Commission on Improving the Status of Children

Commission on Improving the Status of Children

DECEMBER 15, 2020

Agenda

1. Welcome and Introductions
2. Consent Agenda
   a. Minutes from October 2020 meeting
   b. Task Force and Committee Appointments

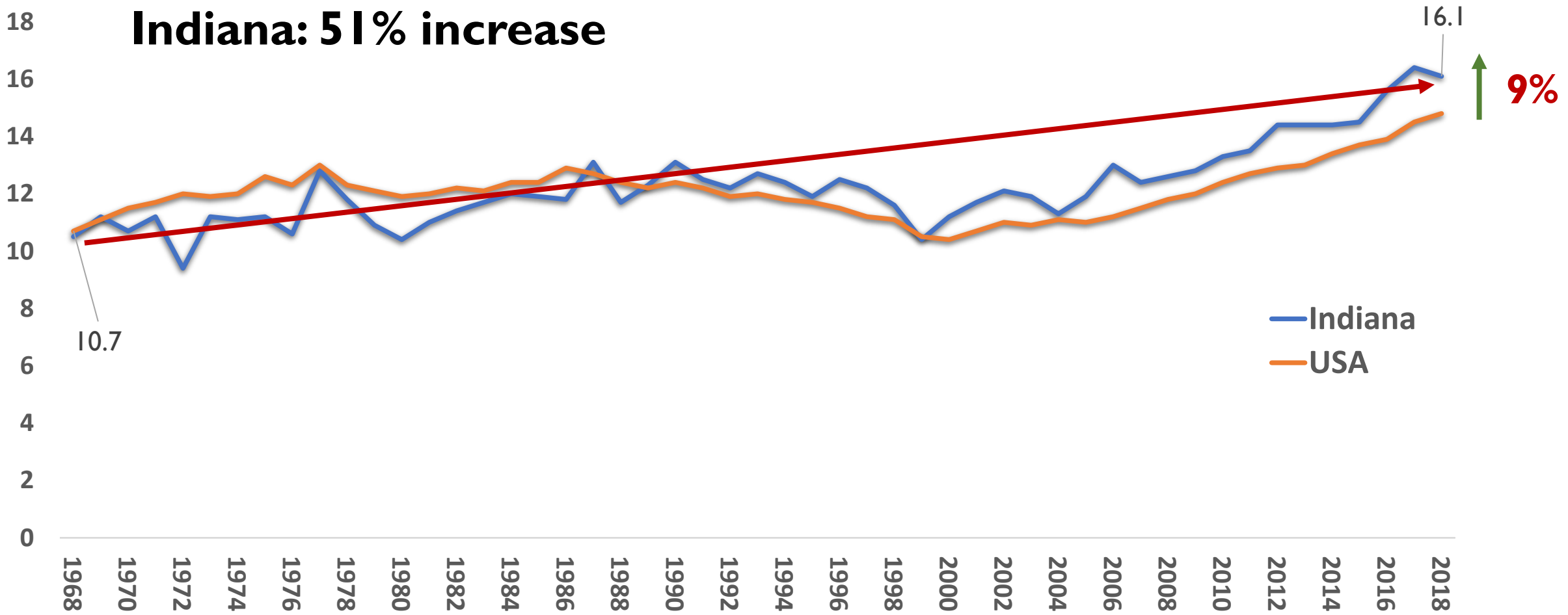
Agenda

3. Mental Health and Substance Abuse
   a) David Berman, Mental Health America of Indiana (MHAI)
      Data pertaining to youth mental health in Indiana

Indiana Youth Mental Health and Suicide Related Data:

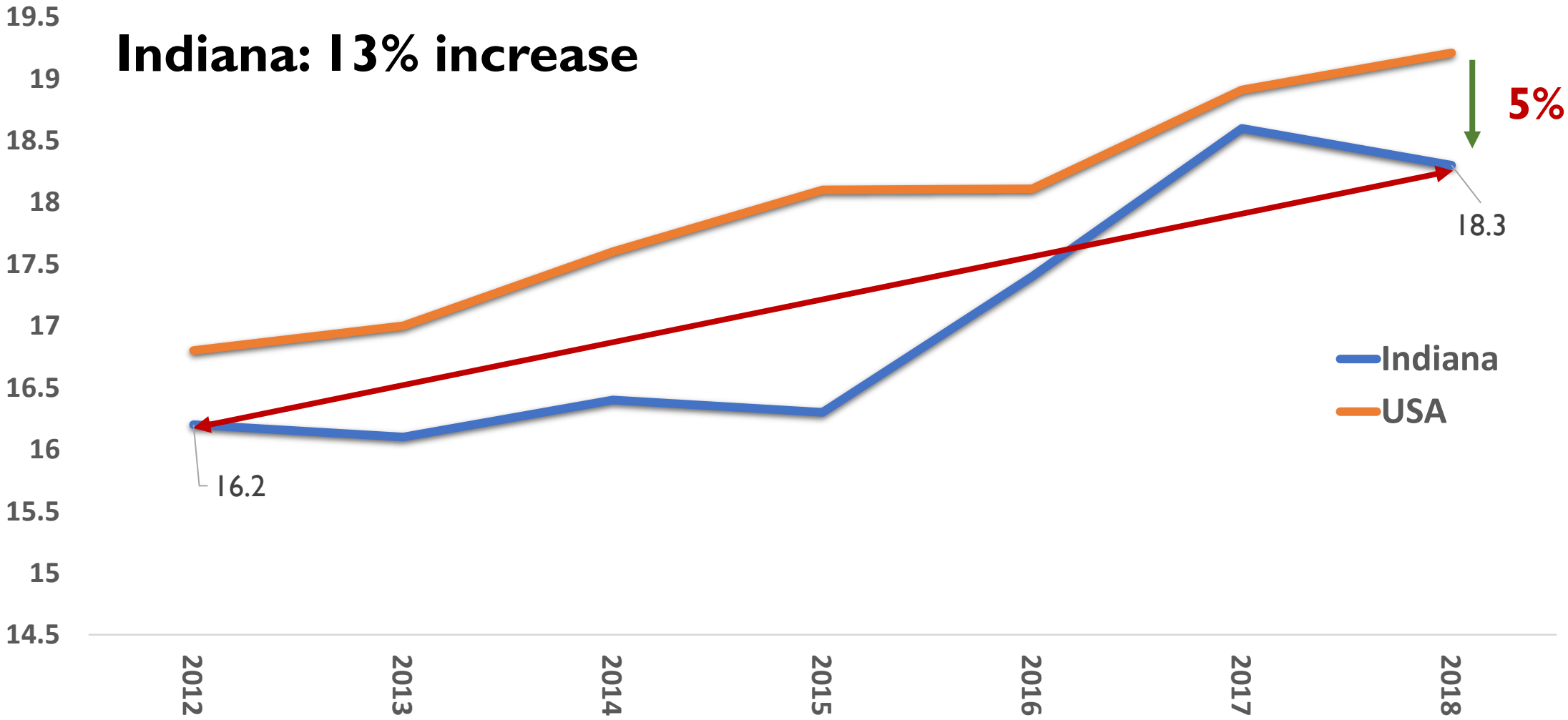
Prepared for the Indiana Commission on the Improvement of the Status of Children
December 15, 2020

