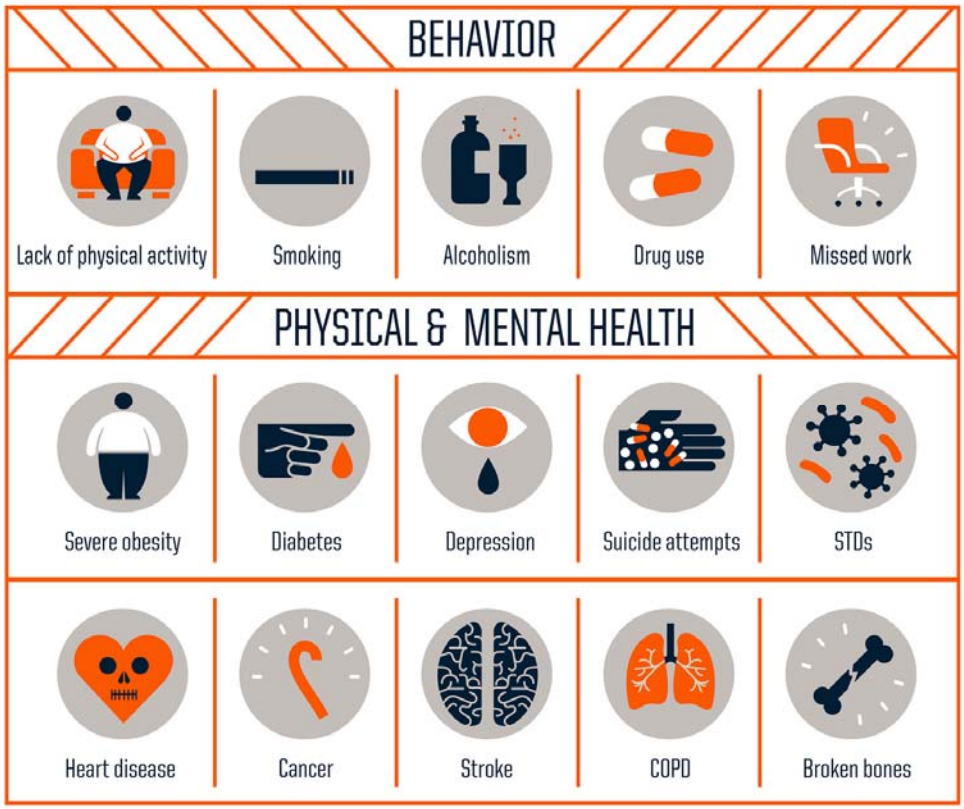
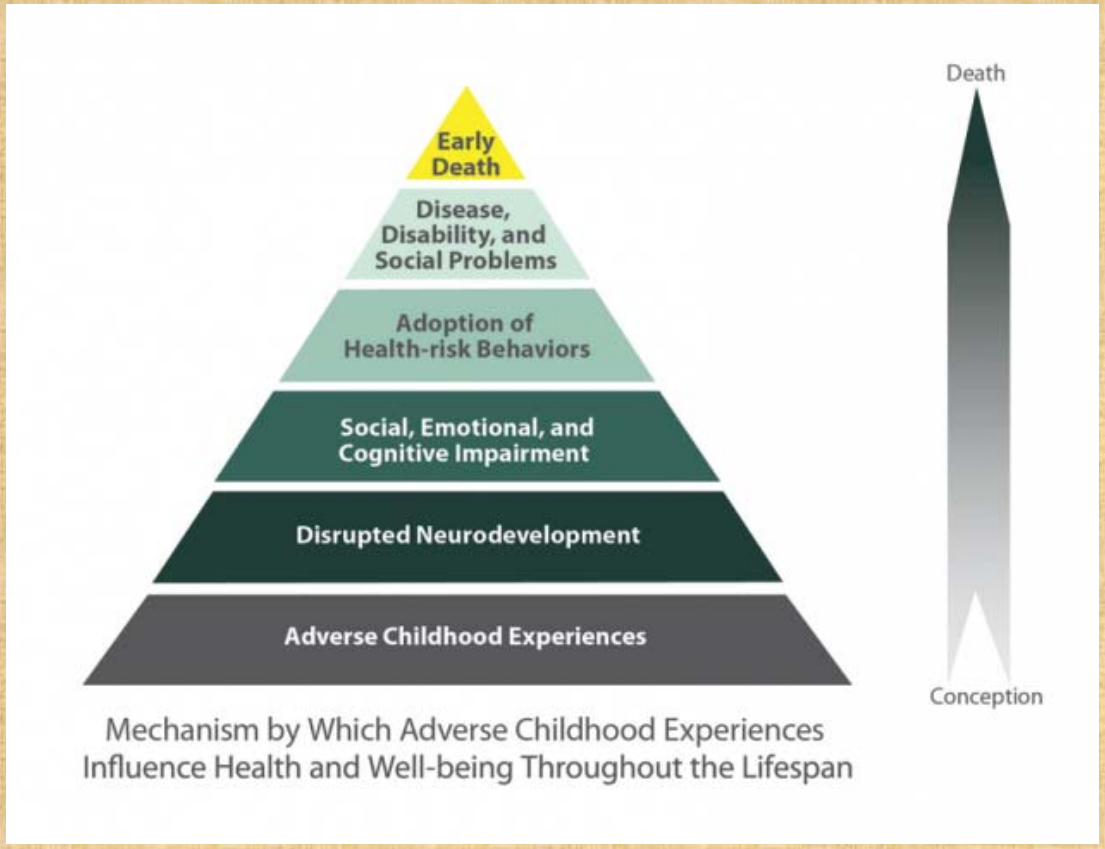


Image from Take Ace Quiz, by Laura Starecheski, NPR
https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean

Relationship of ACE's to the development of risk factors for disease and well being



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Centers for Disease Control
www.cdc.gov/violenceprevention/acestudy/about.html

Why an issue for a juvenile court?

