Iowa Family First – Video Transcript

James: Good evening or good afternoon for you.

Welcome, I want to thank everyone for the opportunity to present some information this afternoon.

How this all started was every year the National

Association of the State Head Injury Administrators puts on an annual symposium in the fall, it's called SOS, State of the States.

NASH is an organization that supports lead state agencies doing work in that space of brain injury and we did a similar presentation last fall.

Michelle reached out to me after the conference and said 'Wow really excited about what I'm hearing, would you be interested in speaking to our neurotrauma folks and our brain injury folks?', and I said sure we would be glad to do that!

So we were hoping in person, but that didn't pan out, so here we are via zoom.

But we're glad to be here so let's get started.

So as Michelle mentioned my name is Jim Pender,

I'm a community health consultant with the Iowa Department of Public Health.

I service the grant manager for the administration for community livings traumatic brain injury state partnership program.

Iowa is 1 of 4, sorry 1 of 28 states that receives funding from ACL.

And you heard me say 4 because in the back of my mind we just learned today there is funding that is going to be available for 4 additional states.

So if you have interest in funding for traumatic brain injury work that is going to be a possibility.

But I'm excited to have with me today Janee Harvey, who's division administrator of adult children and Family Services at the Iowa department of Human Services and June Klein-Bacon, who is a special projects manager at the Brain Injury Alliance of Iowa and we're pleased to be with you.

June is going to be advancing our slides, I see that she's here.

June if you could move us to the next slide.

Just a couple of quick disclosures, I wanted to just make you aware of one thing. I, for a couple of decades, was a licensed foster adoptive parent, adopted 5 special needs children, but my license did lapse a few years ago and I haven't renewed it so I just wanted to make you aware of that.

Next slide.

So a little bit about our objectives this afternoon.

June will share some research related to the intersection of brain injury and multi occurring conditions which are often found in the child welfare system.

Janee will be discussing Iowa's creative approach to child welfare with the Family First program and how it's producing improved outcomes for children and youth in Iowa, really excited for her to share that with you.

I'll share a little bit about the pilot project that we are proposing in Iowa, we're kind of in the last stages of getting that ready, working through some contractual things related to protected health information but hopefully right around the corner we'll get that up and running.

And then June is going to describe the framework, [clears throat] excuse me, and that we're proposing to embed resource facilitation in the pilot.

Next slide June.

Just a couple of things that I wanted to point out about Iowa as we get started kind of related to brain injury.

Services and supports in Iowa are provided to survivors of traumatic and non-traumatic brain injuries.

While we know all brain injuries are acquired, brain injuries some are traumatic, and some are non-traumatic.

In Iowa, child and adult maltreatment syndrome are diagnosable brain injuries in administrative code and many of the numbers provided in that slide that June's showing you with information from the Annie E. Casey Foundation, those would be considered child maltreatment.

Next slide.

So for those of you who ever happen to be on a session with me, you get tired of hearing about Ross Greene, I don't know if he's familiar to you or not, but Ross, Dr. green is a neuropsychologist at Virginia Tech University and I always include this slide because it provides context as to the importance of identifying underlying conditions.

In this case of brain injury, prior to the provision of treatment and services.

Because we know outcomes may be improved when medically necessary accommodations or compensatory strategies are implemented, and in just a minute June will highlight some research that demonstrates how often a brain injury intersects with other conditions that I will note in the next slide.

So as you may know, of the many issues child protective workers address, three seem to stand out.

The first being the need for substance use disorder treatment, the need for mental health behavioral health treatment, and the need for parent skill programming.

So as I mentioned, June is going to share some research that supports how often brain injury intersects with these conditions.

So June I'll let you take it away.

June: Thanks Jim, and I believe that you all will be getting a copy of these slides so don't feel like you have to feverishly jot down some of these stats.

So as Jim indicated, what we're referring to and think about, is really the issue of brain injury as a multi-occurring condition.

As we recognize brain injury rarely happens in a vacuum, right?

So as you likely already recognize, and many of you on this call of course do, there are some areas that intersect when families are involved with the child welfare system.

Substance use disorder is certainly one of these areas, those that misuse substances prior to their brain injury are considerably more likely to return to use.

And we know that approximately 50% of individuals receiving treatment for substance use disorders have previously sustained brain injury.

In addition to that, we know that about 10 to 20% of brain injury survivors develop new onset substance use disorders and new research additionally points to individuals with a history of TBI being at higher risk to die from accidental poisonings such as overdose.

