RESILIENT IOWA BREAKOUT SESSION NOTES

Session: Health Care
Facilitator: Amy Shriver

Main objectives:

- 1. Health care providers are educated on trauma and the influence of trauma; sharing with the families to break the intergenerational cycle.
  - Ideally everyone; family practice providers, primary care settings that work with the patients.
    - Trauma informed care = TIC
  - Also need to include the prenatal/obgyn providers in how to best care for the children that are coming, even before they are here.
  - The leadership needs to have the buy-in too
- 2. Family finance – tax sites is a teachable moment. Conversations about insurance also. Have more information on how to help others find help for those that don't know where to look for the information.
  - How to effectively refer people who are under stress to the right resources
  - Financial health as a big part of your wellness.
    - Social determinants of your health
      - Including housing, finances, etc. that providers could suggest the other sectors that support their overall health.
      - Can have the community health workers that are sometimes inside or nearby the doctors' office, they can have some questions on "social determinants of wellness", so while the family is in for their visit, the doctor and the healthcare providers can flag any questions and help the family find the resources to help them.
- 3. The education system. Teachers might be less informed on TIC than the healthcare professionals. We need to inform and teach the teachers the skills needed for TIC.
  - What is the role of the healthcare community in facilitating TIC in schools?
  - We need to educate the school system on how to best have TIC.
    - Doctors can get a "toxic stress action plan" or (strengths based) "resilient child action plan" for the teachers to know how to best work with each child.
- 4. How can we assure that PCPs (primary care physicians) are able to help with 504s and IEPs?
  - There needs to be some way that we can help health care providers help the families make the right adjustments for the children's education
- 5. How the healthcare system treats the mental health and physical health so differently – why do we do it this way?
  - We need to integrate the two systems because they heavily influence one another.
  - Have the conversations really early so we can identify any issues very early to make a difference in overall well-being

- Schools and primary doctor care are two great places to find the different children and their cases, so we need to use that for finding any issues early and making big changes

- 6. Addressing resilience in health
  - 6 core areas in health that you need to be resilient
    - Nutrition is a top one, because if you aren't getting enough nutrition, you cannot develop properly
    - Sleep
    - Exercise
    - Having time for reflection and relaxation
    - Good mental health
    - Relationships
      - This scale is from Nadine's scale on resilience in health
      - This is a scale for kids, but if we are working with adults, we can add "financial" on as well.
- 7. Transportation in rural areas to healthcare
  - If we screen for it properly, we can make a difference for it early on.

1. Group 1: School and childcare and health provider collaboration group
   a. Dealing with the issues in how to support schools in the health lens
   b. What's already happening:
      i. Programs like "1st Five" helping with resources and referrals (ages 0-5)
         1. Because they get connected with the family in 1st five, they can help the WHOLE family. It helps because they are then in the school system and then the family stays connected with the health care professional
      ii. Telehealth PILOT – mental health with schools in Greene County
         1. Sue Gailing - Got a grant to study this area –looking to expand this
      iii. Marionette Miller – legislation regarding mental health services in the schools – she will introduce it again this year
         1. Her intent is to move this legislation forward
      iv. Mental health counselors in schools – some bigger schools have this within the district that can help (rather than just the HS counselor – who are just looking to get ready for college)
         1. Having this as a backup, and hopefully smaller schools can get this position more in the future
      v. "Warm Line" – CISC (central Iowa) they've been trained – people can call (up until age 21) can call from 5pm – 10:30pm about issues that are happening in school, they can talk about anything on the minds of the teens
         1. Free for families

2. CICS is also doing crisis counseling (like for suicide that happens). You can call CICS crisis line and they will come to your house and meet with you and your family. They will get you help that night. If you need to go to the hospital, they will go with you and help navigate that.

c. Barriers:
    i. Trainings – need more in the schools; childcare nurse consultants; because there is a high turnover, we need to figure out how to fix this
    ii. Lack of time – even with primary care physicians – they don't have a lot of time to meet with the schools.
    iii. HIPPA – to communicate with the schools is hard.

d. Opportunities for Improvement:
    i. Advocating for all child services

2. Group 2: Educating the health care workforce
    a. Happening now:
        i. ACEs pediatric project
        ii. Nine2Thrive
        iii. Developmental Screening
        iv. Connections matter
        v. 1st Five
        vi. Reach out and read
    b. Barriers:
        i. Bias and fear of bias of the health care providers
        ii. Trauma and adversity isn't part of the doctors' health
        iii. Providers lack time and resources
    c. Opportunities
        i. Impact of relationships and mentorship – they can have positive and powerful
        ii. CMEs and CEUs for doctors to participate
        iii. Project Launch Grant – just received
        iv. Expanding First Five
3. Group 3: Social Determinants Groups
    a. Happening now
        i. TILT – statewide trauma informed leadership team
        ii. Provide housing support – housing IS healthcare
        iii. Understanding hierarchy of needs *** Maslow
        iv. First Five, SWYC (new assessment that works better to identify social determinants)
    b. Barriers
        i. Funding is restrictive (only substance abuse looked as seems to be Opioids only, not other substances)
        ii. Limited focus
        iii. Community connectedness is lost (social context)

iv. Narrow focus on Social determinants of Health (SDOH)

c. Opportunities
    i. Slowly but surely we are seeing progress from funding agencies to
    ii. Legislative interest from Kim Reynolds
    iii. Understand prevention and long-term