Crude Suicide Rates, Indiana and USA, 1968-2018

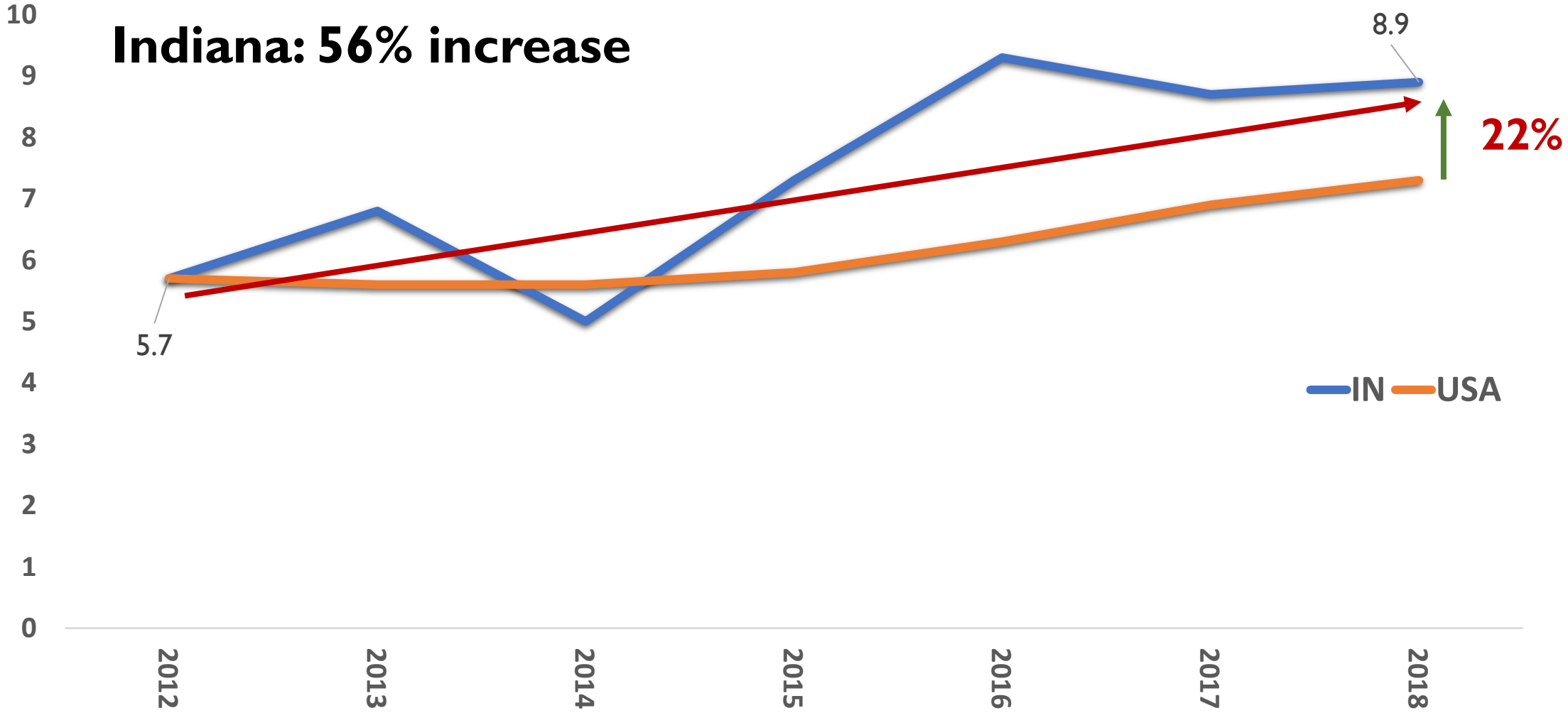


Slide created by CW Drapeau (2020)

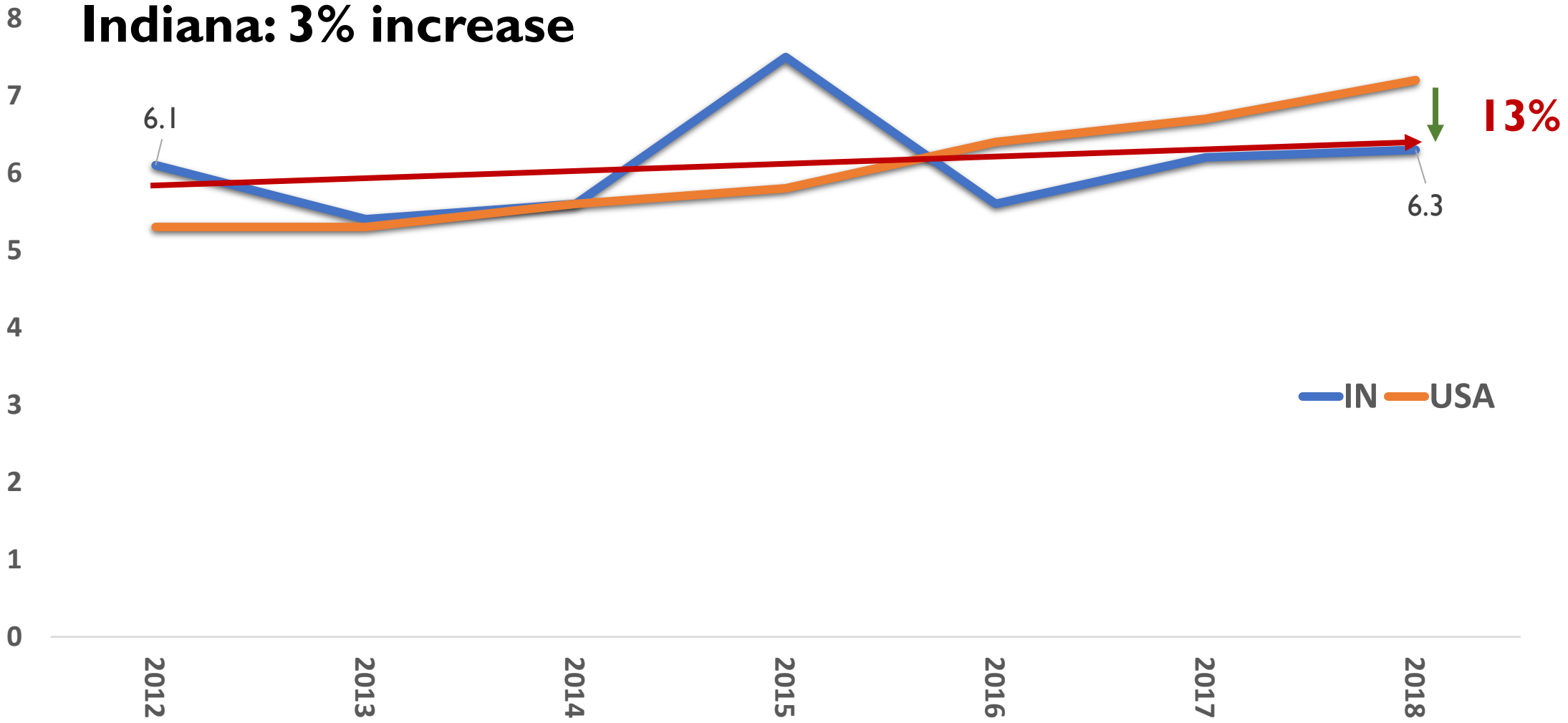
Crude Suicide Rates, White, Indiana and USA, 2012-2018