And of course, I do like to make sure that we note here that just by way of mechanism, that brain injury can also occur by overdose in its own right.

So I would share that as we enter into this slide that references to psychiatric disorder statistics combined with brain injury.

There was a study, this one kind of always blows me away, there was a study out in Ohio that found that 72% of individuals that were in dual treatment for substance abuse disorders and had a severe mental illness also reported at least one traumatic brain injury.

The Danish study that s cited on this particular slide recognizes that TBI increases the risk for developing psychiatric disorders and the highest risk does occur within the first year post injury.

I would note here, that while our pilot is working to screen and address adult brain injury at this point, youth that sustained brain injury are also at higher risk for developing post concussive anxiety disorders, as well as post-traumatic depressive symptoms.

So in addition to some of the stats and information about our pilot that we're doing, as you consider the folks and the families that are intertwined with the child welfare system, we also have it in the back of our mind that we're also thinking about the children that may have sustained injury as well.

However, our specific pilot is beginning work around screening adults for lifetime history of brain injury.

So we do find that it's important for screeners to really think about lifetime history, knowing that somebody that has an injury as a youth in the pediatric phase of their life certainly may go down pathways in their life that intersect with substance use disorder, mental health conditions and alike.

So I just pointed out just a couple of stats really for you guys to hear and hopefully for those of you that are more the child welfare work, this starts to paint a picture of the path that may lead down to understanding that undiagnosed or underdiagnosed, or under recognized brain injury in the populations that we might be collectively serving, may impact individuals ability to live, thrive, contribute to their own communities, or support healthy families long term.

And so, when brain injury is underdiagnosed or undiagnosed, this really can result in labeling, mislabeling, or missed opportunities to address underlying physical, cognitive, neurobehavioral implications that brain injury can have.

It can certainly impact safety, in addition to the work or the tasks that may be required of families to complete in the child welfare arena.

Earlier Jim quoted Dr. Greene that our explanation guides our intervention.

So, while we cannot list all of them in this brief presentation, understanding the deficits as a result of brain injury indeed can lead to challenges with people being able to meet the requirements of their treatment or service plans.

So, if indeed we know that there is a cognitive or even neurobehavioral impact that affects a person's ability to attend to things like appointments, processing information, or other components and if we do indeed understand that the explanation should really be the guide as being deficit or brain injury symptom driven.

The team then can think about identifying interventions, that the persons in a person-centered way, to be more effective and potentially our goal is to elicit success within those service plans.

I am going to turn it over to Janee who's going to share some additional information about how Iowa is implementing families first, and then I'll come back in to talk a bit more about our resource facilitation program here in Iowa and how we're applying it in this pilot.

Janee: Thank you June.

And clearly we have some child welfare specialists on this call today so much of this will feel redundant in the sense that it sounds like Hawaii is already far along in their journey in terms of implementing Family First.

Can you go to the next slide June?

So the simple concept that drove the Family First Act, which was federally signed into law in February 2018, is this very simple notion that children do best in families.

In fact, in Iowa our position is children do best in their own families, so whenever that is possible our commitment to keeping children within their own families is evident.

So Family First, as I mentioned, is a federal regulation that really opened up opportunities, new funding opportunities, in order to help fund evidence-based programs that help keep children out of foster care, while also ensuring their safety.

The second provision of Family First is that if the children cannot safely be kept with their parents, we are required to really do an exhaustive search for relatives and fictive kin, and at least in Iowa, we are really organizing a lot of our programs and resources around supporting those relatives and fictive kin after we have located them.

The reason why we are doing that is it's a research-based decision.

We know, and the research is very clear, that when you are able to keep children out of foster care, or even if they're in foster care, if you're able to keep them in their natural support, so with people who already know them, love them, care about them, you're going to get much better outcomes for the children and families.

You're going to have higher rates of reunification, you're going to have less kids in foster care, and foster care removal from one's family is a traumatic experience.

The child welfare unfortunately has a pretty deep history of erring on the side of removing kids from their parents, in the interest of maintaining physical safety, and has been quite agnostic to the social, emotional, and mental safety that children need.

So really there is a harm that is incurred to children whenever they are removed from their families. Iowa is not trying to be a zero-removal state, that is not what I'm telling people, but

we are being much more cautious and thoughtful and really weighing the harm of those removals before we pursue them, and we are making great strides in keeping children within their natural support systems when we are involved in removing them from the primary care of their parents.

Next slide.