4. Group 4: Financial Well-being
    a. Happening now
        i. Work with families individually – maybe suggest the family to take a financial class
        ii. Not all clinics screen the clients; maybe they could, so they can refer the families in need to the right resources
    b. Barriers
        i. Teachers don't understand personal finance
    c. Opportunities
        i. We need to teach about finance at a young age
            1. Maybe it will stick with them and change their long-term outcomes

Closing:

- What are some opportunities for us to intervene?
    - Make some goals on what we want to see in the next 365 days?
        - Connecting people to resources
            - Food insecure
            - Experiencing ACEs
            - Housing insecure
        - Maybe make the "first five" calling service in schools, so they can call First Five and then First Five can contact the families and help them
    - Also, promote first five at the legislative level
        - Give them their own community resources to promote wellbeing for all families
    - Help the schools learn more about Trauma-informed Services
        - They right now don't know what to do with these kids.
        - There is a real readiness with this, and we need to focus on working on the details
- Find resources for kids greater than the age of 5 also
    - Child Health – a service for those that don't fall under "First Five"
- ONLY primary care providers can refer First Five. But specialty providers (like mental health or disability provider) CANNOT refer to First Five. We need to open that door for ease of use.
    - Figure out a way to either make the process easier
- Be creative about collaborations
    - Like for the TILT team – make sure that the membership on the team is multidisciplinary and looking at the different determinants of health hand make sure there is representation

- *Communication is really the key. If we identify a student/client/child that is really in need, we need to have a TOOLBOX to go to and help this person
- Make a "resource list"
    - Where in the community to send someone to, what is out there, who is out there, what do they do? Make a resource list for Iowa that can be shared.
        - This is also really important for parents to have for their children.
    - *We need a "unified message" to communicate to parents and families about support.
- *211, a resource system that someone can call/parents can call.
    - Barrier: 211 is not well kept up. But it is dependent on people getting their information out and kept up-to-date. We would need to ENHANCE 211 in order to use it effectively
        - Especially in rural areas
- Multi-sector collaboration; continue the collaboration and help enhance the partnerships and build them up. The burden isn't just sitting in one place in the state; we need to work together <u>across</u> the state.
- Session ended at 11:57am.

Session: Juvenile Justice
Facilitator(s): Elley Gould, David Brown

Background info:
-started session at 10:10
-ACEs might be symptom of society, address it early
-need to be seats at table for all sectors of community/society
-network, community conversation, we want to walk out of room w/ action plan
-22 participants besides elley, david, and me

-3 other participants w/ criminal justice background
-155,000 people in Johnson County
-Jessica Peckover
-Polk & johnson counties has CIT training (40 hr crisis intervention training for law enforcement)
-new hires must receive training
-johnson training has local CIT training, it's resource heavy (community and resource available)
-'jail diversion' term keeps coming up

-introductions until 10:33

Learning
-johnson county looked at how their jail diversion worked, from that CIT training sprouted
-looked at data, different reductions and charges, since CIT training, public intox arrests alone have nearly been cut in half, trespass charges have been reduced

-40 hr CIT training occurs over multiple days, Monday-Friday, Joan Becker has been speaking, Mary Neubauer, NAMI speakers are engaged

-role plays at the end of four days, very community-inclusive (students, theater groups, etc)

-elley: work w/ mobile crisis in johnson county, there as a provider

-CIT training is unofficial in plain clothes, many CIT teams across nation are in plain clothes (polos, cargo pants) no negative impact from what elley's seen

-no juvenile justice programs in johnson county RIGHT NOW
-significant time to talk about ACEs, scenarios for role playing is specific to learning that day

-the training seems to allow law enforcement to acknowledge their own ACEs
-ACEs survey needs to be normalized, Joy uses 2-3 hours w/ a graph with the survey/ACEs training; people are usually shocked to see functioning adults w/ 8 or more ACEs

-brought up school resource officer in Florida who just got fired for arresting 6 six old for throwing a tantrum – did he ever have ACEs training?

-having a peer (of a law enforcement officer) involved w/ ACEs training, the conversation about ACEs in law enforcement will go a lot further coming from them compared to coming from us

-rural areas are limited for responding to multiple events that trigger law enforcement officers in one day

-is there a space for officers to decompress? There is a debriefing policy and procedures

-a lot of agencies are enforcing peer support teams internally, but also network amongst their peers

-johnson county access center – vicarious trauma of responding to calls is SIGNIFICANT

-want to reduce the stigma of mental health, especially among law enforcement officers, badge, career, work could be taken away

-when LEOs talk about what they're experiencing, it's easier for them to understand what someone else (someone who they're responding to) might be experiencing

-rural areas, LEOs run into arrestees into public places, it became significant to start to talk about how are we speaking kindly about others? What are you doing to help other people?