- Majority of children involved in juvenile justice have a history of trauma.
  - Victims of abuse or neglect
  - Exposed to substance abuse , domestic violence or community violence
- Traumatic stress adversely affects brain development, impairs many aspects of psychological development, and can impair social skills, and emotional regulation.

Consider:

Through a judge's understanding of the impact of trauma, the court can become more effective in meeting the unique needs of traumatized children.

"A court that is founded on trauma informed principles can be a safe and effective point of intervention for the youth an families it serves."

-*Preparing for a Trauma Consultation in your Juvenile and Family Court*, Shawn Marsh, et. al. NCJFCJ and OJJDP

"Juvenile and family courts hold a unique position among the many stakeholders that comprise a healing community for persons experiencing trauma. Specifically judges and other court leaders can promote the implementation of screening for trauma, the alignment of appropriate and effective treatment for trauma when indicated, and the accountability of systems for coordination and support of such services."

"Lessons Learned from Developing a Trauma Consultation Protocol for Juvenile and Family Courts",
Shawn Marsh, Alicia Summers, Alicia DeVault and J. Guillermo Villalobos
2016 National Council of Juvenile and Family Court Judges

Juvenile courts should:

- Understand and recognize the impact of trauma on a person's well-being, and
- Promote an organizational culture that takes into account structural and environmental conditions as crucial components in the healing process of trauma victims.

"Lessons Learned from Developing a Trauma Consultation Protocol for Juvenile and Family Courts",
Shawn Marsh, Alicia Summers, Alicia DeVault and J. Guillermo Villalobos
2016 National Council of Juvenile and Family Court Judges

Trauma Informed Practices

"Trauma-informed" refers to all of the ways in which a service system is influenced by having an understanding of trauma, and the ways in which it is modified to be responsive to the impact of traumatic stress. ***A program that is "trauma-informed" operates within a model or framework that incorporates an understanding of the ways in which trauma impacts an individual's socio-emotional health.*** This framework should, theoretically, decrease the risk of re-traumatization, as well as contribute more generally to recovery from traumatic stress. (Harris & Fallot, 2001)

From a presentation by Kristine Kinniburgh, LCSW and Brad Stolback, Phd. – National Child Trauma Stress Network

Trauma Informed Courts

- Youth and families feel safe, both psychologically and physically, when at the court.
- Court operated in a transparent manner and in a way to increase trust
- The Court recognizes the family's strengths
- The Court takes a holistic approach and offers paths to trauma recovery rather than reacting punitively to symptoms of trauma
- Court respects family culture and treats family and children with respect
- Refer traumatized children and families for care to an experienced clinicians who use evidence based trauma treatment practices

Goals of a Trauma Consultation or Audit

1. Provide information about current practices from a trauma informed perspective top improve the experiences of families and children
2. Reduce compassion fatigue or secondary trauma experienced by staff and workers

Allen County's Trauma Audit was conducted over two days and was completed by two representatives of the NCJFCJ

AGENDA
NCJFCJ CHILD IN NEED OF SERVICES TRAUMA AUDIT
Allen Superior Court – Family Relations Division
February 20 – 21, 2019

Wednesday, February 20, 2019

8:15 a.m. — **NCJFCJ Team arrives.**

8:15 a.m. – 9:00 a.m. — **Tour of Courthouse and Introductions**

9:00 a.m. – 12:00 p.m. — **Trauma Assessment Activities:**

- **Court observation (Incl. *Facilitation*): Judge Pratt** — **9:00-11:00 a.m.**
- **Focus Groups with stakeholders: Conference Room**
  Group I: *Service Agencies* — **11:00-11:45 a.m.**

12:00 p.m. – 1:00 p.m. Lunch with ***Great KIDS make Great Communities*** & ***Great KIDS Leadership Academy***

1:00 p.m. – 4:30 p.m. — **Trauma Assessment Activities**

- **Focus groups with stakeholders: Conference Room**
  Group II: *Department of Child Services Legal Staff* — **1:00-1:30 p.m.**
  Group III: *Public Defenders* — **1:30-2:00 p.m.**
  Break — **2:00-2:15 p.m.**
  Group IV: *Guardians ad Litem* — **2:15-2:45 p.m.**
  Group V: *Foster Parents* — **2:45-3:15 p.m.**
  Group VI.: *C.A.S.A.* — **3:15-4:00**
  Group VI: *Court reporters and Clerk* — **4:00-4:30 p.m.**

Thursday, February 21, 2019

8:30 a.m. – 9:00 a.m. — **NCJFCJ Team arrives at courthouse**

9:00 a.m. – 12:30 p.m. — **Trauma Assessment Activities:**

- **Court observation: Magistrate Morgan** — **9:00-10:15 a.m.**
- **Focus groups with stakeholders: Conference Room**
  Group VII: *Department of Child Services Leadership* — **10:15-11:00 a.m.**
- **Meeting with Dual Status Team** — **11:00-12:00 p.m.**

12:00 – 1:00 Lunch: **observe *Family Recovery Court* case staffing**

1:00 p.m. – 4:30 p.m. — **Trauma Assessment Activities:**

- **Court observation: Magistrate Hartzler** (Family Recovery Court) — **1:00-2:00 p.m.**

Break — **2:00-2:15 p.m.**

- **Focus Groups with Stakeholders**
  Group VIII: *Family Group Decision Making Team* — **2:15-3:00 p.m.**
  Group IX: *Department of Child Services Case Managers* — **3:00-3:45 p.m.**
  Group X: *Court Services Team* — **3:45-4:30 p.m.**