So with Family First the new services that are eligible for funding are, they must be evidence based.

So the idea is, if you're working with the most vulnerable families, and you're providing interventions to them, we should be assured that those are interventions that actually work.

So in Iowa we've made a couple of big decisions around new programming as a result of Family

First. We have implemented statewide a program called Safe Care.

Safe Care is an intensive home-based parenting program that is skills based.

This is a program that has been done effectively with parents with lower IQ functioning, even in developmental delays.

It has been proven to work well with parents who are non-reading so illiterate, and it's also been proven to have equal effectiveness with predominantly Native American communities of which we have a number of tribes identified in Iowa.

So Safe Care, those families who received this intensive parenting program, they are known to have a 75% lower rate of returning to the attention of child welfare systems when they graduate from that program.

The other programs that we have implemented in Iowa include solution-based casework and we have implemented a family preservation, it's a really intensive model that has basically daily contact with families, and all of the practitioners of family preservation have been trained in motivational interviewing.

Next slide.

The value of evidence-based programs in the child welfare space is that these programs have a shorter length of service.

In child welfare if you know families, or have ever worked with families who become involved with child welfare, it is sometimes hard to get one case closed.

Many of the families that we serve are nominally stable, they have lots of risk and once we get involved it can feel really, really hard to know when is the appropriate time to close the case.

When we are implementing evidence-based programs there is a kind of strict discipline and a fidelity to these models that help us know what skills are we looking for and the parents are also aware of when they achieve those skills so we're all kind of on the same page and working towards case closure.

I already talked a little bit about the reduction in repeat maltreatment, but any of the child welfare evidence based programs have been demonstrated to produce sustained positive impacts for family, which typically include lowering rates of repeat maltreatment.

Next slide.

So I talked about Safe Care, that's described on the left-hand side of your screen and then the solution based casework, that population is not restricted by age so every family, as long as you have a child under the age of 18.

It is a model of practice that is really flexible, is high on family engagement, it has also been demonstrated to lower rates of child abuse repeat maltreatment and our family preservation which I already mentioned.

Next slide.

So I want to give you an example outside of evidence based programming, how we have implemented the philosophy of Family First.

Really this idea that children don't just need families, and they do need families, but whenever possible we need to keep them with their own families because those relationships matter, connections matter.

Next slide.

So what happened is a lot of my work involves engagement with our judicial branch.

In Iowa, decision making around whether a child is placed in foster care or not really sits with the judges.

So DHS does not actually do the removals because we don't have really that authority.

Judge's order the removal based on evidence that the DHS social worker or County Attorney has presented.

So that's important for you to understand because I was talking with some judges and they were really buying into this idea of removals cause harm, how are we how do we try and avoid them, and what else can we do?

And the judge told me, she said 'you know Janee,

I get a call at 2 in the morning and it's somebody calling saying you know I'm asking you to remove these kids and I'm typically signing off on these requests.

I've never been in the home, I don't know the family and so I have this second hand information and I don't feel like I have any tools in my toolbox to question the request.

So I basically sign off on them even though I want there to be a different way to do the work.'

And this was really key because out of this conversation we came up with four questions that judges could ask anytime they were asked to sign off on a removal.

Go to the next slide please.

So here are the four questions up on the slide in front of you and they're so simple.

This is such a do-it-yourself type of hack that it's shocking how effective it is.

So the very first thing we asked the judges to ask is, what can we do to remove the danger instead of removing the child?

The second question, can someone the child or family knows move into the home temporarily in order to mitigate the danger?

Can the caregiver and child go live with a relative or fictive kin?

Or, could the child move temporarily to live with a relative or fictive kin?

So each one of these questions is predicated on the idea that keeping the family together is critical.

And so we enlisted 7 judges from around the state and I asked them for four months, ask these four questions keep track of the data.

I want to know of the request you received how many did you sign off on and what happened to the kids?

Pretty simple, pretty simple pilot.

So let's see what happens.

Next slide.

So what the data showed us and so I want to draw your attention to the bottom of the screen.

That is the timeframe: December 2019 through March 2020.

That is when the seven judges consistently asked these questions.

And you can see during that time period, there's four months, they received 83 requests and they only approved 44, so a little over half they approved.

And of the kids they agreed for those kids to go into placement, 24 of them they kept with relatives, five of the kids went with fictive kin, so if you add up those percentages

66% stayed with relatives or fictive kin.

34% went with foster parents and none went to shelter.

So that's impressive data but it's more impressive if you look at the time period immediately before them having access to these questions.

