



# Iowa Department of Human Services

---

Terry E. Branstad  
Governor

Kim Reynolds  
Lt. Governor

Charles M. Palmer  
Director

December 15, 2015

Michael Marshall  
Secretary of Senate  
State Capitol Building  
LOCAL

Carmine Boal  
Chief Clerk of the House  
State Capitol Building  
LOCAL

Dear Ms. Boal and Mr. Marshall:

Enclosed please find copies of report to the General Assembly relative to the Children's Mental Health and Well-Being Workgroup as required by 2015 Iowa Acts, Senate File 505, Division XXII.

The Department of Human Services worked in cooperation with the Departments of Education and Public Health to develop the attached report, and respectfully submit this report making recommendations on children's mental health and well-being in Iowa.

Please feel free to contact me if you need additional information.

Sincerely,

Paige Thorson  
Policy Advisor

PT/av

Enclosure

cc: Terry E. Branstad, Governor

# Iowa Department of Human Services



## Children's Mental Health and Well-Being Workgroup Final Report

December 15, 2015

## Table of Contents

Executive Summary.....	2
Introduction.....	2
Children’s Mental Health Subcommittee .....	3
Discussion .....	3
Category 1: Preventino, Early Identification, and Early Intervention .....	3
Category 2: Mental Health and Substance Use Disorder Treatment .....	4
Category 3: Recovery Supports.....	6
Category 4: Community-Based Flexible Supports.....	6
Children’s Mental Health Subcommittee Recommendations.....	6
Children’s Well-Being Subcommittee .....	9
Discussion .....	9
Vision .....	11
Operating Elements.....	11
Emerging Examples.....	12
Children’s Well-Being Subcommittee Recommendations .....	12
Conclusion.....	13
Appendix A: Expanded Definitions of Selected Children’s Mental Health Services .....	<a href="#">14</a>
Appendix B: Framework for Child and Family-Focused Systems.....	<a href="#">18</a>
Appendix C: Children’s Well-Being Core Values and Guiding Principles.....	<a href="#">19</a>
Appendix D: Senate File 505 Division XXII .....	<a href="#">21</a>
Appendix E: References and Acknowledgements.....	<a href="#">22</a>
Appendix F: Children’s Mental Health and Well-Being Workgroup Membership. ....	<a href="#">24</a>

## Executive Summary

The Children's Mental Health and Well-Being Workgroup was formed in response to legislative direction to facilitate a study and make recommendations regarding children's mental health and the systems that assist children and families in Iowa. The Workgroup was broken into two subcommittees; one on children's mental health and another on children's well-being. Over five meetings, the workgroup identified and defined services, supports, and essential characteristics necessary for children's mental health and well-being. This report summarizes the conclusions and recommendations of the subcommittees.

The Children's Mental Health Subcommittee identified, defined, and prioritized a core set of mental health services for children. The subcommittee determined it would be difficult to implement the entire array of children's mental health services at once, and recommended a process to phase in children's mental health crisis services in two geographic areas at a time. The subcommittee recommended \$300,000 for this effort. The subcommittee also recommended evaluating the expansion of telehealth for children's mental health services, to better coordinate mental health crisis and referral telephone lines, to revise Iowa Code to reflect the recommendations of the subcommittees, and to develop a public information campaign.

The Children's Well-Being Subcommittee worked to identify barriers to child and family success, operating elements for coordinated cross-system child and family support, and emerging examples of this approach in Iowa. The Children's Well-Being Subcommittee recommended the development of three to five "learning labs" where systems engaged in cross-system, family-focused case management shall report on their approaches and outcomes. The subcommittee also recommended that an advisory group be established to prepare the learning labs, continue the subcommittee's efforts, and coordinate with the Children's Mental Health Subcommittee. Finally, the subcommittee recommends the General Assembly appropriate \$300,000 to support the learning labs.

## Introduction

Senate File 505 Division XXII directed the Department of Human Services, in cooperation with the Departments of Education and Public Health to facilitate a study by a workgroup of stakeholders which shall make recommendations relating to children's mental health and the systems that serve children in Iowa. The Director of the Department of Human Services established and charged the Children's Mental Health and Well-Being Workgroup to address these requirements (List of Members in Appendix E).

Currently, while there are mental health providers in Iowa who serve children, there is no statewide, coordinated mental health system that structures or directs these services. In Iowa, there has been extensive work implementing Systems of Care principles, Integrated Health Homes, and trauma-informed care. The mission of the Children's Mental Health Subcommittee was to identify and define core mental health services for Iowa's children, with a focus on mental health crisis services.

There are several systems in Iowa that serve and protect children; however these systems are often fragmented and confusing for children and families. The Children's Well-Being Subcommittee worked to identify barriers to child and family success, operating elements for coordinated cross-system child and family support, and emerging examples of this approach in Iowa.

## Children's Mental Health Subcommittee

### Discussion

The Children's Mental Health subcommittee (the subcommittee) developed a list of children's mental health services with service descriptions that should be available to Iowa children experiencing mental health challenges and their families. The list of services was derived from the Core Services described in the 2013 *Children's Disability Workgroup Final Report*. Subcommittee members also considered information in the *Statewide Call for Action: A Strategic Plan for a Children's Mental Health Redesign* and the comprehensive list and descriptions of children's mental health services from the State of Minnesota and other states. The subcommittee recommended children's mental health services be delivered using system of care principles and evidenced-based practices whenever possible.

**System of Care** is defined as a child and family-driven, cross-system spectrum of effective, community-based services, supports, policies, and processes for children birth to young adulthood, with or at risk for physical, emotional, intellectual, behavioral, developmental, and social challenges and their families that is organized into a flexible and coordinated network of resources, builds meaningful partnerships with families, children and young adults, and addresses their cultural and linguistic needs, in order for them to optimally live, learn, work, and recreate in their communities and throughout life.