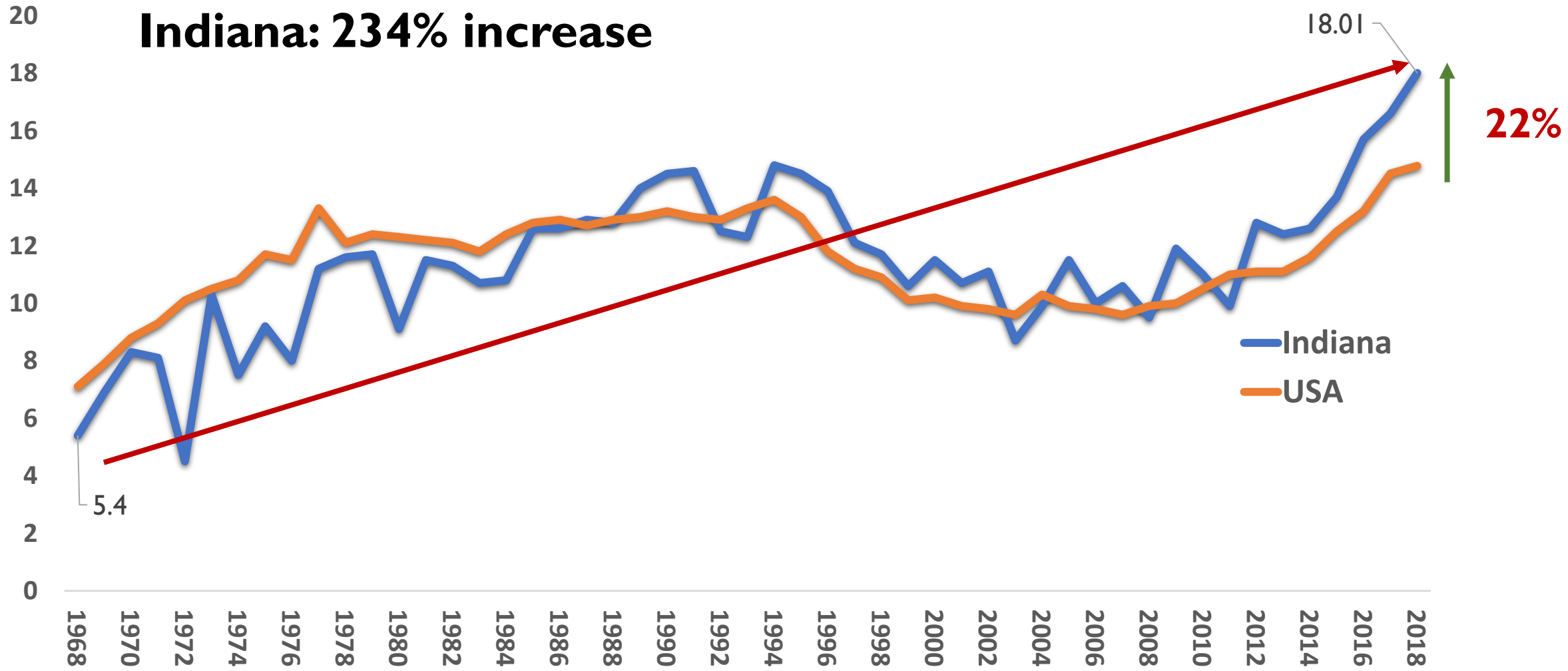
Crude Suicide Rates, Black, Indiana and USA, 2012-2018