So we went to August to November, the exact same judges.

I couldn't find, we didn't have data on how many requests they'd received, I only knew how many they'd granted.

So over those four months they approved 99 requests for removal.

51% of the kids stayed in their natural support, the same percentage went to foster parents, but 13% went to shelter.

So we went from 99 removals down to 44 over the same duration of time.

One period of time they didn't use the questions, the other period of time they did use the questions.

Now this is not an exact science in terms of being a controlled study but it's pretty close.

And the judges feedback we started to get is that when these judges ask the questions of the DHS social workers or other people who were asking for the removals they said wow we can't answer these questions. They started, it started really moving the needle because before people even contacted the judges they started working through these questions so our requests for removals have also gone down in the state.

Next slide.

Jim: I think that's me.

So great information Janee.

I can say that just over the years in my experience as a foster adoptive parent absolutely this is the right approach so I'm so excited that

I was doing this.

I wanted to share a little bit of information with you about what we're thinking about with our pilot and our approach.

Of course our, you know our aim, our goal, our objective however you want to describe it, is to keep families together to reduce out of home placements.

You know if a child or youth is already out of home, to get them back into the home.

And so what we want to do is to have a dedicated Neuro Resource Facilitator and I have what we call that a NRF (Nerf).

And they're really, Neuro-Resource Facilitators are subject matter experts in brain injury, and this will be someone that's with Brain Injury Lines of Iowa, June Klein-Bacon.

And what we're going to do is we're going to work with select individuals who you know, have had a founded or confirmed with high risk assessment, who might consider, want to consider being screened for a lifetime history of brain injury.

To see if it's impacting their ability to be able to address the concerns that maybe led to the involvement in the child welfare system or is presenting a barrier to be able to address the things that they need to do to ensure the safety of their children.

So what we're going to be doing, we are going to start small here, some of the eligibility criteria for the program is you have to have one child under the age of 5, live in one of three counties in eastern Iowa.

I call that the eastern seaboard, a guy can wish, Iowa has a little bit of a seaboard with the Mississippi River.

And then having one or more of the following issues, substance use disorder, mental health/behavioral health concerns, parental skill deficit, or also a survivor of intimate partner violence.

Earlier today on we had a session discussing that relationship between brain injury and intimate partner violence and so we suspect that we'll be seeing that as well.

So those who screen positive, who agree to participate in the program, it'll be voluntary.

If they screen positive then that NRF will provide some recommendations based on some additional assessment, Mayo-Portland Adaptability Inventory, which is an assessment tool that our Medicaid enterprise uses for part of their eligibility review for the home and community-based waiver.

And then what they'll do is that NRF will you know, take that information and put together a kind of recommendation of you know these are some of the types of things that we think, that you're probably going to see. You know, maybe someone is not showing up on time for their appointments, if at all.

You know, maybe you give them a number of tasks to do but they have difficulty completing those tasks.

Well that, you know, maybe a function of a frontal lobe injury.

So with the technical assistance from that NRF we hope we'll be able to work with those frontline workers.

And in Iowa that interdisciplinary team is called a solution focus team.

You know, provide that solution focused team with some guidance to tweak the way you do things so that you can improve those outcomes.

And then, June if you want to go to the next slide.

So the next two slides I'm not going to go through those in detail, you can kind of look at those after the session.

But the next two slides are really kind of the flow chart on how we see this process working in Iowa.

So as we've spent a lot of time, had a lot of meetings with the department, with Brain Injury Alliance of Iowa and ourselves, and to you know kind of put together a protocol for how this will work.

And lastly, June if you go to the next slide.

So this is Iowa's screening tool, all of this really kind of is predicated on having an evidence based screening tool.

So Iowa worked with doctor John Corrigan at the Ohio State University who developed an evidence based screening tool.

This tool is normed for usage for individuals age 13 and up and it is a tool that has good reliability and validity.

We worked with Dr. Corrigan through our Advisory Council on brain injuries to take this tool, modify it for use in Iowa, to recognize some of Iowa's non-traumatic brain injuries and so that tool is the one that we'll be using.

So really that tool asks for four questions.

It asks if an injury caused a loss of consciousness, that's the first question we get at.

And then within that the second question, if there's been repeated impacts to the head, if there's ever been lost consciousness from a drug overdose or being choked, and if an individual's been told by a doctor they have another health condition which could be like a tumor, effects of toxic substances, exposure to drugs and so on.