**Evidence-based practices** (EBP) are practices that have consistent scientific evidence showing they improve individual outcomes. EBPs have the following characteristics:

- Transparency: Both the criteria and the process of review are subject to peer-review.
- Research: Accumulated scientific evidence based on randomized controlled trials.
- Standardization: The practice's essential elements are clearly defined.
- Replication: More than one study and group of researchers have found positive effects.
- Meaningful Outcomes: Consumers are shown to achieve meaningful outcomes.

The subcommittee identified the following service descriptions that have been grouped using the categories of services from the 2013 Children's Disability Workgroup Report. Each service was listed once in a service category that it fit in the best. More expansive definitions of some of these services are included in Appendix A of this report.

### Category 1: Prevention, Early Identification, and Early Intervention

#### Mental health and substance use education

A statewide program that provides education regarding the signs, symptoms, and effective responses for mental health and substance use disorder conditions in children. The program is intended to support children and their families experiencing mental health challenges and provide public awareness to reduce stigma regarding mental health issues. Specifically designed education is provided to the following groups:

- Youth, especially youth with a severe emotional disturbance (SED)
- Parents and family
- Educators
- Other child care providers
- The community at large especially peers of the youth

### Primary care screening for mental health and substance use disorder

- Training for primary care providers regarding the signs, symptoms, and effective responses for mental health or substance use disorder conditions in children including the toxic effects of stress and trauma.
- Using a standard screening tool recommended to be used by primary care providers in all well child visits.
- Adopt the principles of screening, brief Intervention, and referral to treatment as a statewide model of early intervention.

## **Category 2: Mental Health and Substance Use Disorder Treatment**

### Assessment and evaluation

A complete holistic health, mental health and substance use disorder assessment that includes social determinants of health and the toxic effects of stress and trauma done by a licensed mental health professional designed to identify issues as a basis for a treatment plan.

### Medication prescribing and management

*Medication prescribing* means services provided by an appropriately licensed professional including, but not limited to, determining how the medication is affecting the individual; determining any drug interactions or adverse drug effects on the individual; determining the proper dosage level; and prescribing medication for the individual for the period of time before the individual is seen again.

*Medication management* means services provided by a licensed professional including, but not limited to, monitoring effectiveness of and compliance with a medication regimen; coordination with care providers; investigating potentially abusive activities or misuse of medication pursuant to licensed prescriber orders.

### Collaborative Psychiatric Consultation Service

Collaborative Psychiatric Consultation Services provides licensed prescribers access to a board certified child psychiatrist to consult with medication management and prescribing. Experts in the field will determine which medications and dose ranges would be eligible for psychiatric consultation. Calls for assistance will be triaged by a licensed mental health professional. If determined appropriate, the call will be referred to a project child psychiatrist for telephone consultation to the licensed prescriber. The service is free of charge to all callers.

### Crisis intervention and stabilization

A crisis is when a child's safe baseline level of functioning is disrupted and the child or the child's family, school, or community is lacking the immediate internal and external resources to return the child to a safe baseline of functioning. Children's mental health crisis response services are intensive face-to-face, short-term mental health services initiated during a crisis to help the child/youth return to their baseline level of functioning. Children's crisis response services must be provided by a crisis response team outside of urgent care, inpatient or outpatient hospital settings.

Crisis response providers must be experienced in mental health assessment, crisis intervention techniques, have emergency clinical decision-making abilities and knowledge of local services and resources. Services include:

- Crisis Screening
- Crisis Assessment
- Crisis Intervention
- Crisis Stabilization

### Individual, group, and family therapy

Individual, group and family therapy means a dynamic process in which the therapist uses professional skills, knowledge and training to enable children and their families to realize and mobilize their strengths and abilities, take charge of their lives, and resolve their issues and problems. Therapy services may be provided to individuals, groups, or families. Therapy will not be unnecessarily limited by site of service and includes in-home family therapy. With approval of the family and the child, the child's individual therapy plan and therapeutic approaches will be coordinated with and integrated into the child's individual education program, if one exists, and/or the child's general education program.

### Integrated Health Home Care Coordination

Integrated Health Home Care Coordination means activities designed to help children and their families locate, access, and coordinate a network of supports and services that will allow children to experience resilience and recovery and live a safe, healthy, successful, self-determined life in their home and community.

### Intensive Evidence-Based Treatment

*Intensive in-home* services provide therapeutic interventions to children with an SED and their families that are at risk of inpatient treatment or out of home placement that is designed to prevent such placements. Intensive in-home services are designed by a team that includes the child and their family that combines individual, group and family therapy and behavioral interventions with the support of paraprofessionals. With approval of the family and the child, the child's intensive in-home interventions will be coordinated with and integrated into the child's individual education program, if one exists, and/or the child's general education program.

*The Youth Assertive Community Treatment (ACT)* provides a menu of intensive mental health services provided in a comprehensive, coordinated team approach.

### Residential or Inpatient Treatment

*Acute inpatient psychiatric hospital* treatment is defined as treatment in a hospital psychiatric unit that includes 24-hour nursing and daily active treatment under the direction of a psychiatrist and certified by The Joint Commission (JC) or the National Integrated Accreditation for Healthcare Organizations (NIAHO) as a hospital. An identified number of inpatient psychiatric hospital beds geographically dispersed across the state will be available to admit all children regardless of the acuity of their mental health symptoms and successfully ameliorate their acute symptoms. Such identified beds will be adequately reimbursed for this more intensive service.

*Psychiatric Medical Institution for Children (PMIC)* is a non-hospital facility that provide inpatient services to individuals under 21 years of age and that is accredited by the JC or any other accrediting organization with comparable standards recognized by the State that meets the standards set by the Centers for Medicare and Medicaid Services and is licensed and certified by the state. An identified number of PMIC beds geographically dispersed across the state will be available to admit all children regardless of the acuity of their mental health symptoms and successfully ameliorate their acute symptoms. Such identified beds will be adequately reimbursed for this more intensive service.