Crude Suicide Rates, Hispanic/Latino, Indiana and USA, 2012-2018

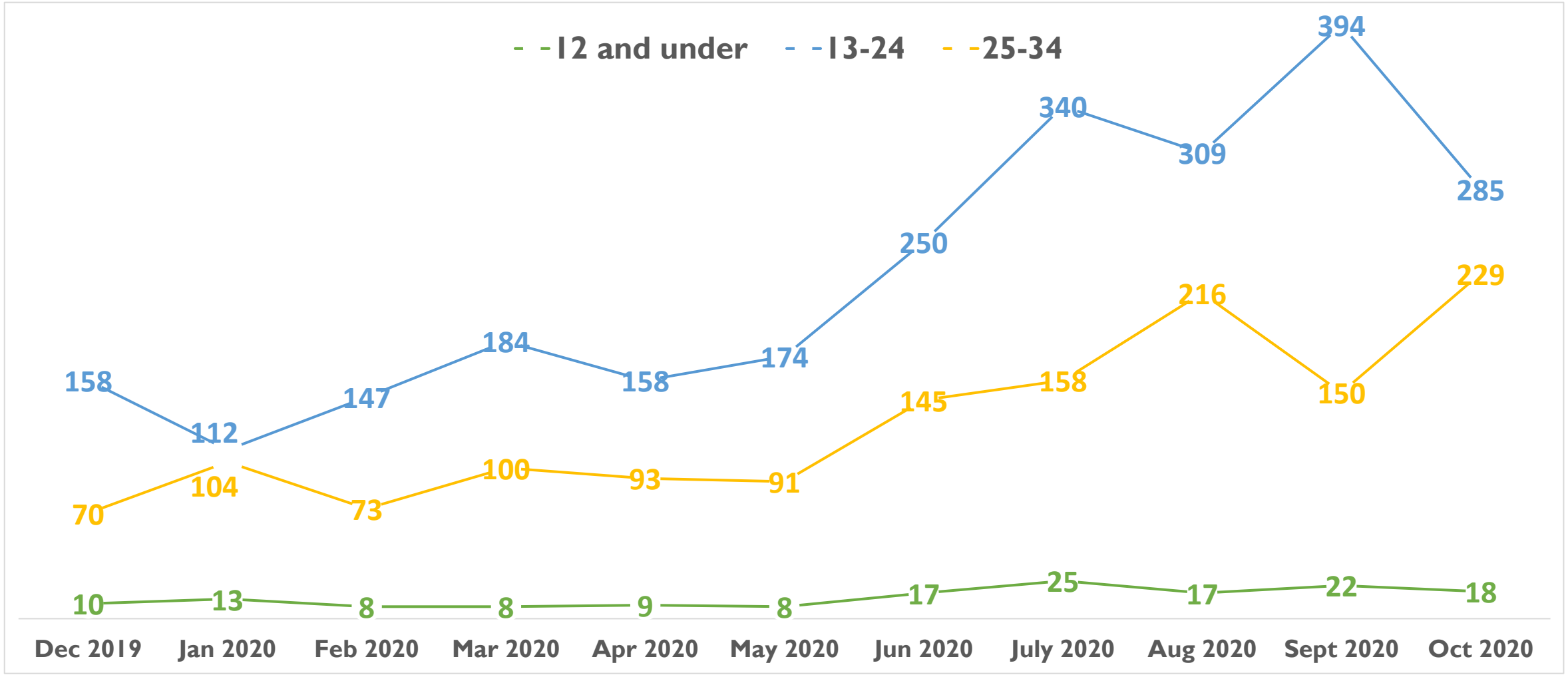


Crude Suicide Rates, 15-24 years, Indiana and USA, 1968-2018



Slide created by CW Drapeau (2020)

Indiana Suicide Hotline Calls by Age Group



Slide created by CW Drapeau (2020)

Indiana Originated Mental Health Screening Data

Mental Health America. (2020) Indiana Screening Data.
Tableau file generated from https://screening.mhanational.org/screening-tools