Again it's not a diagnostic tool it's just a brief screening tool, but anyone who screens positive for that after those questions, if they want to, can be referred onto the Brain Injury Alliance.

June I'll turn it back over to you.

June: Absolutely, so once we complete the brain injury screening process and someone screens positive and of course agrees.

Our pilot will offer the opportunity for families to participate in our NRF program, that Neuro Resource Facilitation program, that Jim was mentioning.

There are some enhanced opportunities in the pilot but in short, we will be completing an intake that includes a risk assessment in addition to evaluation of barriers individuals might be experiencing and in navigating their community, health, behavioral health care.

In addition to that will complete the Mayo-Portland Adaptability Inventory to take a look at what kinds of symptoms they might be experiencing as a result of brain injury.

With that information our facilitator will provide opportunities for families to get feedback, work on strategy development, engage with the solution focus team to provide technical assistance, and to support providers within the service delivery system.

May it, you know, it could be substance use disorder treatment team, mental health provider to gain some information on brain injury and evaluate how their service plan or their treatment plan might be altered, per say, or accommodations might be included to help optimize that Service plan.

So as we mentioned earlier, and we're going to hit on it again, the explanation of the symptoms or the deficits of brain injury are going to continue to guide the interventions that we propose.

The strategy development supports or even the accommodations that a provider might engage with that are needed to support those successful outcomes.

The Neuro Resource Facilitator will support development of those compensatory strategies to address a variety of areas but a few that you know, just around this virtual table if you will, to consider might be building strategies around organization, information processing, or even memory deficits that might create scenarios where they're forgetting to attend court dates, they're losing track of time, they're arriving late or missing appointments altogether.

All of which are skills that really may be required to be successful in the tasks that are being required of them for a service or treatment plan.

We do have a couple of slides here that have just some simple compensatory strategy considerations that we are using.

This first one is on impulsivity.

We have, gosh, I think we have about 13 or 14 of these tips, what we're calling tip sheets, that we have worked to create as a starting point that are loaded on our website, at the Brain Injury Alliance of Iowa website.

And we're actually in the process of creating about 20 more tip sheets that give people just a starting point.

It gives a definition of a skill area that somebody might want to take a look at.

Looking at that definition is.

Looking at if you had a deficit in this area what would you look for?

And then we go into, again starting point not a silver bullet just a starting point, for accommodations to consider.

So in this one here we can think about impulsivity and thinking about maybe someone that is doing or saying things without regard to safety for their family.

So what could we look at in terms of implementation of some strategies?

We could talk about grounding exercises, we could talk about promoting checklists and step by step instructions to help prevent maybe impulsive decisions and to work with providers to understand how to give clear and consistent and sometimes even concrete instructions depending on the person's need.

Another one that we just highlighted here as another example is delayed processing.

So you might have someone that is struggling with missing components of instruction or having difficulty following conversation.

One of the things that I've heard from, just I guess I didn't mention early on, I'm also a current foster and also an adoptive parent here in Iowa.

But hearing some of the parents, families that we’ve worked with, how they go to group and how that can be really challenging to follow conversation, missing some of the instruction, that kind of thing.

So some accommodations that might the team might need to work on is using again, clear and concise language, sometimes concrete language, working with providers and also potentially that adult or that parent with limiting distractions that they can eliminate or limit, providing extra time.

Potentially doing things like providing text messages or phone calls as a reminder for appointments.

Not accepting, and many of you around the table know that, you know, accepting 'uh yeah

I get it' or 'yes I understand' as truth but working with that person to make sure that they understand through two-way communication, mirrored communication, with that person.

So those are just a couple of examples, I think once I pull the screen down I will put into chat the links that you all can find those tip sheets.

I would say that we pulled much of this information from some work that Dr. Corrigan did, as well as some work from Colorado and also the model TBI systems work that they did as well, just to build some very simple starting point sheets, tip sheets that we could that we could share with folks that we're working with.

I do have a slide here that just has all of our contact information, who we are here today.

But also wanted to say thank you for inviting us.

It's always a pleasure to talk about the exciting work that we're doing and what we're implementing, as well as hearing what other states are doing.

So I think, I'm not positive, but I think we might have a little bit of time for questions if there are some.

So I'll go ahead and pull this down and I guess turn it back over to Michelle to see how you want to proceed.

Michelle: Thank you so much, all of you.

What a terrific presentation!

We do have one question, if I can find it.

Lots of kudos also, what an amazing program.

This is great information so thank you so much.