*Subacute mental health services* are short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

### **Category 3: Recovery Supports**

Family Support provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

#### Youth Peer Support

Youth peer support is to assist youth experiencing an SED to learn from someone with a lived experience that recovery and resiliency is possible and to provide guidance, coaching and encouragement during the youth's recovery journey. Youth Peer Support provider is an individual in the youth's identifiable age group that has had lived experience of an SED and has been thoroughly trained as a peer support worker.

Respite Care provides temporary direct care and supervision for the child with an SED.

Attendant Care provides a child with an SED that would otherwise be placed in a more restrictive setting personal support and supervision services.

Family Resource Home provides short-term and intensive supportive out-of-home resources for the child with an SED and his/her family without the family needing to give up custody of their child.

Education Support provides a child with an SED an individual education program plan developed with and agreed to by the family and the child that ensures the child receives appropriate supports for the child to be successful in school and, with approval by the family and child, the child's mental health treatment is incorporated into the child's education program. The Local Education Agencies (LEAs) supported by the Area Education Agencies (AEAs) should offer the same full array of current evidence-based practices and models of service delivery regardless of student's education placement.

### **Category 4: Community-Based Flexible Supports**

Wraparound Services are designed to meet the goals set by the child and family team and to provide flexible support to the child and family. The services in a wraparound plan, also known as direct support services, differ from traditional mental health services and include the flexible use of funding to meet children and family needs.

## **Children's Mental Health Subcommittee Recommendations**

### **Children's Mental Health Services Priorities**

The Children's Mental Health Subcommittee recognized that not all of the identified services can be implemented at once, and agreed that children's mental health crisis services are the highest priority service. Therefore, the subcommittee recommends that these be the first children's mental health services developed, and that they be developed based on the definitions in this report, be comprehensive in nature, and be phased in over several years across the state.



## **Request for Proposals for Children's Mental Health Crisis**

### Overview

The subcommittee recommended that the Legislature approve a phased-in approach for children's mental health crisis services. The approach would involve awarding two planning grants one year followed by full implementation of children's mental health crisis services in the two areas awarded a planning grant and awarding two additional planning grants the next year. In state fiscal year (SFY) 2016 two entities would be awarded planning grants. The selected entities would develop children's mental health crisis services to the extent possible within available resources. The entities would also develop a plan for implementation of the full range of children's mental health crisis services in each entity's defined region. The entities' plans would identify the amount of state funds needed to fully implement their plans. The plans would be reported to the Department of Human Services. The Department would combine the information from the two planning grants and provide a recommendation to the Governor and the Legislature during the 2017 session. The Governor and Legislature would consider the funding needs of the first two planning grants and authorize two more planning grants for SFY 2018.

### Next Steps

The subcommittee recommended that the Iowa Legislature appropriate \$300,000 to the Department of Human Services in SFY 2017 for a request for proposals (RFP) for two planning grants for children's mental health crisis services. The subcommittee further recommended that the Legislature direct the Department of Human Services to develop an RFP to award these funds in consultation with the Department of Public Health, Department of Education, and the Iowa Judiciary. The Legislature should direct that the Department of Human Services to issue, direct and manage the RFPs and all work associated with the RFPs.

The RFP should be based on the children's mental health crisis services described in this report and should be awarded to two lead entities. Each lead entity should be a member of a specifically designated coalition of three to four other entities that propose to serve geographically defined areas of the state. (Note: The entity is not intended to be the mental health and disability services regions. The subcommittee recommended not giving MHDS regions the responsibility to serve children.)

The RFP should describe and establish any statewide standard requirements for the children's mental health crisis services defined in this report including, but not limited to:

- Standardized primary care practitioner screen,
- Standardized mental health crisis screen,
- Standardized mental health and substance use disorder assessment, and
- Requirements for some inpatient psychiatric hospitals and psychiatric medical institutions for children to accept and treat all children regardless of the acuity of their condition.

The RFP should require the grantees to develop a plan for children's mental health crisis services for their defined geographic areas that includes the following:

- Identification of the existing children's mental health crisis services in defined area.
- Identification of gaps in children's mental health crisis services in the defined area.
- A plan for collection of data that demonstrates the effects of children's mental health crisis services through the collection of outcome data and surveys of children and their families. (Note: The RFP should encourage seeking foundation support for data collection and analysis efforts)

- A method for using braided funding to support children’s mental health crisis services.
- A plan to use available braided funding to implement children’s mental health crisis services where it is possible to do so without additional funding.
- Use of collaboration processes developed from the recommendation of the Wellbeing subcommittee contained in this report.
- A recommendation to the Governor and the Iowa Legislature for any additional state funding needed to complete a children’s mental health crisis service system in the defined area.

The RFP should require that the plan be submitted to the Department of Human Services by December 15, 2016. The Department will combine the essentials of the plans and present a recommendation to the Governor and the Legislature by January 15, 2017.

As the services in this plan develop over time, the Department of Human Services should recommend the governance of children’s mental health services in consultation with the Department of Public Health, Department of Education, the Judiciary, and the advisory group described below.

### **Additional Study and Reports**

The Legislature should require the Department of Human Services to provide a report including the items listed below by December 15, 2016. The reports should be developed in consultation with the Department of Public Health, the Mental Health and Disability Services Commission and the Mental Health Planning Council.

#### Expanded Telehealth

Evaluate the barriers that exist for providing remote access to critical clinical services including, but not limited to, child psychiatry.

#### Statewide Crisis Line

Inventory all information and referral or crisis mental health telephone lines that exist in Iowa and make a recommendation to the Governor and Legislature regarding what changes should be made to improve effectiveness and access to these services.

#### Fine-tuning Iowa Code

Review existing Iowa Code to determine what code changes are necessary to reflect the recommendations, principles, and services described in this report.