Trauma audit included

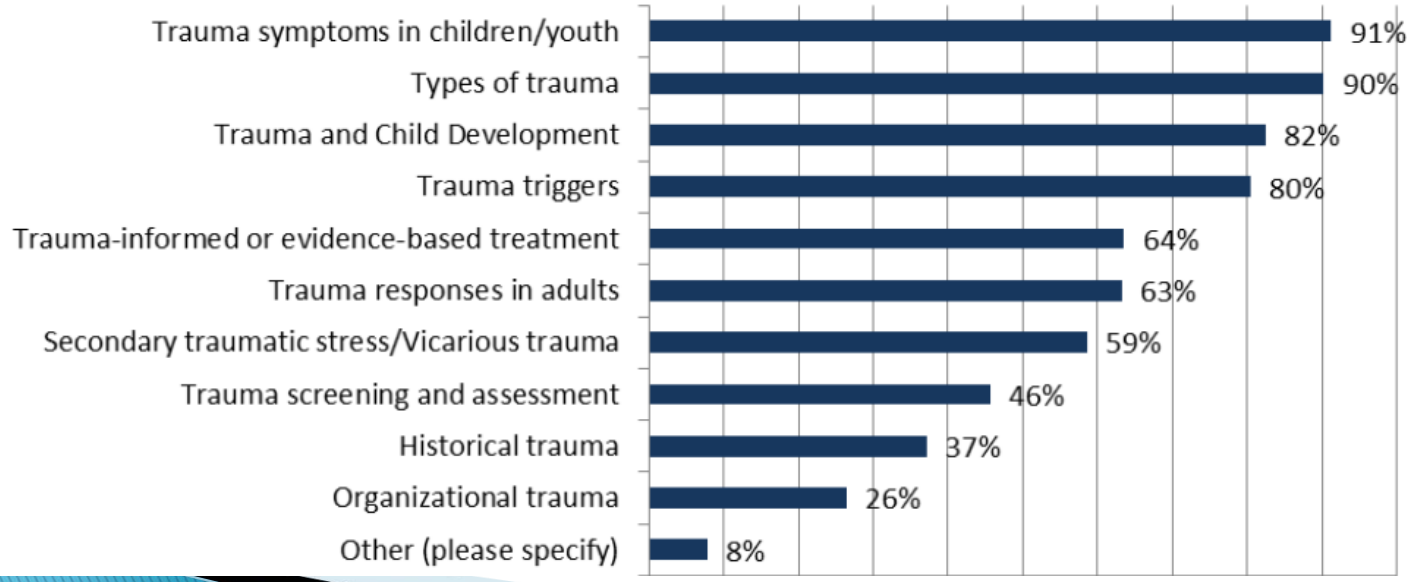
- Pre-survey of stakeholders, and
  a two day site visit that included:
- Interviews of focus groups
- Observations of physical environment
- Interactions between and within litigants and system stakeholders
- Court observation and evaluation of judicial engagement
- Court processes and practices including calling parties to hearings

Focus Groups

- DCS Leadership
- DCS Case Mangers
- DCS Legal
- Public Defenders
- Guardian ad Litems
- CASA
- Service agencies
- Court reporters and Court Services
- Dual Status Team
- Family Group Decision Making Team
- Foster Parents

Approximately 82% of participants (*n* = 376) indicated that they have received trauma training in the past. Stakeholders were also asked to indicate the different topics that were discussed in their trainings and 307 people replied. Trauma symptoms in children/youth (91%), types of trauma (90%), trauma and child development (82%), and trauma triggers (80%) were the most commonly cited as topics discussed in training seminars. The least common was organizational trauma (26%). Those who listed "other" indicated topics such as complex trauma, ACE's, PTSD, and EMDR.

Figure 2. Topics Covered in Training (n=307)



ATTITUDES AND UNDERSTANDING AROUND DEALING WITH TRAUMA

	I am confident in my ability to help a client who has experienced trauma.	I have a clear understanding of what trauma informed practice means to my professional role.	I fully understand how trauma affects parenting.	u i t ł	I am aware of the evidence based practices available in my jurisdiction to help those who have experienced trauma.	I am aware of how domestic violence affects parenting behaviors.	There are resources available to me if I feel overwhelmed working with my clients.
Strongly Disagree	0%	2%	1%		3%	1%	2%
Disagree	6%	6%	9%		15%	4%	12%
Neutral	22%	20%	20%		29%	11%	23%
Agree	54%	42%	41%		38%	54%	37%
Strongly Agree	18%	30%	29%		15%	29%	25%

Organizational policies

	My organization has a written policy establishing a commitment to the use of trauma-responsive practices.	It is the policy of my organization to regularly screen clients for trauma.	My organization has specific protocols in place to reduce the "burnout" associated with working with clients who have experienced trauma.	The diversity in my organization reflects the populations we serve.
Strongly Disagree	3%	4%	8%	5%
Disagree	17%	23%	24%	15%
Neutral	44%	34%	37%	33%
Agree	27%	28%	25%	34%
Strongly Agree	9%	11%	5%	14%

ORGANIZATIONAL PRACTICES

	Clients are routinely screened for trauma using a standardized tool.	Efforts are made to minimize stressful aspects of the child protection case process.	unde ng imp tra incor int de m pra my	An understanding of the impact of trauma is incorporated into daily decision-making practice at my agency.	nts and ren are ed with spect.	Systems stakeholders treat each other with respect.	I discuss trauma-related concerns cross-systems partners.
Never	26%	11%		8%	1%	1%	12%
Sometimes	42%	38%		33%	5%	31%	35%
Often	22%	38%		43%	7%	49%	38%
Always	10%	13%		16%	7%	20%	15%

Assessment:
Physical environment:

- Noise level: area around courtroom doors and offices are crowded and congested.
- Small hearing rooms can become warm depending on the number of people in attendance
- Inadequate waiting areas
- No child and family friendly areas

- We have reassigned spaces for waiting areas
- We believe correcting the calendar will reduce congestion
- Seeking additional space for waiting
- Training DCS and attorneys to take advantage fo allotted space

Court Hearing Observations

- Block calendaring is not best practice
- Not in every instance did the court and professionals address parents by their proper name rather than “mom” and “dad”
- Court introduced rather than allowing each participant to introduce themselves
- Did not permit children to attend hearings and court processes
- Court was not making ICWA inquiries at ***every*** hearing.
- Court ran over frequently (timeliness)
- Transferring to time-certain calendaring
- Training to correct
- No planned change
- Currently reviewing recommended practices
- ICWA inquiries have been corrected. Added to judges notes.
- Readdressing scheduling: moving to a *one court-one family team approach*

Court Hearing Observations

- Current placement educational needs, safety a, physical mental health, family time, and efforts to reunify should be discussed by the judge.

FINDINGS

Our court regularly discussed placement but varied in the other areas of concern. The question. "*are there any safety concerns that would preclude the return of the child into the home today*?" was not regularly asked.

- Judges notes are being revised to address these issues.
- Training on reunification processes will be developed
- Preparation for this dialogue needs to be provided to DCS

Judicial Leadership

- Stakeholders agreed that relationship with court was good.
- Applauded dependency mediation practice
- Recognized court's cross sector collaborations
- Applauded Indiana's Dual Status process
- CHINS facilitation and Family Group Decision Making practices in place since 1999
- Great KIDS make Great COMMUNITIES funded in part by Foellinger Foundation

Need for Distribution

"The NCTSN *Child Welfare Trauma Training Toolkit* identifies essential elements of trauma-informed child welfare practice to guide caseworkers:

(a) maximize the child's sense of safety,
(b) assist children in reducing overwhelming emotion,
(c) help children make new meaning of their trauma history and current experiences,
(d) address the impact of trauma and subsequent changes in the child's behavior, development, and relationships,
(e) coordinate services with other agencies,
(f) utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services,
(g) support and promote positive and stable relationships in the life of the child,
(h) provide support and guidance to the child's family and caregivers, and
(i) manage professional and personal stress."

"Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice" Susan J. Ko , Julian D. Ford, Nancy Kassam-Adams, Steven J. Berkowitz, Charles Wilson, Marleen Wong, Melissa J. Brymer, Christopher M. Layne *Professional Psychological Review and Practice*, 2008, Vol. 39, No. 4 Pages 396-404

Further recommendations

- Adoption of a universal precaution model throughout the court system. This mean implementing protocols that seek to promote well-being of both consumers and staff:
  - Presume all court stakeholders and families/youth have a history of exposure to trauma
- Implement a trauma screening protocol to be used by all system involved agencies
- Continue training on trauma
- Provide self-care and employee assistance
- Consider a therapy dog

Broader Challenges

- Need for standardized language
- State-wide adoption of standard trauma screening tools
- Develop state-wide training on trauma and resiliency factors
- Understand cross sector implications for Dual Status Youth
- Understand and recognize that trauma impact's a child well-being and seriously endangers the child's physical and mental health

Specifics:

- Identify/screen youth who have been traumatized
  - Screeners must be able to correctly administer the screen
  - Accurately interpret results

This essential element should be a state-wide project.

Specifics

- Trauma Informed Programming and Staff Education
  - The training should be at the onset of employment and should continue regularly
  - Training should include skills for interacting with justice involved youth and families
- Prevention and Management of Secondary Stress
  - Staff could receive educational resources so that they can readily identify when they or a co-worker are experiencing secondary traumatic stress
  - Ensure confidential access to care
  - Funds are needed

Essential Elements

- Trauma Informed Partnering with Youth and Families
  - Traumatized families and children suffer from experiences of powerlessness. By giving them a voice and removing the trappings of adversarial posturing, families and youth will be less likely to ignore court orders and are more likely to cooperate

Need to reform legal practice standards

Specifics:

- Trauma Informed Cross System Collaboration
  - Cross system collaboration facilitates integrated services
  - Ensure service providers use trauma informed practices and have trauma informed policies
  - Develop cross sector communication systems

Essential Elements

- Trauma-Informed Approaches to Address Disparities and Diversity
  - Receive and offer training on the needs of diverse youth
  - Secure services for youth that reduce disparities and meet specific needs

Being trauma informed means asking

"What happened to you and how can we help?"

versus

"What is wrong with you?"

Agenda

7. Strategic Planning
   - Kate Shufeldt and Lacey McNary

STRATEGIC DIRECTION SETTING, SESSION 1

CISC

AUGUST 2019

TODAY'S PURPOSE

To begin a strategic direction setting process.

TODAY'S OBJECTIVES

- Kick off strategic planning process.
- Introduce consultants.
- Hear preliminary results from initial survey.
- Plan to engage all members on the strategic planning process.