So Kristen is curious, about what types of professionals facilitate these programs?

Is it a multi-disciplinary team?

You might have already answered some of that.

June: So I'm not sure which team that she might be mentioning.

The solution focus team, and Janee might be able to respond to this a little better than myself, but the solution focused team involves multiple disciplines at the table and our Neuro Resource Facilitators, our subject matter experts in brain injury will join that table to provide some technical assistance and support.

But Janee perhaps you want to respond to that as well?

Janee: Yeah, we use a number of different types of conferences woven into our child welfare practice and one of our key meetings is solution focused meetings.

So our approach will be to incorporate those individuals who can support the parents around the TBI, or anybody who might be needed in the room, in order to do some of those

grounding exercises or some of the other accommodations for the parents who have the TBIs in order to remain in those conferences.

That's one of the key places that the multi-disciplinary team all comes together, the service provider, the DHS worker, other people who have significant relationships with the parent.

It's also a key space where we identify and develop what needs, or services do the parents have?

So if we have at that point identified that they have a TBI that would be the place where we would start weaving into some of our differential approaches with them.

Michelle: Thank you.

For everyone that's on here I have your emails so I'll be sending you the PowerPoint, the tip sheets, the mapping that Jim shared.

Jim what is that called?

The process flow

Jim: Yeah.

Michelle: and their contact information.

We have another question, what kinds of reactions are you getting from the parents and foster parents?

Jim: We're not, we haven't gotten to that point yet.

So when we do, we'll, I'll stay in touch with you Michelle.

Michelle: Maybe we can have you back on for an update.

Jim: Yeah.

Michelle: Whenever that

Jim: Right.

Michelle: Have other judges come on board to participate in the work that you folks are doing?

Jim: Not at this time.

We're really going to be starting out with what I would call, Janee correct me if I'm wrong I remember back to my old child protective days, but the voluntary cases.

So these will be individuals who have really not had involvement in the system, the child welfare system, and are not court ordered yet.

I think that's kind of, you don't want to overwhelm the process as you begin so that's where we'll be starting.

But I certainly hope and believe that as we find this to be beneficial that we'll grow.

Janee: Yeah, I just want to add to that.

So by a voluntary case it means they have been reported for abuse and neglect to the department of Human Services.

We have conducted an assessment and at the end of that assessment we do a valid risk assessment tool.

Those families would have been having some type of probably a moderate risk rating for future abuse and neglect, which makes them eligible for services, that does not mean we necessarily are taking court action to oversee their case.

So they have some level of DHS involvement for sure, so there's risk, but just they're not necessary in a courtroom.

I think it's a really great question though, if we see that this pilot is effective and we grow we would definitely get in the room with our county attorneys and judges so they start to get educated on TBIs and how that might have to modify some of the ways that they approach their own work because we are an integrated system.

Michelle: Well I was curious because you know, judges are like everybody else and they're going to discuss their work with one another.

And you saw, you showed us the changes already just from asking them to track right?

Then they started looking at what they were doing, so I was wondering if it affected the system on a larger basis?

But enough about me there's a couple more questions, do you use MOUs in the MDTs?

Sorry I don't know what MDTs are.

Rosemary?

Janee: She probably means multi-disciplinary team, I'm guessing, but Rosemary correct me if I am wrong.

So when we were talking about multi-disciplinary teams in our conferencing spaces all of the people in the room already have signed either confidentiality agreements, or applications for service.

So they, we don't have to have MOUs in the ways that maybe she's thinking about it.

We do have MDTs in the state, outside of the TBI, this pilot project.

Those MDT's we do have MOUs that layout confidentiality agreements, what case consultation looks like.

So yes, MOUs affect our MDT's but this space we're doing the TBI pilot or the project,

MOUs are not required.

Michelle: Rosemary let me know if that was answered or if you need additional follow up on that.

From Violet... Oh thank you, thank you Rosemary.

Violet was asking, 'apologies if I missed this, but are the children also evaluated in case they have sustained a brain injury?'

Jim: Well certainly while our focus you know, on the adult caretakers, if throughout the course of a case that were involved in, or the department worker has concern about that we certainly will absolutely look at that.

I will, well I didn't share it tonight we also have developed a pediatric screening tool that's developed in consultation with Colorado State University that's normed for use in children age 5 to 21.

So we have a similar screening tool available for that as well.

So certainly if that comes into our awareness absolutely we'll look at that.

Michelle: That seems to be it for the questions. [Video Ends]