#### Public Awareness Campaign

Development of a public awareness campaign that targets reduction of stigma for individuals with mental illness and supports children and their families in seeking effective treatment. The plan should include potential methods for funding such a campaign.

### **Continuation of an advisory group**

The subcommittee recommends that an advisory group shall be activated at the beginning of 2016, with consideration given to continued service by the Children’s Mental Health Subcommittee members. The advisory group would provide guidance regarding implementation of the recommendations contained in the report, review and comment on subsequent reports to the Governor and Legislature, and continue coordination with the advisory group being recommended by

the Children’s Well-Being Subcommittee. The advisory group should include members of the Department of Human Services, Department of Public Health, Department of Education, the Iowa Judiciary, and key children’s advocates.

## Children’s Well-Being Subcommittee

### Discussion

The need for a defined children’s mental health system is clearly understood. A system designed to support children’s well-being, however, is not clearly defined or understood. According to the Center for Disease Control, (CDC), while there is no clear consensus around a single definition of well-being, most definitions include a combination of factors including:

- The presence of positive moods and emotions
- The absence of negative moods and emotions
- Satisfaction with life

In simple terms, well-being can be described as judging life positively and feeling good. The well-being of a child is based on interrelated life domains: family and social environment, economic circumstances, physical environment and safety, behavior, education, and health. While a child’s mental health is critical to well-being, addressing it alone is not sufficient for youth who experience difficulties in several domains.

Trends for such youth nationally are clearly illustrated by data from multiple sources, including behavior health, child welfare, juvenile justice, education, housing, and food insecurity – such as in Table 1.

**Table 1:**

<b>Number of children living in poverty</b>	<b>15,686,000</b>
<b>% of children living in poverty</b>	22%
<b>High School Dropout Rate</b>	3.3%
<b>Teens 16 to 19 not in school and not High School Graduates</b>	690,000
<b>% of Teens 16 to 19 not in school and not High School Graduates</b>	4%
<b>Youth residing in Juvenile Detention, Correctional and/or Residential Facilities</b>	54,148 or 173 per 100,000
<b>Youth who are victims of abuse/neglect each year</b>	9.1 per 1,000
<b>Youth in foster care (under age 18)</b>	5.5 per 1,000
<b>Teen births age 15-19</b>	273,105
	26 per 1,000

Trends for such youth in Iowa are clearly illustrated by data from multiple sources, including behavior health, child welfare, juvenile justice, education, housing, and food insecurity – such as in Table 2.

**Table 2:**

Many youth in Iowa are not reaching a successful adulthood		
100,000 youth live in poverty (<\$22K for a family of 4)	and	Youth in poverty are 2x more likely to drop out of school and 7x more likely to be abused or neglected
30,000 youth age 16-19 have dropped out	and	Dropouts are 3.5 times more likely to be arrested as an adult
20,000 youth are arrested each year	and	50-70% of youth sent to juvenile corrections recidivate within 2 years
15,000 youth are victims of abuse and neglect each year	and	40% of youth in the child welfare system do not finish HS by age 19
10,000 youth are in foster care	and	45% of youth who leave foster care become homeless within a year
5,000 youth age 15-19 become mothers each year	and	Only 51% of teen mothers earn a high school diploma by age 22

The Children’s Well-Being Subcommittee (the subcommittee) examined elements necessary to building a system that promotes overall child well-being, and the gaps that currently exist. The subcommittee also examined elements of infrastructure and funding and how they can create barriers to addressing children and family well-being goals across systems.

**Social Service systems are child centered and problem focused.**

The current system approaches children and their families from a punitive perspective as opposed to a resource or support perspective. The subcommittee agreed this misses the very important inclusion of the context of community and family support, as well as the critical element of a strength based approach. Strong children are the result of strong communities supporting families to be strong protectors, educators, and advocates for their children.

**Funding and infrastructure barriers prevent collaboration.**

Every system responds to their independent funding sources and strings, performance measures, documentation, and outcomes expectations. These structural barriers are very insular and while cross-system collaboration as a process is valued, it remains a difficult and somewhat counterintuitive task for agencies to embrace as a foundational premise necessary for family success. In reality, all families are complex and all families have strengths. They may, at some time, access multiple systems for support and assistance, and the responding systems must not be a hindrance to growth and development.

**Systems are, by design, placed in the “driver’s seat” when dealing with families.**

Systems are the protectors, the educators, and the treatment experts in social services with the authority and often mandate to intervene in the lives of families. Consequently, the family is asked to navigate multiple systems in “our way”, using “our forms”, and in “our timeframes.” The only commonality between systems is the expectation for compliance.

Each system approaches the family using its own lens or view of the “presenting problem”, with little regard for the complexities of the family situation. Rather than being viewed as experts in their own lives, families are placed in the “back seat” of the case planning process with often more than one “case manager” charged with arranging for and monitoring service provisions and family compliance. The family becomes part of the system functioning, rather than the system focusing on supporting the functioning of the family.

In order to better address the needs of youth with complex needs in ways that help them succeed in all areas of their life, through strong and healthy families and supportive communities – we need to discover and design how cross-systems work can operate.

### **Vision**

The subcommittee envisioned a system where families are understood to be the most knowledgeable entities regarding their strengths and needs. The service system must support the family system in the least restrictive and most community-based way in order to realize successful outcomes. The day-to-day work in this system must exemplify a culture of coordination; working at all levels to eliminate barriers, siloes, and operating procedures built on system needs rather than family needs. When parents and children are driving the delivery system, services must be provided in a culturally competent, fiscally responsible, and aligned way to enhance a family’s opportunity to address concerns and build on existing strengths. The fully functional system recognizes it exists to support and advocate on behalf of strong families rather than blame and shame families into compliance. The information provided in Appendices B and C of this report outlines the roadmap for success of a fully functional system built to maximize child well-being in the future.