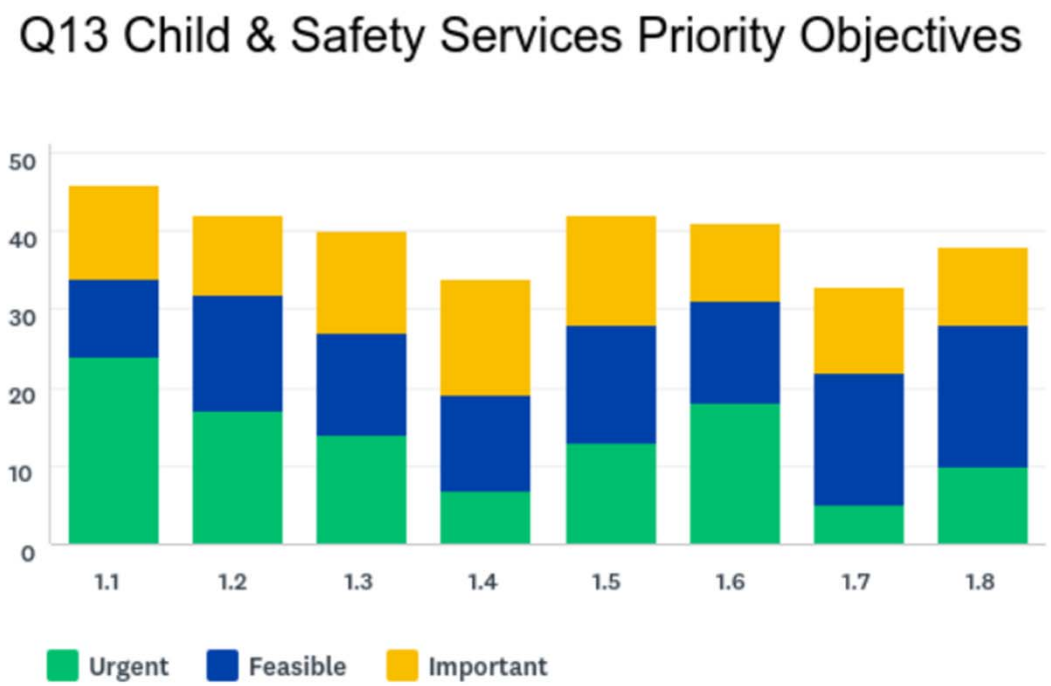
AGENDA

- Introductions
- Overview of Survey Findings
- Brief Discussion
- Next Steps

An ounce of performance is worth pounds of promises – Mae West

INDIANA YOUTH INSTITUTE

SURVEY FINDINGS



1.1 Support efforts to prevent child abuse and neglect

1.2 Support efforts to ensure the safety of children in state care

1.3 Promote programs and services that support older youth with successful transition to independence

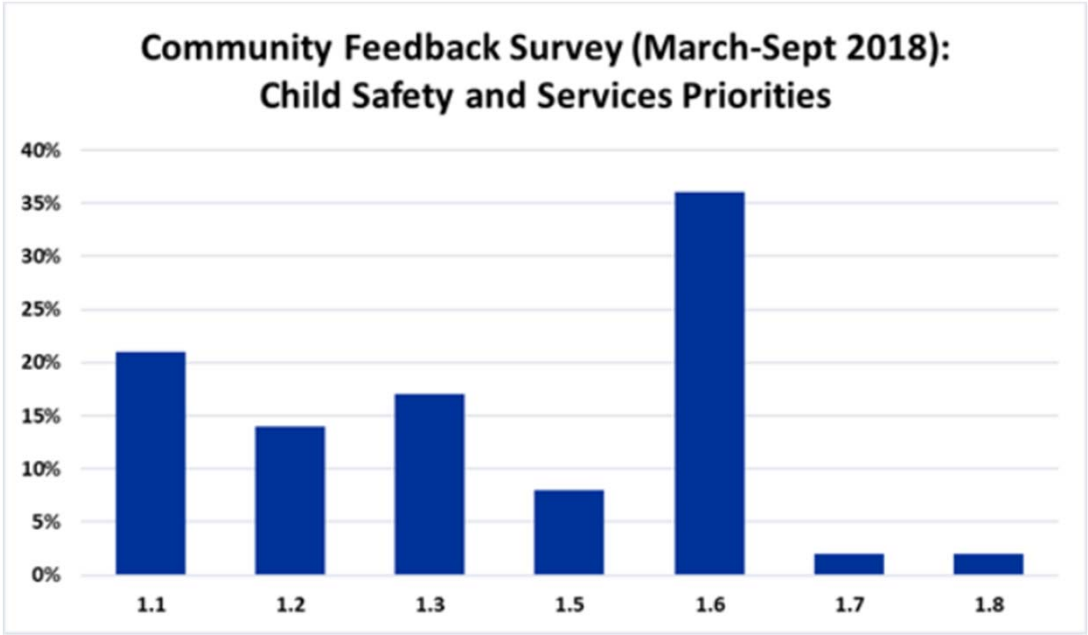
1.4 Promote the practice of funding for money follows the family/child

1.5 Study and evaluate barriers to receipt of Medicaid for prevention, early intervention, and treatment

1.6 Promote an improved understanding of the impact of trauma on children and youth and the efficacy of trauma-informed practice