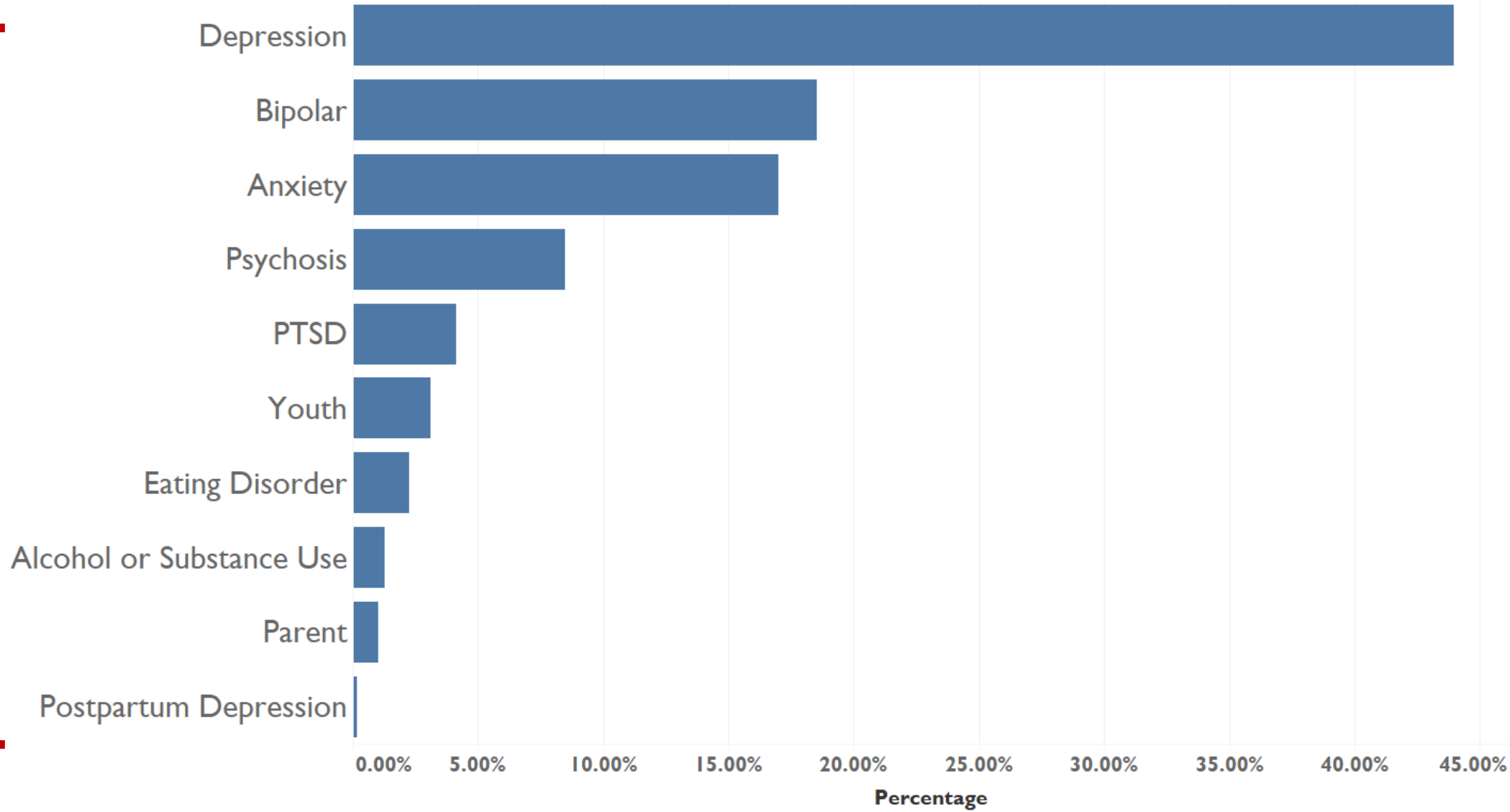
About Mental Health America (MHA) Screening

- Launched in 2014 with the assistance of mental health care professionals and leading researchers across the county
- Most widely used online screening tool in the country