### **Operating Elements**

The subcommittee agreed that developing coordinated, cross-systems operating elements that support child and family well-being would rely on a clear Intended Impact and Theory of Change. The subcommittee envisioned that the Intended Impact and Theory of Change will be developed as part of the first year’s implementation plan, in conjunction with learning labs.

However, there are several key elements that must be present and integrated into cross-systems operations for youth and families involved with mental health and at least two other systems (i.e. domestic violence, child welfare, special education, substance abuse, housing, juvenile justice, etc.):

- Data should be integrated and metrics should be public
- A shared commitment and accountability in the form of a memorandum of understanding (MOU) or a charter
- A comprehensive, coordinated and integrated youth and family plan that is culturally responsive and strengths and success-oriented
- A comprehensive assessment informs holistic short and long-term results
- Funding should include a mix of traditional and flexible resources
- Workflow processes and protocols for cross-systems work should be outcomes-driven, clearly documented, and followed
- A lead, cross-systems team coordinator is identified, as determined by a priority system and the family. The team lead can change over time to meet the needs of the child and family
- The team has common, joint training, as determined by families’ goals, on how to collaborate with shared responsibility for results
- The cross-system problem-solving process, continuous quality improvement (CQI), and oversight functions are clearly defined and owned by all

## Emerging Examples

Collaborative efforts to better address cross-systems barriers for youth with complex needs are underway across the country, and in several local communities throughout Iowa. These emerging efforts are diverse in their defined scopes, target populations, involved systems, and number and variety of partnerships. The following are examples in Iowa:

- In North Central Iowa, County Social Services Mental Health Region is piloting crisis stabilization for children and families through Francis Lauer Youth Services. Crisis stabilization requires parents to participate in family therapy along with individual therapy for the child with a licensed, clinical therapist. Parents must agree to participate in the therapy weekly with the therapist, and in weekly meetings with the in-home provider that will provide the aftercare beyond discharge. The therapy addresses family dynamics, trauma and the mental health concerns of the child and parents. The in-home counselor provides skill counseling to address parenting issues and family guidelines. The region hopes to extend this across the region in 2016 by braiding the funding and services currently provided by child welfare agencies and Decategorization Boards.
- In Des Moines, Blank Children's Hospital in partnership with Visiting Nurse Services of Iowa is piloting a multidisciplinary model of care in pediatric primary care that prioritizes the prevention, early identification, and early intervention of social, emotional, behavioral, and developmental conditions. The model also incorporates on-site support and assistance for families on social determinants of health integrating the aspects of life that affect the health outcomes of children and thus their ability to succeed as adults.
- In Cedar Rapids, Four Oaks is leading TotalChild – designed to coordinate services and supports, including housing, so that youth achieve and maintain stability until age 18.
- The Iowa Department of Public Health's 1st Five initiative builds partnerships between physician practiced and public service providers to enhance high quality well-child care. 1st Five promotes the use of developmental tools that support health mental development for young children during the first five years. By using a standardized and validated screening tool for all children that includes social and emotional development and family risk factors, providers are able to identify children at risk for developmental concerns that, if left untreated, would play out later in life.

Emerging, collaborative efforts to address well-being for youth and their families can be further encouraged by creating a structured learning network to deepen and expand this work. The intent would be to engage in a year-long, multi-site learning process to better understand what is beneficial and how best to implement and operate across systems for child well-being.

## Children's Well-Being Subcommittee Recommendations

The subcommittee is proposing three recommendations for action by the Legislature during the 2016 Session. These recommendations are based on the need for a staged approach to defining, testing, and implementing the Children's Well-Being Committee's multi-year strategy.

### 1. Learning Labs

The subcommittee recommended that a year-long learning network shall be designed to have impacts at several different levels (family, process and learning outcomes). The learning network shall be comprised of:

- Three to five learning labs, including 200-250 cases in aggregate
- Include both urban and rural projects to ensure better cross learning.
- Target population must include mental health and at least two systems: public health, education, justice system, human services

## 2. Advisory Group

The subcommittee recommended that an advisory group shall be activated at the beginning of 2016, with consideration given to continued service by the Children's Well-Being Subcommittee members. This group would be responsible to:

- Prepare for and manage learning labs:
  - Assure commitment to joint learning and comparisons for all sites
  - Assure solicitation process includes sufficient criteria are in place: family-focused, culture and science of coordination; superordinate goal
  - Utilizes metrics and public reports
- Continue the Workgroup's efforts to evaluate results and make recommendations for 2017 and beyond
- Includes: Human Services, Public Health, Education, and the Judiciary
- Continue to coordinate with the Children's Mental Health Subcommittee until the future children's system structure is established.

## 3. Investment

The subcommittee recommended that learning networks be supported through incentive funding, engagement and recognition. Specifically, the subcommittee recommended the Iowa Legislature appropriate \$300,000 to support the year-long Children's Well-Being Learning Labs. The advisory group shall define parameters for use of funds, in conjunction with preparation of the work plan and solicitation process, during the spring of 2016.

At the end of 2016, lessons learned, suggested design refinements (including a theory of change and intended impact), and implications for further work needed (including funding, policy, and practice) will be summarized and shared. Those results could then be used to determine recommendations for the next stage.

## **Conclusion**

The Iowa General Assembly charged the Department of Human Services in cooperation with the Departments of Education and Public Health with the substantial challenge to develop recommendations on children's mental health and well-being in Iowa. In response to the charge, the Children's Mental Health and Well-being Workgroup was formed with key stakeholders representing a wide array of children and family perspectives.