1.7 Coordinate and communicate child safety efforts with Indiana Perinatal Quality Improvement Collaborative (IPQIC)

1.8 Coordinate with the Indiana State Suicide Prevention Advisory Council



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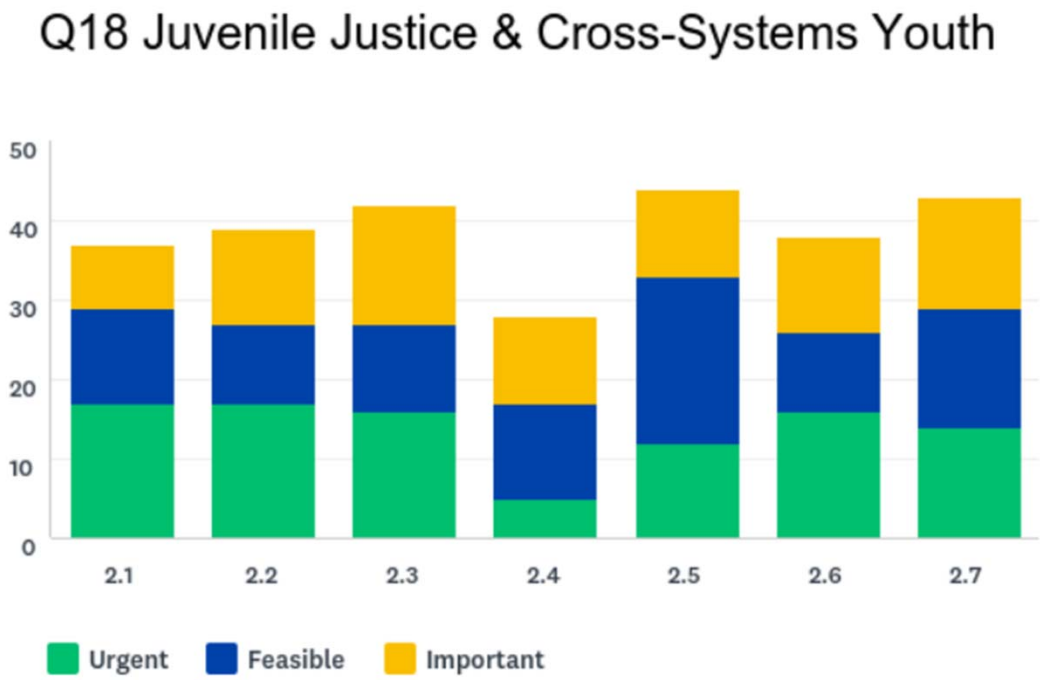


2.1 Advocate for increased availability of and access to emergency shelter care and alternative therapeutic placements

2.2 Support the enhancement of services across the spectrum (in-home and residential)

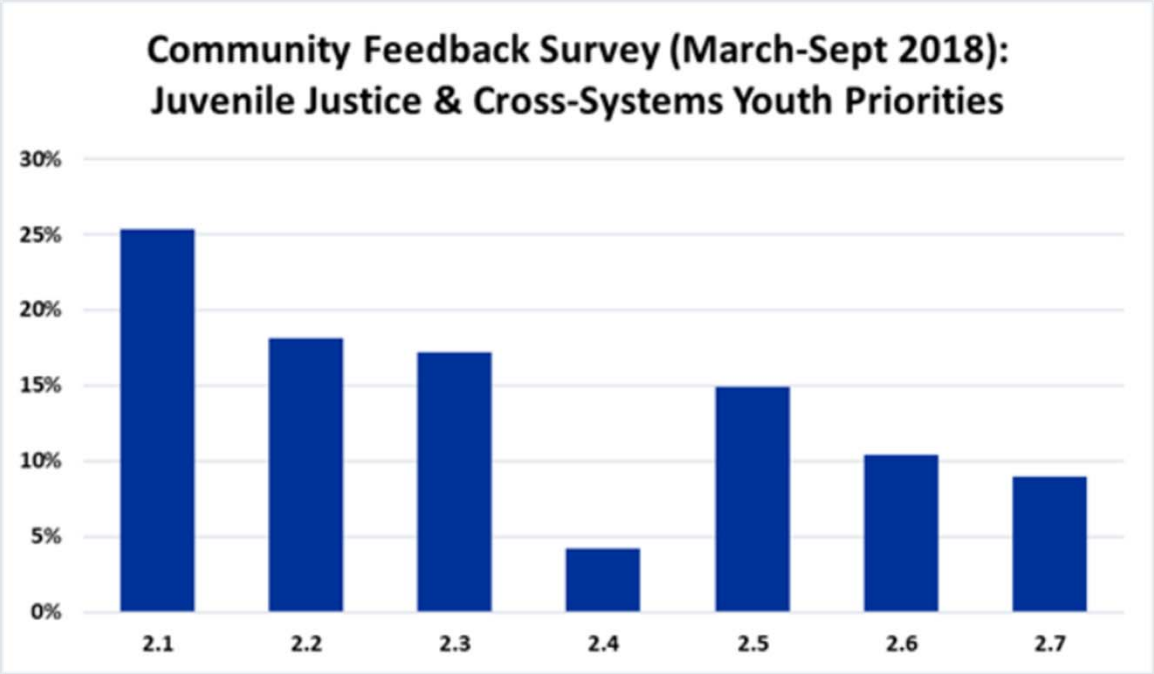
2.3 Support efforts to decrease youth violence, including assessing the root causes of youth involved in violent crimes and/or crime involving weapons

2.4 Study and make recommendations on services to address the complex needs of runaway children and missing children

2.5 Study and evaluate whether “status offenders” should be removed from Delinquency code and moved to CHINS code in collaboration with Child Safety & Services Task Force

2.6 Support funding for innovative youth programming through expansion and increased funding of the Justice Reinvestment Advisory Council

2.7 Support the on-going efforts of the Commercially Sexually Exploited Children (CSEC) workgroup in addressing the identification of exploited juveniles and the coordination of services related to juvenile victims of human trafficking