- Anonymous, free, and confidential, and all data is deidentified
- Next steps provide a variety of additional information, including worksheets, tools, and apps, as well as access to peers, and referrals to care and services

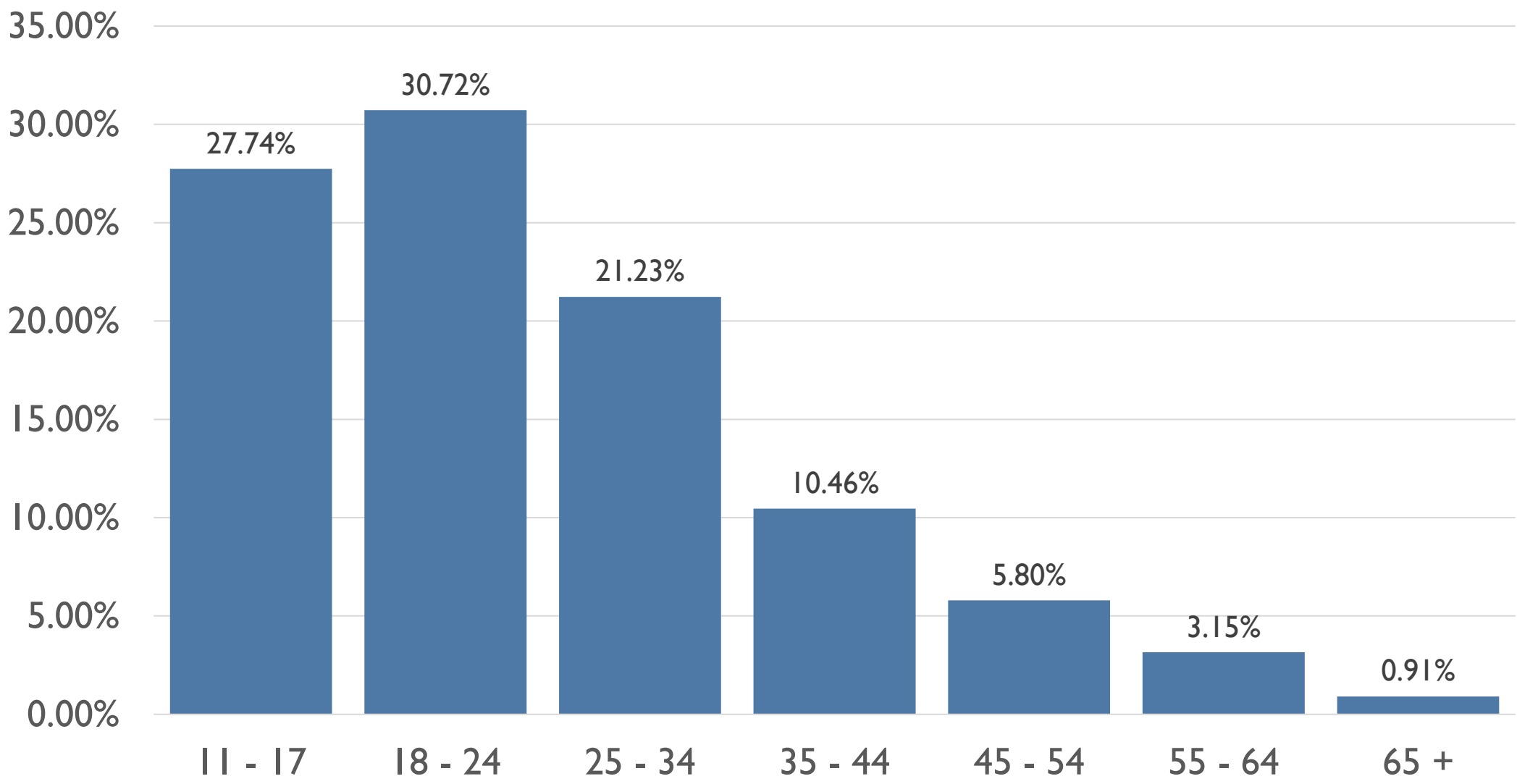
https://screening.mhanational.org/screening-tools