-arrestees aren't our kids, but they are our community!

-program in Iowa City, Inside/Out program, prison re-entry program working w/ volunteers,

-Lee and Des Moines counties: parenting classes for inmates, it can be hard for parents to transition back to being a parent, especially w/ younger kids; re-entry has significant impacts if parents can leave jail and re-establish w/ kids

-david: what would be best practice for diversion programs in schools?

-elley: the most significant thing that needs to happen is COLLABORATION; convos between educators, leos, administration, etc

-mental health training requirements for educators has been bumped up to one hour this year; same mandate for Iowa (one hour a year for 4 years, or 4 hours every 4 years)

-continuum: where can we step in w/ kiddos, talking about mental health, sexual activity, trauma?

-if your longevity/continuity in community, if you're stuck looking at same services over and over, we need to educate ourselves and look back to where the person started from, and figure out how to support them moving forward (generational passing down is troubling, INSTITUTIONS HAS NOT CHANGED)

-intergenerational information: it's slow to change, schools especially

-socioemotional learning and academic training, now you need to wear both hats to learn everyone is a gatekeeper as an adult

-juvenile justice and education are running on parallel tracks
    -parents patriate jurisdiction goal of gov't agencies,
        -justice system is supposed to reform
    -in local parentis in place of the parent (educational philosophy)
        -school is supposed to be equalizer
-similar to juvenile mental health and substance use

-how can we bridge education and justice system?
    -at the grassroots level? Cherokee county (school system) – student empowerment team meetings; mental health centers, care coordination, juvenile justice, DHS, local police, county sheriff's dept, faith based talk about specific kids allowed someone to learn about those services, make connections, network, talk about Jane Doe's issues that are going on in school

-kids form attachments w/ adults at school, esp. school nurses; school nurses are valuable components to juvenile justice system
    -some rural school districts don't have school nurses anymore

-drug endangered child coalition; teachers, leos, sheriff's department, social worker, someone from ER
-COLLABORATION – what can we offer child and the child's parents, punishment vs. consequence

-code of conduct deal w/ schools, how they treat kids and what they get back
-compassion and empathy do a lot before you have to deal w/ code of conduct; should be on individual basis; the question of 'what's wrong w/ you?' to 'what happened?'

-mobile crisis; more for adults not children
-johnson county has mobile crisis for children and adults model: always responds w/ 2 crisis counselors, divide and conquer helps parents and child at the same time
        -works in schools and communities as well

-leos become bad guys because they're only called for negative/bad things
    -there's a better alternative than calling leos for educational issues

-training, don't call police as initial training, call counselors first – change is happening
    -training for educators
    -push for CIT training – the earliest time you can intervene the better, same with schools, sooner it can be acknowledged and addressed, it'll support the student more

-educational staff included should feel psychologically and physically safe; including support from administration, what tools can we use to respond
    -what's behind the students' acting out behavior
    -teachers don't feel safe, so they call leos on the first time leos need to learn how to

take care of themselves so they're at their best to serve the public

-children's advocacy center – multidisciplinary approach; all disciplines must come together at the same table
-representation of every role brings perspective that looks at child and family holistically; no silos or tunnel visions

-seclusion rooms – solitary confinement for students in schools
    -what is a space for teachers, and students, to feel safe
    -teachers are supposed to help with de-escalation; look for warning signs before action from student 'leave me alone teach' might actually be helpful to leave student alone

-transition coordinator for areas for kids that are involved w/ juvenile court, dhs, foster care, it's a statewide initiative and REQUIRED
    -some kids can have the best plan, but opt out to not be involved

-job court – school is sometimes sending student; student is required to be involved in that diversion program

-play book – framework to help communities set up jail diversion, you don't know how to do something you want to do
-mobile crisis perspective – any research to guide whether if police based mobile crisis is okay for kids based on trauma? Johnson county if the kid remains safe, and people around them, leos don't need to respond; the goal isn't to arrest; law enforcement w/ kids aren't generally called if there's a crisis, crisis counselors/mental health professionals are (if safety is an issue, that might not happen and leos/mobile crisis might be called/respond); polk county ideal response does not include leos

-racial profiling – anxiety builds up when leos are around
-polk county mobile crisis response do sequential intercept model for children and adults; decided this because of one event, leos have to respond initially, but don't have to stay the whole time

-johnson county trains ALL law enforcement in 40 hr CIT training

-action plan
-the playbook – a handbook, a lot of converations to come together to put together a best practice model that most jail diversion programs replicate their services after; not happening right now; it's available, and replicatable
-can we map out what's happening in all counties? That might be first step to creating the Iowa playbook, and not solely adult focused, about young people and how it connects w/ their families

-go back to own communities, and map out, then go larger w/ statewide committee to work together collaboratively

-safe schools programs – in school therapists (1 hour 20 minutes into recording -ish)
    -bridging gap between law enforcement and families
    -if we're working with young person, how effective is it to provide therapy to just that young person? Should we provide family therapy to whole unit as one?
-started w/ initial referral by someone

-child advocacy center role – there are trauma screens for everyone coming into center; even if trauma isn't confirmed
-universal trauma screening, especially w/ referrals to mental health services, using evidence based treatment/therapy models
-universal mechanism? Development of assessment, some group working on it in the state, will make recommendation to the state

-keep in mind that there are barriers to house file; recommendations start screenings start at 3 months old. Who's doing those screenings? Pediatrician? Check, where does the info go, how does everyone have access HIPPA?