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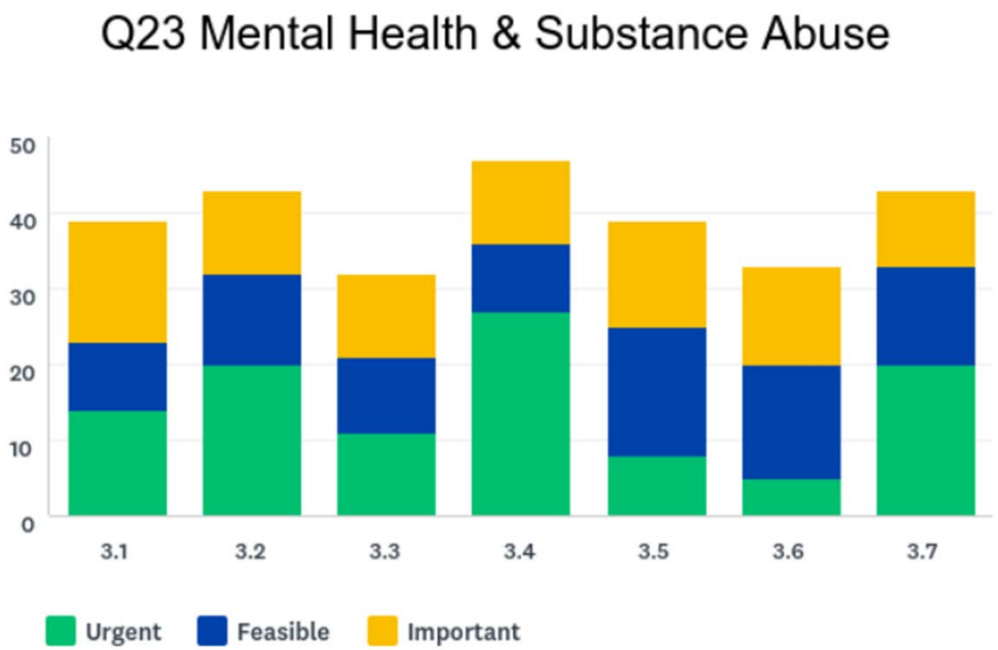


3.1 Explore policy change to promote integration of behavioral health and primary care for children

3.2 Identify and promote evidence-based and other effective supports and services that reduce youth mental health issues and substance abuse

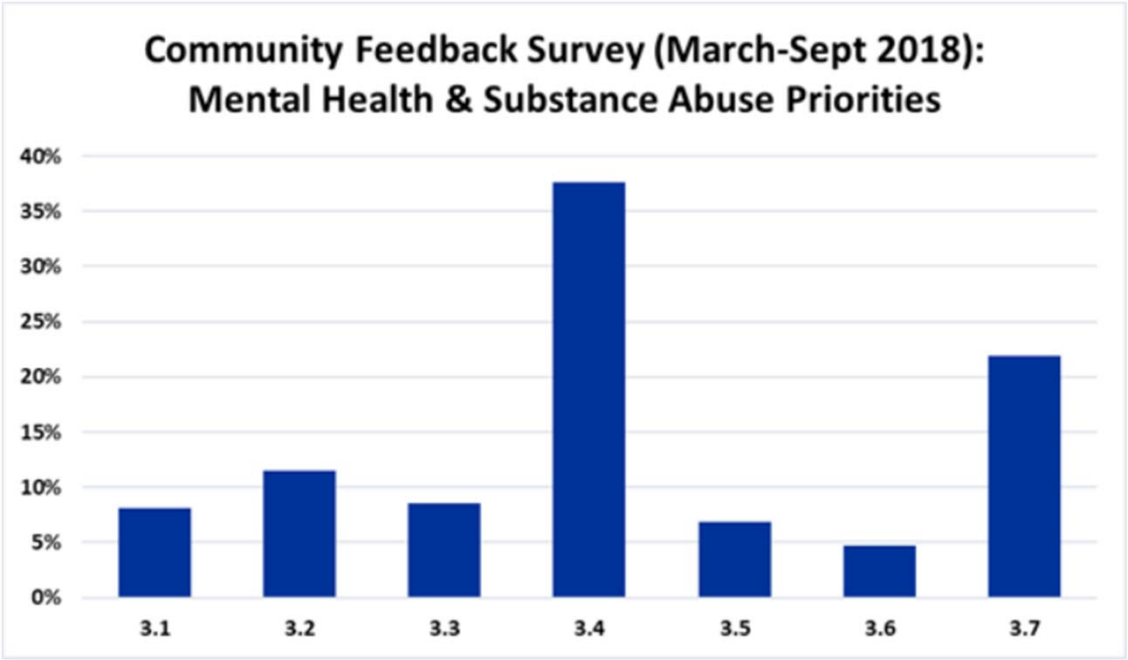
3.3 Support effective alternative locations, modalities and treatments for substance abuse and mental health services

3.4 Support efforts to increase the number of mental health and substance abuse providers; improve service coordination to simplify delivery of services for children and their families

3.5 Support development of models to identify youth at-risk for substance abuse and mental health issues

3.6 Engage with Governor's Commission to Combat Drug Abuse to address issues of children's use of prescription drugs and children being raised by parents suffering from addiction

3.7 Support efforts to ensure access to care / treatment for youth and parents with substance abuse issues, including inpatient, outpatient, and rural coverage as well as services for youth after release from JJ / DYS



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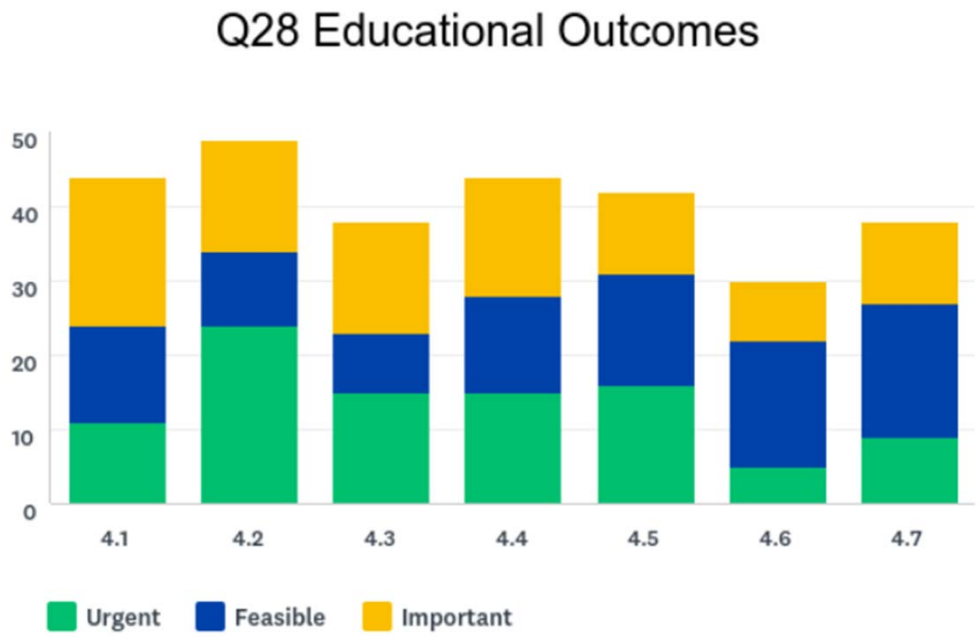