The Children's Mental Health Subcommittee identified and defined starting points and next steps for implementing a children's mental health system consistent with its legislative charge. Children's crisis services have been developed in other parts of the country; the subcommittee intends to learn from others' successes and phase-in an array of services in Iowa. This is a large undertaking, and therefore the workgroup has recommended a process by which services can be developed and implemented in a way that is manageable and sustainable. The Children's Well-Being Subcommittee has worked to identify starting points for improving systems in Iowa that support children and families that are involved across multiple systems. There are already areas in Iowa where excellent, coordinated support is taking place, and the workgroup believes it is best to learn from these examples and expand on them. While the subcommittees worked separately in order to address the charge, the subcommittees' recommendations complement each other and are intended, when combined, to lay the foundation for building a unified Children's Mental Health and Well-being System over the next several years. The Workgroup did not answer all of the questions related to children's mental health and well-being. Therefore, it is recommended that a sustaining effort be continued on these important issues.

## **Appendix A: Expanded Definitions of Selected Children's Mental Health Services**

### Crisis intervention and stabilization

A crisis is when a child's safe baseline level of functioning is disrupted and the child or the child's family, school, or community is lacking the immediate internal and external resources to return the child to a safe baseline of functioning. Children's mental health crisis response services are intensive face-to-face, short-term mental health services initiated during a crisis to help the child/youth return to their baseline level of functioning. Children's crisis response services must be provided by a crisis response team outside of urgent care, inpatient or outpatient hospital settings.

Children's mental health crisis response services are intensive face-to-face, short-term mental health services initiated during a crisis to help the child/youth return to their baseline level of functioning. Children's crisis response services must be provided by a crisis response team outside of urgent care, inpatient or outpatient hospital settings.

Crisis response providers must be experienced in mental health assessment, crisis intervention techniques, have emergency clinical decision-making abilities and knowledge of local services and resources.

### *Crisis Screening*

Prior to doing crisis assessment conduct a screening of the potential crisis situation. The screening must:

- Gather information using a standard screening guide;
- Use the screening guide to determine whether a crisis situation exists;
- Identify the parties involved; and
- Implement an appropriate response whether or not a crisis response is needed.

Crisis screening must be available 24 hours a day 7 days a week and may be done over the telephone

A single statewide crisis telephone line should be available.

### *Crisis Assessment*

A standardized crisis assessment is an immediate, face-to-face evaluation by a physician, mental health professional or practitioner, to determine the recipient's presenting situation across all life domains, and identifying any immediate need for emergency services.

- Provide immediate intervention to provide relief of distress based on a determination that the child's mental health or behavior is a serious deviation from his/her baseline level of functioning;
- Evaluate in a culturally appropriate way and as time permits the child's:
  - Current life situation and sources of stress;
  - Symptoms, risk behaviors, mental health problems, and underlying co-occurring conditions;
  - Strengths and vulnerabilities;
  - Cultural considerations;
  - Support network;
  - Physical health; and
  - Functioning.



Conduct the crisis assessment anywhere that the individual and clinician determine is safe and appropriate including, but not limited to, the recipient's home, the home of a family member, school, or another community location. Determine the need for crisis intervention services or referrals to other resources based on the assessment.

### *Crisis Intervention*

Crisis interventions are face-to-face, short-term intensive mental health services started during a mental health crisis or emergency to help the recipient:

- Cope with immediate stressors and lessen his/her suffering;
- Identify and use available resources and recipient's strengths;
- Avoid unnecessary hospitalization and loss of independent living;
- Include a family team meeting;
- Develop action plans including providing needed short term support and/or treatment outside the family home; and
- Begin to return to his/her baseline level of functioning.

Crisis intervention services must be:

- Available 24 hours per day, seven days per week, 365 days per year;
- Provided on-site by a mobile team in a community setting;
- Culturally appropriate; and
- Provided promptly.

### *Crisis Stabilization*

Crisis stabilization services are mental health services provided to a recipient after crisis intervention to help the recipient obtain his/her functional level as it was before the crisis. Provide stabilization services in the community, based on the crisis assessment and crisis plan.

Consider the need for further assessment and referrals. Update the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with the school and other service providers in the community. A transition plan from crisis services is written and implemented that includes a "warm hand-off" to on-going treatment services.

### The Youth ACT

Provides the following services in a comprehensive, coordinated team approach:

- Individual, family, and group psychotherapy
- Individual, family, and group skills training
- Crisis assistance
- Medication management
- Mental health case management
- Medication education
- Care coordination with other care providers
- Psycho-education to, and consultation and coordination with, the recipient's support network (with or without recipient present)
- Clinical consultation to the recipient's employer or school
- Coordination with, or performance of, crisis intervention and stabilization services
- Assessment of recipient's treatment progress and effectiveness of services using outcome measurements
- Transition services
- Integrated dual disorders treatment

- Housing access support

Recipients and/or family members must receive at least three face-to-face contacts per week.

Family Support provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for a child with an SED. For the purposes of this service, "family" is defined as the persons who live with or provide care to a child with an SED, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

This involves:

- Assisting the family in the acquisition of knowledge and skills necessary to understand and address
- The specific needs of the consumer in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the consumer's symptom/behavior management;
- Assisting the family in understanding various requirements of the waiver process, such as the crisis plan and plan of care process;
- Training on the child's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the consumer with mental illness while living in the community.

Family Support is provided by a family member of a child with an SED that has successfully completed Family Support training.

Respite Care provides temporary direct care and supervision for the child with an SED. The primary purpose is relief to families/caregivers of the child. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Normal activities of daily living are considered content of the service when providing respite care, and these include: support in the home/after school/or at night, transportation to and from school/medical appointments/or other community based activities, and/or any combination of the above. Transportation is included as a part of this service.

Respite Care can be provided in a child's home or place of residence or provided in other community settings. Other community settings include: Licensed Family Foster Home, Licensed Group Boarding Home, Licensed Attendant Care Facility, Licensed Emergency Shelter, Out-Of-Home Crisis Stabilization House/Unit/Bed.