-early intervention/early prevention

-public health dept
    -prevention, intervention, response (our convo's been in response sphere)
    -dept is overwhelmed with issues
-lifespan constructs – first experience of violence or ACEs, change the environments in which we bring people up
-project catalyst: futures w/o violence, national training and technical assistance; started screening for domestic violence
-would it make more sense to spend time on assessment where people share what they choose OR universal education, presenting protective factors, intergenerational transmission
-improving response while also thinking about healing centered engagement universal education!
-prevention program: youth specific group w/ healing centered engagement run by youth w/ cultural specifics
-instead of responding to symptoms, what are the things we need to do to create proactive policies? IT'S NOT AN INDIVIDUAL ISSUE

    -ISU extension – evidence-based programs, prevention programs

    -learn from each other; if we don't collect and keep data, we won't understand the problem, PROTECT THE DATA (privacy and balance)

-some communities had showings of paper tigers
-facilitated discussion, and after that, influx of communication between school systems, family and communities

-regular community engagement events with k-12 schools

-regions are pulling together to COLLABORATE to figure out when children are first start to express themselves violently; why, what are they trying to communicate, POSITIVE BEHAVIOR SUPPORT NETWORK IN POLK COUNTY

-growth mindset

-get more inclusive in wellness, institutionally, slow change
-look at de-escalation; how can we understand need and bring individual down so they don't throw chairs, etc
-sped teachers have CPI training, all teachers should have that (David)

Session: K-12
Facilitator(s): Armeda Wojciak

Introductions:
-13 participants including Armeda and me

-Armeda – looked at trauma care at a school-wide level
-worked w/ families at-risk, how to use trauma care in a functional way
-yearlong training, school-wide, about 6 years ago; started w/ paras and now district-wide

-Williamsburg schools, Chad Garber – showed 'Resilience' rather than 'Paper Tigers'
-split into 4 groups, 2 neuroscientists, impact on hippocampus, ACEs 101 – Jude Jenson's curriculum, collaborative PD time and implementation

-creating classes and PD w/in membership org., PD academy for license renewal (allowing credits in socioemotional courses), mental health professional learning & create safe/supportive environ., self-care/secondary trauma/compassionate fatigue workshops, building a support system as a system, local assoc., state-wide trainings, partnering w/ multiple org., works w/ school counselors for training, school administrators of Iowa (SAI)

-state-prep program for FCS educators w/n ISU; how to build healthy relationships, collaboration w/ therapist, mental health pros, responsive training for educators, etc.

-Rolling Hills region starting mobile crisis response teams Nov 1 for children and adults

-Sioux River region mental health/first aid for adults, youth, paper tigers, collaboration w/ schools, educators, community; trainings in summer for educators and comm. members (leos); mental health counselors in schools and liason

-ISU extensions – coordination for prenatal parental programs, nutrition for adults, youth literacy (for k)

-Weems - schools in NO after Katrina; trauma services; test anxiety program; cultural changes in Iowa schools; intervention for anxiety in kids targeted towards testing anxiety

-Catholic Charities: family therapy w/ newly-diagnosed autism; schools are interested in trauma informed everything; 'trauma invested' beyond trauma informed in school; refugee and resettlement programs; developing secondary trauma support for staff members

-Strengthening Families program – substance use prevention, risk and protective factors, evidence-based programs; PPSI – implementation of evidence-based practices

-United Way of Central IA – support children's health promotion and prevention, mental health supports, investments & community support, CAMI for Kids Coalition – collaborative state sectors to develop common message and ask of policy makers

-Blake Hospital – CAMI for Kids, universal screening panel work group – who should be screening? What ages are we screening? How are we screening? What are we screening?, esp. in primary care – access to children and solid referral process; schools have important role too - what do teachers/administrators want in their role of screening kids?

-PIAL – facilitations of curriculum modules; resiliency and risk factors module; connection w/ DHS; Trauma Informed Care Project; focus on positive identification and recognition of protective factors

-Des Moines PS – behavioral health dept, brand new 2 years ago; to create support of program; socioemotional learning, peer support, supportive of trauma-sensitive schools w/n DMPS

-community adolescent pregnancy prevention program

-ended 3:23

Session began 3:24
-Armeda - held monthly meetings for 2 years; people from across state interested in k-12 edu. and trauma informed work; multi-pronged approach, impact schools now but also how do we get to pre-service?
-usually means 3rd approach – legislation, educator (teacher, administrator, school counselor) education
-collaboration – learn from AEAs to stay connected
-presented at Iowa Assoc. for College Teacher Prep Program – how do we reach those who are preparing teachers? Self-care, trauma, resilience, how do you talk about this?