4.1 Explore models to develop an “educational passport” to provide a comprehensive understanding of the educational history of vulnerable children and youth when they move from place to place and school to school

4.2 Advocate for additional and improved services integrated in schools to address mental health and wellness

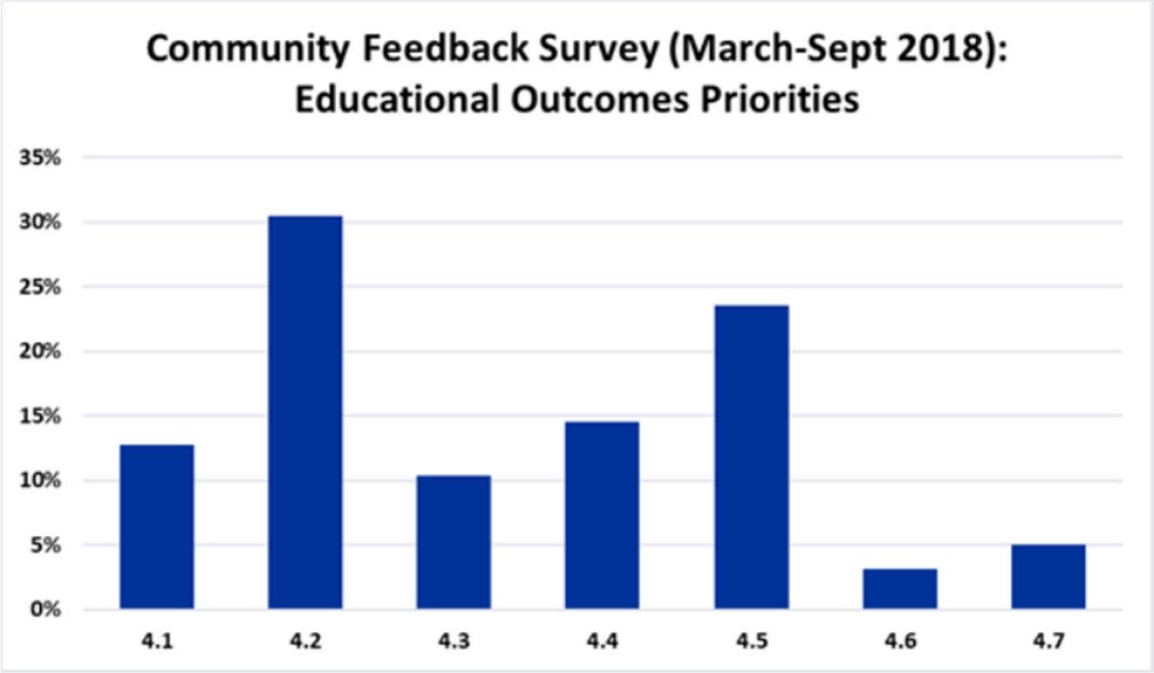
4.3 Recommend methods to incentivize schools to help vulnerable youth complete high school

4.4 Recommend strategies for promoting a positive learning climate for all students to address disproportionality in school discipline practices and to stop the tide of bullying

4.5 Support efforts to develop alternative educational options and resources for youth not able to survive/thrive in a traditional school setting

4.6 Study and report on the graduation rate of vulnerable youth

4.7 Study and report where youth coming out of the juvenile justice system and/or cross-system youth are being educated



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SURVEY RESPONSE THEMES

Current Strategic Plan:

- Though most of the objectives are still considered valuable, there are priorities
- It's a lot of work
- Very broad on some objectives- could use more detail
- Would like to see more information sharing and coordination between task forces- topics overlap
- Need funding to make some of these work
- What's going well at the local level that we can promote as best practices?

Commission Communications and Operations:

- We should educate people and agencies on the Commission
- Should research, coordinate with, and promote other good initiatives or campaigns
- (CISC and Agencies) Need to celebrate our good work and progress- while also being humble enough to look at ourselves objectively
- Plan and smooth transitions when there are changes in appointments or staff turnover
- The participants are mostly state-level

NEXT STEPS

Small group to convene to continue planning

Integrate Community Feedback

Additional Interviews

Commission Work Session

Agenda

8. Annual Report
   - Kathryn Dolan

Agenda

9. Committee Updates
   - Data Sharing and Mapping—written update

Agenda

10. Executive Director Update
    - Julie Whitman

2019 Goals

1. Increase awareness of the Commission
2. Produce action on the Commission's strategic plan
3. Increase accountability by reporting outcomes of Commission actions
4. Increase input from community, youth, and underrepresented groups
5. Increase use of data

Accountability Report

Working on:

- HEA 224-2018 (Mental Health Licensing)

Others:

- Services for older foster youth
- School district personnel for SEL & Mental Health
- YRBS participation
- Juvenile public defense

Commission on Improving the Status of Children

Contact Information

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