Attendant Care provides a child with an SED that would otherwise be placed in a more restrictive setting due to significant functional impairments resulting from an identified mental illness. This service enables the child to accomplish tasks or engage in activities that he/she would normally do him/herself if the child did not have an SED. Assistance is in the form of direct support, supervision and/or cuing so that the child performs the task by him/her self. Such assistance most often relates to performance of Activities for Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in his/her home and community. The majority of these contacts must occur in customary and usual community locations where the child lives, works, attend schools, and/or socializes. Services provided at a work

site must not be job tasks oriented. Services provided in an educational setting must not be educational in purpose. Services furnished to an child that is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with an intellectual disability, or institution for mental disease are not eligible.

Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is part of this service.

Family Resource Home provides short-term and intensive supportive out of home resources for the child with an SED and his/her family without the family needing to give up custody of their child or disrupting the child's school. The intent of this service is to provide out of home support for the family in order to avoid psychiatric inpatient and institutional treatment of the child by responding to potential crisis situations through the utilization of a co-parenting approach provided in surrogate family setting. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the youth, there is regular contact with the family to prepare for the child's return and his/her ongoing needs as part of the family. It is expected that the child, family, the professional resource family, and, with the family's permission, the school are integral members of the child's individual treatment team. Transportation is provided between the child's place of residence and other services sites or places in the community and the cost of transportation is part of this service.

Wraparound Services are intensive, holistic services that engage the family and their children to meet the goals set by the child and family team and to provide flexible support to the child and family. The goal of wraparound services is to ensure the child lives successfully in the family, is successful in school and is a participating member of the community. The services in a wraparound plan, also known as direct support services, differ from traditional mental health services because they:

- Are primarily provided in the homes of families and in settings in the community rather than in an office setting;
- Are available when families need them, including before or after-school, in the evenings or on the weekends instead of only during office hours;
- Emphasize treatment through participation in purposeful activities, giving children the opportunity to practice life skills and make positive choices through involvement in community activities, instead of focusing on treatment through talking about problems; and
- Are built around engaging the child and family in activities that interest them and meet their goals instead of just around a goal of stopping negative behaviors.

## **Appendix B: Framework for Child and Family-Focused Systems**

The following four categories and necessary elements comprise the framework for well-being focused system integration:

### Commitment

- Leadership: lead agency ideal & strong leadership among all
- Shared and articulated definition of wellbeing is advanced in all policies and practices
- Shared articulated values
- Transparency among partners including data, policies, imperatives, and priorities
- Communication: routine and problem-solving protocols
- Efficiencies: compromises and coordination are privileged over paperwork/business rules
- Policy myths, practice myths, & agency/service cultural preferences are on the table to reform

### Clarity

- Pathways for vulnerable families are clearly lit
- Front-line workers and families inform pathway development
- Shared outcomes are agreed upon across service arms/agencies
- Data integration is mapped and undertaken – step by step – with shared data dictionary
- Implementation is mapped, tracked, and measured
- Population of highest concern is well identified across various measurement sources considerate of needs, strengths, assets, and liabilities

### Accountability

- Achievement of outcomes requires mutual dependency of agencies
- Services that maximize FFP are delivered by relevant agency (rational financing)
- Roles of all for each critical element are described and managed
- Tireless pursuit of quality
- 360 degree evaluation of quality

### Service Elements

- Screening/assessment and early identification
- Comprehensive, coordinated care management/Care management
- Health promotion
- Transitional care (hand-offs and on-boards)
- Individual and family support (including governance voice)
- Community based service array: accessible and expert
- Services: right time, right dose, right care
- Re-evaluation of need/strength at regular intervals

## **Appendix C: Children's Well-Being Core Values and Guiding Principles**

The Framework for well-being focused system integration is reinforced by Core Values and Guiding Principles:

### Core Values

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

### Guiding Principles

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes, schools and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.
14. Ensure that data driven decisions are utilized to help determine individual service delivery, system resource allocation, and to ensure substantive outcome measures for change at both the individual and system level. Data should consist of objective and timely sources comprised of objective facts as well as the more informal wisdom rich information gathered from youth, families, and communities.

## **Appendix D: Senate File 505 Division XXII**

The department of human services, in cooperation with the departments of education and public health, shall facilitate a study by a workgroup of stakeholders which shall make recommendations relating to children's mental health. The workgroup shall study incorporating a coordinated response in children's mental health services that emphasizes implementation of mental health issues across the various systems that serve children, taking into account the effects of mental health, child welfare, and child welfare systems and services, and that specifically addresses the effects of adverse childhood experiences and child poverty. The workgroup shall create interdepartmental awareness of issues relating to children's mental health. The workgroup shall develop interdepartmental strategies for helping improve children's mental health and shall develop strategies to promote community partnerships to help address issues of children's mental health. In carrying out its charge, the workgroup shall review a 2014 report by the children's defense fund on the state of America's children containing the most recent and reliable national and state-by-state data on many complex issues affecting children's health, including data on more than 7,000 homeless public school students in Iowa. The workgroup shall submit a report on the study with recommendations, including but not limited to recommendations relating to the creation and implementation of a children's mental health crisis response system to aid parents and other custodians in dealing with children experiencing a mental health crisis. The workgroup shall submit its report to the governor and the general assembly on or before December 15, 2015.