-planting the seed to become less-removed from education level – mandates, requirements for prep for teachers, where do we even put this in the curriculum?

-educators feeling unprepared to talk about resiliency, self-care successfully

-trying to build examples of this work in our state, peer support, etc

-harder time: awareness building, but it seems like this has happened, needs to go to legislation/requirements for teachers and counselors; educators need to respond to requirements that are there

-potential next steps? What can we do? How do we move intentionally and thoughtfully?
-state level - FS 2113, children's mental health, but what can we have as a driving force to think about?

-thoughts/goals

-FS 2113 should be bigger, it doesn't say how much you need to teach ACEs

-youth mental health/first aid somewhat limited

-work w/ legislature to litigate toxic stress
-teachers role in identifying children w/ ACEs
-teachers are craving in-classroom intervention & supports – what's the process of referrals, what's their role?
-contact 'first 5' for resources child will need, they do a good job of following up
-legislature need to understand what schools need and what teachers need – GOOD REFERRAL PROCESS
-proposal: why isn't there something like first 5 for teachers? What would that look like? Who are the collaborators? If we're going to charge schools w/ screenings, we need to back them up w/ resources and funding

-trauma assessment, resilience assessment, also focused on family – being intentional, family centered; we need to integrate, holistically everything for at-risk students
-how do you create connection and have referral sources there?

-what is first 5?
-a public/private partnership w/ funding through title 5 that supports pcps to do appropriate developmental screening
-as kids are identified w/ developmental needs, kids are given 5 referrals (psychologist, AEA, early access, food pantry, etc)
-pediatricians use it as main referral resource for health

-there's a lack of prevention, more of a reaction to crises
-mental health integration into schools would be imperative
-behavioral health interventions services have to be done in the home, but w/o Medicaid it costs parents money

-how to address mental health issues in k-12 education?
-interconnected framework system (IFS) – brought in framework of how to go through process w/ community, community partners w/ mental health services

-consider tension points around community/mental health services in schools
-tends to be a lack of coordination/comprehension of services in schools there needs to be someone to coordinate services! usually central coordinator (school counselor), IEPs play a role in coordination
-teachers in the classroom are asking 'what do I do?' 'where do I go?' COORDINATION IS IMPERATIVE esp w/ educators in school buildings

-counselor, family, teacher need to know where kid needs to go, collaboratively
-if you want effective care that meets people's needs, there needs to be someone taking on that role; diversity of school systems makes it difficult to implement for everyone
-team needs to be ready before the program's put in place – sustainability

-what can we create in the classroom to help student self-regulate and it doesn't take away and distract every other student? Or other staff in building who can support student. Buddy classroom? SYSTEM OF SUPPORTS, BEING INTENTIONAL ABOUT PEOPLE'S ROLES TO BE FREE TO ACTUALLY FULFILL ROLES THEY INTENDED TO TAKE ON

-AEA behavioral specialist – has decreased in funding, restore the funding for AEAs

-teacher leadership programs are heavily funded
-there can be growth w/ teacher and parent engagement across the board; insurance barriers prevent families from truly engaging in mental health counseling

Session: Public and Community Health
Facilitator(s): Holly Hanson

- What is currently going on in health agencies/partners:
  - Building awareness
  - Training
  - Implement strategies (clients, staff) (macro to micro level)
  - Working with partners (not knowing potential connections or doing the work and not being contacted)
- 1-5 year goals
  - Connecting agencies and forming relationships. Develop trust, act as sounding boards (community networks to support the work, rotating org. assessments)
  - Braided funding
  - Unrestricted funding
  - Help communities develop a culture of self-care, stress management
  - Create a culture where we take care of each other
  - Creating organizational culture of self-care
  - Help this become a youth-led movement, let youth advocate for themselves
  - Universal access to resources, trauma care (including for the "middle class")
  - Improve mental health services in high school
  - Communities to build social networks, rebuilding communities ("get off technology", become more personal)
  - Paradigm shift to prevention and NOT solely a focus on intervention
  - Learn from Philadelphia – they invest in prevention programs, it has significantly reduced juvenile delinquency (maybe invite speaker for next year's workshop)
  - Collective impact theory – need to understand the theoretical framework behind the models we use in trauma informed care
  - De-stigmatization of seeking care, performing self-care
  - Promote buy-in from upper management (self-care)
  - Create opportunities for reflection, "reality check"
  - Prioritize self-care and safety

Trauma informed care continuum:

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Pre-aware (limited collaboration, limited knowledge, limited training)
Trauma-aware
Trauma-sensitive
Trauma-responsive
Trauma-healing
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Session: Public Policy
Facilitator(s): Chaney Yeast, Dave Stone

- Introductions
- Topics:
    - Collaboration and how to move policy forward
    - Legislative policy
        - What are some things that your organization's policy "wish list" would include? Local level? State level?
            - Brainstorm as a large group, then brainstorm as a small group.
    - What can we do within an organization to move Trauma-informed care (TIC) forward?
- ACEs policy coalition hand-out
    - Legislative priorities for children last year
- Background
    - ACEs policy coalition for 5 years now
        - Involves stakeholders who are interested in ACEs research and applying that to moving recommended policies forward. Also trauma and resiliency policies forward.
        - In the past several years, they have a list of priorities that they have for moving forward. They have been successful because the work is done on many levels.
        - Organized lobby day – people come to the capital and they introduce you to the individual legislators
            - They train people on how to talk to the legislators (very quickly, less than 5 minutes if you're lucky)
        - Communication with legislators – do's and do not's
            - How to build those relationships as a constituent and have a unified voice at the state level.
            - When legislators hear that at both levels, it seems to "click"
- Program
    - First Five – family supports, developmental screening for resources
        - We know it directly links into children's positive mental health for the future
        - Positive health for the families
        - In all but 11 counties in Iowa
            - Working hard to get the rest of the counties
            - Question: Why don't the 11 have them?
                - Johnson County (Iowa city)
                    - Probably a resource-rich community; if they have limited funds, provide it to another rural place that doesn't have those resources

        - Northwest Iowa
            - Several counties up there
            - Lack of funding
- Children's mental health
    - Lots of movement on this; especially since the gov't took this on through one of her priorities.
    - House file 690: children's mental health bill.
        - A good first step in building the children's mental health in this state.
    - Medicaid and children's health: 1 out of every 5 children in Iowa. In Rural Iowa it is 1 out of every 3 on Medicaid.
        - 50% of the population in Medicaid are children, and they cost less than older adults
        - Important for people to remember that Medicaid is also for the children, not just older adults
    - Prenatal home visitation
        - Largely due to the work that Lisa leads with Pilot programming throughout the state
            - How do we actually provide services to the mom and family? What needs are high *before* the baby? Also, what about after the baby is born (First Five)?
            - Working with an OB clinic to assess the mom's stressors (family stressors); then that information goes out to a community advisor, then they can relate them to resources they need (food, housing, support mechanisms, etc.).
    - Building a trauma informed child welfare system
        - System improvement and system change
            - Federal family-first legislation
                - Turning the child welfare system on its head
                - Giving the resources from later but starting it earlier on:
        - The families need resources EARLIER ON, <u>before</u> it comes down to foster care and shelter needs
        - Narrowed focus to 3 goals:
            - 1. Reducing caseloads for workers (recommendation from DHS and child neglect deaths)
            - 2. Investing in the comprehensive child welfare information systems (data systems)
                - Old systems that are not even updated anymore
                - These antiquated systems are putting the children at risk
                    - Example: peanut allergy with a young kid that wasn't in the "paper folder" sent to the

new family. So out-of-date that it's actually dangerous.

- 3. Investing in evidence-based practices
  - Those cost money for training times for staff; not only one time, but clinical supervision on an ongoing basis. Supporting each other and the clinical decisions being made on-going. All of those cost money and are all worries of child welfare providers as they move forward.

- Successes
  - The governor asked for a strategic plan of how everything works together across the entire state.
    - Started out with the development of the children's "state board"
      - They needed to know the scope of the board
      - "Complex Needs Work-group" for the adult group gave a great example for them
        - One thing that was clearly evident is that they were "an army" with the "Same message, the same voice"
          - They worked TOGETHER. No one deviated from the plan. They brought it TOGETHER.
  - Kim Scorza of the season center in Sioux City, tried to suggest that they need to be like the "complex needs work-group" adult board.
    - They created the children's coalition of varied people (business, education reps, law enforcement, teachers)
    - They needed a "consistent, clear, concise message" that is refined; the same message being said to the legislators time and time again.
    - Developed the coalition around this concise message.
    - They named their program the "Cami for kids" (not sure how to spell that)
      - It is almost a year old right now.
      - Cheney developed a great triangle of the full spectrum of services in our state. The best practices of what the mental health of children would look like. (Triangle was passed around; also on the web).
        - Very concise. Legislators appreciated the triangle. Was easy to follow and helpful to understand.
    - They had a lobby day with key legislative leadership from both parties and both groups and told them the things to consider (the triangle)
      - The lobby day was very successful for the coalition
    - The strength of the coalition was key in "singing from the same hymn" and giving the same message.

- House file 690 was introduced; went to the government first;
    - Cami for kids helped this process go smoothly by answering any questions quickly throughout the process.
    - 24 hours later was the sub-committee. The coalition analyzed and synthesized the bill. They requested the needed changes with "clear bill vocabulary" for the suggested amendment changes, and "most all" was passed forward.
    - The bill passed in both chambers
    - The governor signed it in May of 2019
        - The coalition "case study" worked excellently and they are already meeting again to start developing what they will do in 2020.
            - They didn't talk about funding with them; they were told to have the legislators think about funding them.
            - Now in 2020 they are trying to figure out how to fund this coalition's progress and project.
- The focus of the group now is doing a gap analysis
    - What are the funding sources that can help?
    - What are the true costs?
        - (This is the question that are trying to answer now)
    - County dollars vs state dollars; What if your tax dollars are being taken across the state to a different county? Some people don't like that.