## Appendix E

### References and Acknowledgements

- 1) United States. Iowa Department of Human Services. Division of Mental Health and Disability Services. *Children's Disability Services Workgroup Final Report*. Des Moines, IA: Iowa Department of Human Services, 2013. Print.
- 2) *Statewide Call for Action: A Strategic Plan for a Children's Mental Health Redesign in Iowa*. Rep. no. 1. Vol. 1. Des Moines, IA: Coalition for a Children's Mental Health Redesign in Iowa, 2015. Print.
- 3) United States. Minnesota Department of Human Services. Mental Health Services. *Children's Mental Health Crisis Response Services*. Minnesota Department of Human Services, 23 Feb. 2015. Web.  
<[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_058041](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058041)>.
- 4) Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health, & National Council for Community Behavioral Healthcare (2012). *Youth Mental Health First Aid USA for Adults Assisting Young People*. Mental Health Association of Maryland, Inc.: Lutherville, MD
- 5) "Children in Poverty (100 Percent Poverty)." [Http://datacenter.kidscount.org/](http://datacenter.kidscount.org/). The Annie E. Casey Foundation, 2015. Web. 2015.
- 6) Stetser, Marie C., and Robert Stillwell. "Public High School Four-Year On-Time Graduation Rates and Event Dropout Rates: School Years 2010–11 and 2011–12." *Public High School Four-Year On-Time Graduation Rates and Event Dropout Rates: School Years 2010-11 and 2011-12*(2014): n. pag. *Nces.ed.gov*. United State Department of Educations, 2014. Web. Dec. 2015.
- 7) "Teens Ages 16 To 19 Not In School And Not High School Graduates." [Http://datacenter.kidscount.org/](http://datacenter.kidscount.org/). The Annie E. Casey Foundation, 2015. Web. Dec. 2015.
- 8) "Youth Residing In Juvenile Detention, Correctional And/Or Residential Facilities." [Http://datacenter.kidscount.org/](http://datacenter.kidscount.org/). The Annie E. Casey Foundation, 2015. Web. Dec. 2015. <<http://datacenter.kidscount.org/data/tables/42-youth-residing-in-juvenile-detention-correctional-and-or-residential-facilities#detailed/1/any/false/36,867,133,18,17/any/319,17599>>.
- 9) Heisler, Kurt, PhD. "Child Maltreatment." *United State Department of Health and Human Services* (2013): n. pag. *Www.acf.hhs.gov/*. Department of Health and Human Services, 2013. Web. Dec. 2015. <<https://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf>>.
- 10) "Foster Care." *Child Trends*. Child Trends Data Bank, 31 Dec. 2014. Web. Dec. 2015. <<http://www.childtrends.org/?indicators=foster-care>>.



- 11) "Teen Births By Age Group." [Http://datacenter.kidscount.org/](http://datacenter.kidscount.org/). The Annie E. Casey Foundation, 2015. Web. Dec. 2015. <<http://datacenter.kidscount.org/data/tables/8125-teen-births-by-age-group#detailed/1/any/false/36/8/15589,15590>>.
- 12) "Children in Iowa." *Children in Iowa*. Children's Defense Fund, Nov. 2008. Web. Sept. 2015. <<http://www.childrensdefense.org/library/data/state-data-repository/cits/children-in-the-states-2008-iowa.pdf>>.
- 13) Kost, K., Henshaw, S., & Carlin, L. (2010). U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity, Guttmacher Institute, January 2010.
- 14) Brooks-Gunn, J., Future of Children, Children and Poverty, Vol 7 No 2, 1997.
- 15) National High School Center at AIR, High School Dropout: A quick Stats Fact Sheet, September 2007.
- 16) Center for Juvenile Justice Reform, Supporting Youth in Transition to Adulthood: Lessons Learned from Child Welfare and Juvenile Justice, April 2009
- 17) Mendel, Richard A., Less Cost, More Safety: Guiding lights for Reform in Juvenile Justice, American Youth Policy Forum.
- 18) Perper, Kate, MPP, Kristen Peterson, BA, and Jennifer Manlove, PhD. "Diploma Attainment Among Teen Mothers." *Diploma Attainment Among Teen Mothers*. Child Trends, Jan. 2010. Web. Sept. 2015. [http://www.childtrends.org/wp-content/uploads/2010/01/child\\_trends-2010\\_01\\_22\\_FS\\_diplomaattainment.pdf](http://www.childtrends.org/wp-content/uploads/2010/01/child_trends-2010_01_22_FS_diplomaattainment.pdf).
- 19) "A Critical Look at Foster Care: Foster Care Outcomes." *A Critical Look at Foster Care: Foster Care Outcomes*. Lifting the Veil, 16 May 2010. Web. Sept. 2015. <<http://www.liftingtheveil.org/foster14.htm>>.

## **Appendix F: Children's Mental Health and Well-Being Workgroup**

### **Children's Mental Health Subcommittee**

Lynn Bopes	MHDS Region CEO, Eastern Iowa MHDS
Sarah Brown	Iowa Department of Education
Susan Christensen	District Associate Judge, Fourth Judicial District
Wayne Clinton	County Supervisor, Story County
Erin Drinnin,	United Ways of Iowa
Jerry Foxhoven, Chair	Drake University Law School
Scott Hobart	Chief Juvenile Court Officer, Scott County
Marcus Johnson-Miller	Iowa Department of Public Health
Vickie Miene	The University of Iowa
Krista Moellers	Youth Member
Tammy Nyden	Coalition for a Children's Mental Health Redesign in Iowa
Kim Scorza, Director	Seasons Community Mental Health Center
Rick Shults	DHS, Mental Health and Disability Services
Renee Speh	Coalition for a Children's Mental Health Redesign in Iowa

### **Children's Well-Being Subcommittee**

Gail Barber	Iowa Courts
Anne Gruenewald, Chair	Director, Four Oaks
Phyllis Hansell	Council on Human Services
Bob Lincoln	MHDS Region CEO, County Social Services
Wendy Rickman	DHS, Adult, Child, and Family Services
David Tilly	Iowa Department of Education
Michele Tilotta	Iowa Department of Public Health
Shanell Wagler	Early Childhood Iowa

### **Legislative Members**

Representative David Heaton  
Senator Liz Mathis  
Senator Mark Segebart  
Representative Art Staed

### **Casey Family Programs**

Rebecca Jones Gaston  
Kali Scolnick  
Nadia Sexton  
Page Walley