- Top two things people are worried about in 2018 is the economy and mental health
    - This is a huge plus to try and remove the stigma from mental health services
        - We need to make sure that in 2020, mental health stays the priority
- Families that are directly impacted kept showing up to the legislators time and time again; that's why we have the medical cannabis law in Iowa. The families made that happen.

- Next, group up. What do you see in your world as policy issues regarding ACEs, or Trauma-informed care?
    - Little policy issues within an organization?
    - Big policy issues within the legislators?

- Question from Group 1:
    - What about the kids that are already in the system (foster care, high ACEs, highly traumatic pasts, etc.)? If we are giving more funding for "prevention in the

future", what about the kids that are already affected by this? Are we just wanting to forget about them and "fix the next batch"?

- The shelters are full, the foster families are really full and when they are taking more kids, the level of care is going way down, even ending with abuse by the other siblings or associated family members.
- There are no therapeutic foster homes available. So what happens to them?
- DHS is so overworked, that there is almost no follow up; and the follow-up that does happen, doesn't do anything thorough and is missing huge components.
- Therapeutic foster care has NOTHING and kids are committing crimes to get put in jail and juvy so that they "don't have to be in a place where they feel unsafe"
- She is definitely ("for sure") seeing that there are kids in homes that are unfit for them.
- The shelters need more training as well in TIC and ACEs. A lot of the kids that come to them from the shelters tell them (Unity Point) things that are "really hard to hear"

- How do you make positive change from "where you are" in your organization?
  - Everyone in the organization needs to be trained on TIC for <u>all</u> of the staff.
    - They are using "sanctuary", the TIC training program for program. It took them 3 years to be full trained in that across their organization AND making sure that the programs are working in "sanctuary" program style. They eventually got some grants to <u>pay</u> for the training. Then, after the grants ended and the training is done, they have to sustain some money to keep the training-yearly checks going. The non-profit has been TIC trained for 10 years now.

Session: Practitioner
Facilitator(s): Gladys Alvarez

We need to change the question from what is wrong with that person, to what happened to that person

Trauma informed care is not a mental health intervention, it is a systematic approach that EVERYONE needs to be trained in

Four essential elements:

- Connect – focus on relationships. All learning happens within the context of a relationship, all pain happens in the context of a relationship.
- Protect – requires trust, in order to have trust, must have a relationship to build that trust upon.
- Respect – focusing on choice and collaboration. Many things we can give give a choice on, once given a choice, you have some control over the situation. Using a variety of entities involved in the process. Legal, health, policy…collaborating with the entire community. Also collaborating with resources.
- Redirect – skill development and redirection. change your perception from the negative to the skill. Do an environmental scan.

Self Care

- Stress shrinks your "window of tolerance". Needs to happen both at the organizational level and the individual level. Organizations have some responsibility to provide resources, but needs to be on the individual level. Its your responsibility to do some regular self care routines (spiritually, physically, mentally)
- Three things you can do at work to stay calm
- Safety plans – in the moment what are you going to do when you're stressed
- Have your coworkers know about your safety plan (part of building relationships as well)
- Proqol assessment – measures compassion fatigue
    - https://proqol.org/Compassion_Fatigue.html

Group Discussion

- Getting team buy in has helped in implementation, somewhat of a prep heavy model to implement, awareness, desire, actual organizational change
- Tip 57 book about trauma informed interventions and organization trauma informed care
- *Creating Cultures of Change* – Community Connections article
- Trauma Champions group should not just be clinicians – top/down and everybody in between

Session: Rural
Facilitator(s): Cheryll Jones

High need, low volume. How do we serve these populations?

Challenges:

- Turnover
- Lack of providers
- Finding qualified staff to fill positions
- No health insurance benefits
- Staff serving a lot of counties, a lot of drive time
- Lack of capability for people to access technology or know how to work it
- Time to do reports online (takes longer than paper)
- Not practical to do assessments online (too slow)
- Have to do more with less
- Static funding or cuts
- Credentialing, more reporting, losing the mission/goal of seeing families. Hard to get things done because of the additional requirements.
- Windshield time. Technology not available for video meetings
- Lack of providers, have to get creative to find providers for individuals needing crisis services. But then even if there is a provider they can't get there

Opportunities

- Increased use of Zoom for meetings
- Trying to use it more with skype with families as well. Telehealth (especially with the inmate population, trying to expand that to non-inmates as well)
- ERs using telehealth, including for mental health
- Schools open to collaboration on mental health issues
    - Finding that parents are more of a barrier, still a lot of stigma attached, don't want their kids talking about suicide
- Utilizing local newspapers and radio stations to educate the community
- Including more financial education. Criticize how they spend their money but what do we do to help?

Coalitions/Collaborative opportunities

- Getting kids a full day preschool experience
- Subgroups started out of a public health program analysis, were just for that analysis but continue to meet and the ACE's group formed out of that as well
- Partners for children and families – community provides areas of education they want and are bringing in various trainings.
- Southeast iowa children's mental health collaborative – how do they more effectively deal with the health needs of kids

What resources do you use in your community?

- ECI
- Community service
- CAP agencies
- 211? – only as good as the information that has been put in. Opportunities to enhace it, but not very well funded, doesn't cover parts of the State.

There is worry that once they create all of these crisis services, they won't have the money to sustain them. MCO's are not paying out. Some regions don't have the funding balances.

Session: Business
Facilitator(s):

HIGHLIGHTS for Trauma Informed Business:

- Biggest barrier: building trust with businesses and organizations.
- With trauma informed curriculums, businesses want more quantitative data, not qualitative. Employee data, turnover rates, etc. There's a gap because no data for manufacturing, focuses mostly on traditional, college-educated workplaces.
- There are efforts to connect with the business communities. Businesses need more of a focus on networking and resource sharing than a focus on implementation.
- Conversations highlight the need for EAP resources to be utilized.
- Need to address trauma-informed info with staff who work with clients. They deal with trauma reading medical records, etc. Also for nurses, health care providers, people who deal with trauma day-to-day. How can we do this for businesses? First step is asking people what they need.
- Businesses are interested in absenteeism and retention, but also intervening and mitigating trauma as having an impact on their health benefits.
- How can we avoid traumatization in the workplace that break traditional standards we don't consider? For example, letting the employees choose a meeting location for employee-based meetings that are more comfortable for the employee. Also, eliminating open work spaces that remove personal, safe spaces and comfort items (ex: family photos) for employees.
- Need to build stronger relationships and trust between managers and employees. For example, the manager leaving their office door open so they remain approachable.
- Build an assessment around how trauma-informed-care in the workplace will make sense for rural community business or businesses that have minimal employees.
- Include trade unions in the conversation.

NOTES:

How are we engaging people in the business community about trauma formed education?
Lucy Holmes and Abby Madison- program manager for Prevent Child Abuse Iowa/ Connections Matter
Scott Willsey and Jan Melby – CWRTP
Catherine Bergman – director of child care center
Heidi – Growing Strong Families
?? - Blank Children's Hospital
Dave Stone
Goal – to do share-out, workshopping about what needs to be part of the conversation around business around trauma informed systems

Connections Matter within Workplace– community based prevention, educ on the impacts of trauma when unmitigated and how resiliency and hope build better health and stronger communities

Biggest barrier: building trust with businesses and organizations. Piloted 2 pilot sites, doing a 3rd- small wealth management firm in DSM, funded by polk county. Iron Horse Wealth Management (10-15 employees). Third pilot is Principal Financial Group – 40 people. "How can I interact better with my client?" is how it has been viewed in the past. With trauma informed curriculums, businesses need a half day and email follow ups. Businesses want more quantitative data, not qualitative. Employee data, turnover rates, etc. There's a gap because no data for manufacturing, focuses mostly on traditional, college-educated workplaces.

Are there trauma-informed systems being discussed? For businesses- building skills from past incarceration, people who can't hold a job chronically.

Across the state- reported from community groups- communities are on different levels. More are more trauma and ACES informed than others. There are efforts to connect with the business communities. More of a focus on networking and resource sharing than a focus on implementation.

EFR does employee assistance programs but aren't connected with United Way and Connections Matter. Conversations highlight the need for EAP resources to be utilized.

Want to move to a train the trainer model

Businesses are interested in absenteeism and retention, but also intervening and mitigating trauma as having an impact on their health benefits. Could Wellmark get behind this?

Need to address trauma-informed info with staff who work with clients. They deal with trauma reading medical records, etc. Also for nurses, health care providers, people who deal with trauma day-to-day. How can we do this for businesses? First step is asking people what they need.

There are no pilot curricula with Connections Matter outside of Iowa that are focused on business-based curricula, it's mostly educator-based and community-based.

How can we avoid traumatization in the workplace that break traditional standards we don't consider? For example, letting the employees choose a meeting location for employee-based meetings that are more comfortable for the employee.

Make managers more approachable and build a sense of help and trust with their employees. Ex: leave office door open unless on a conference call. How are their physical workspaces helping? Maybe open-floor spaces aren't the best because they take away the personal space.

Do you see businesses in your county engaging with trauma-informed curricula?

Would a community approach be better for single-owned businesses in smaller communities? Would business-based approached work? Places where the biggest employer is schools, biggest businesses are hospitals, etc. How can we make this work and what is a feasible way to implement this?

How can we engage rural communities where businesses have minimal employees?

How does it affect my "bottom line"? There is a need for it to be scaled towards the size of the business.

Return on investment is important to consider.

Trauma-informed training can help to keep employee turnover low and keep employees engaged. There is a need to talk to trade unions, who struggle to find employees.