Total Indiana Screenings: Jan 2015 – Nov 2020

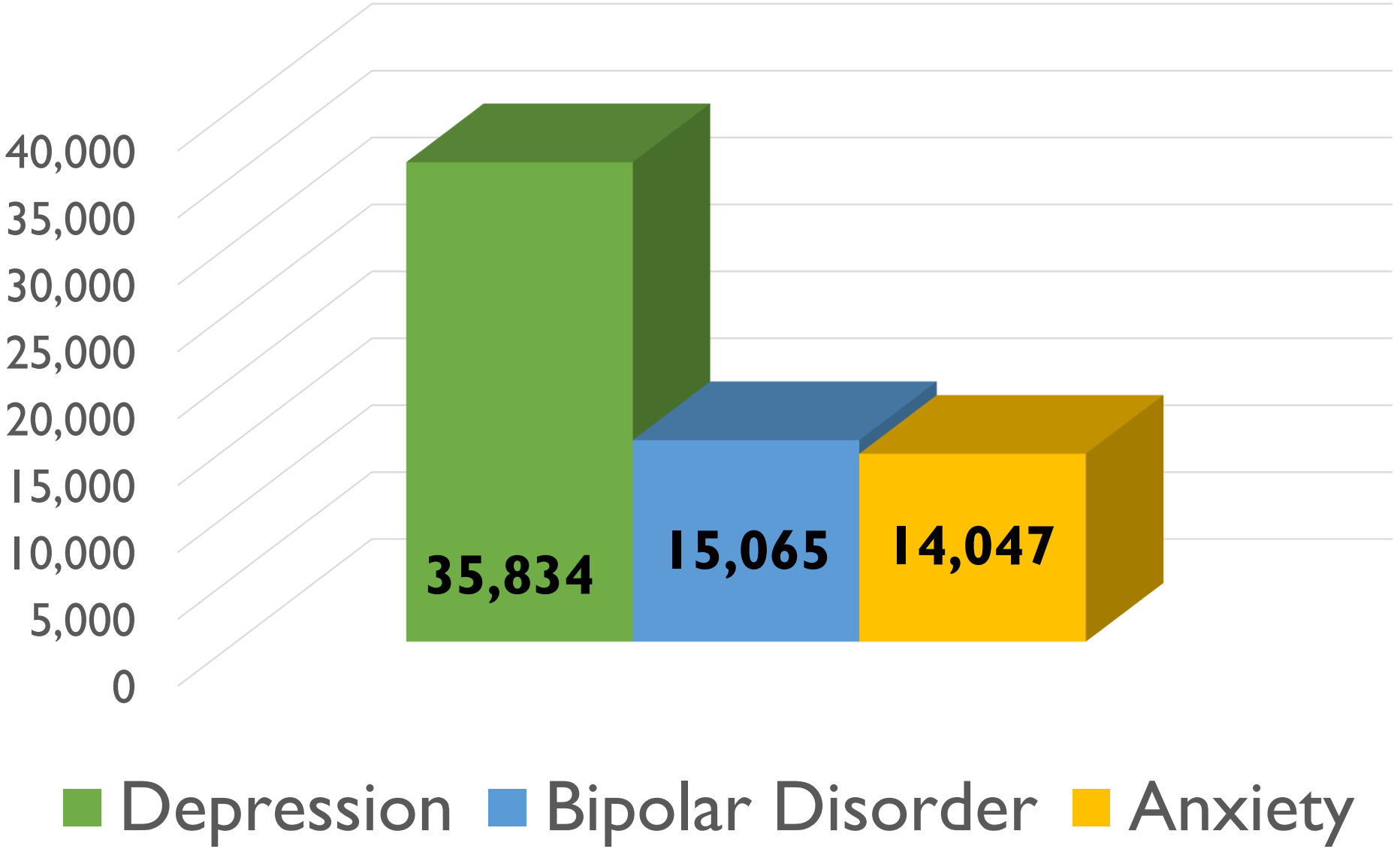
81,755



Age of Individual Completing Screening (2015 - 2020)



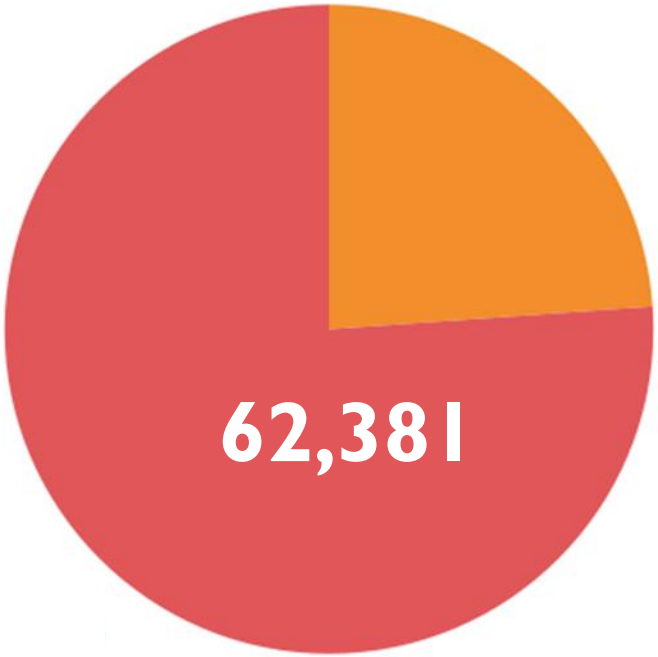
Top Three Screenings (2015 - 2020)



64,946 or **80%** of all screenings

Screen Result Severity (2015 - 2020)

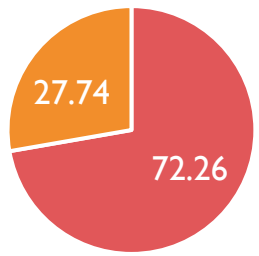
23.88%%
Negative or
Minimal to Mild



76.12%
Positive or
Moderate to Severe

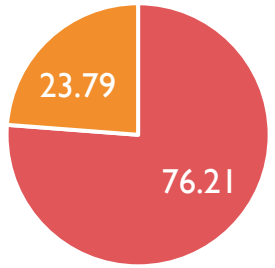
Screen Result Severity By Ethnicity (2015 – 2020)

Black or African American



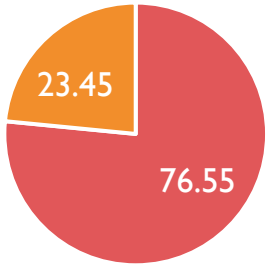
- Positive or Moderate to Severe
- Negative or Minimal to Mild

Hispanic or Latino



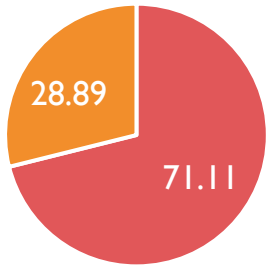
- Positive or Moderate to Severe
- Negative or Minimal to Mild

White



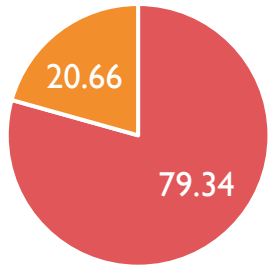
- Positive or Moderate to Severe
- Negative or Minimal to Mild

Asian



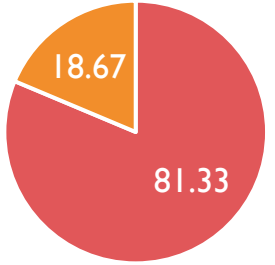
- Positive or Moderate to Severe
- Negative or Minimal to Mild

Multi-racial



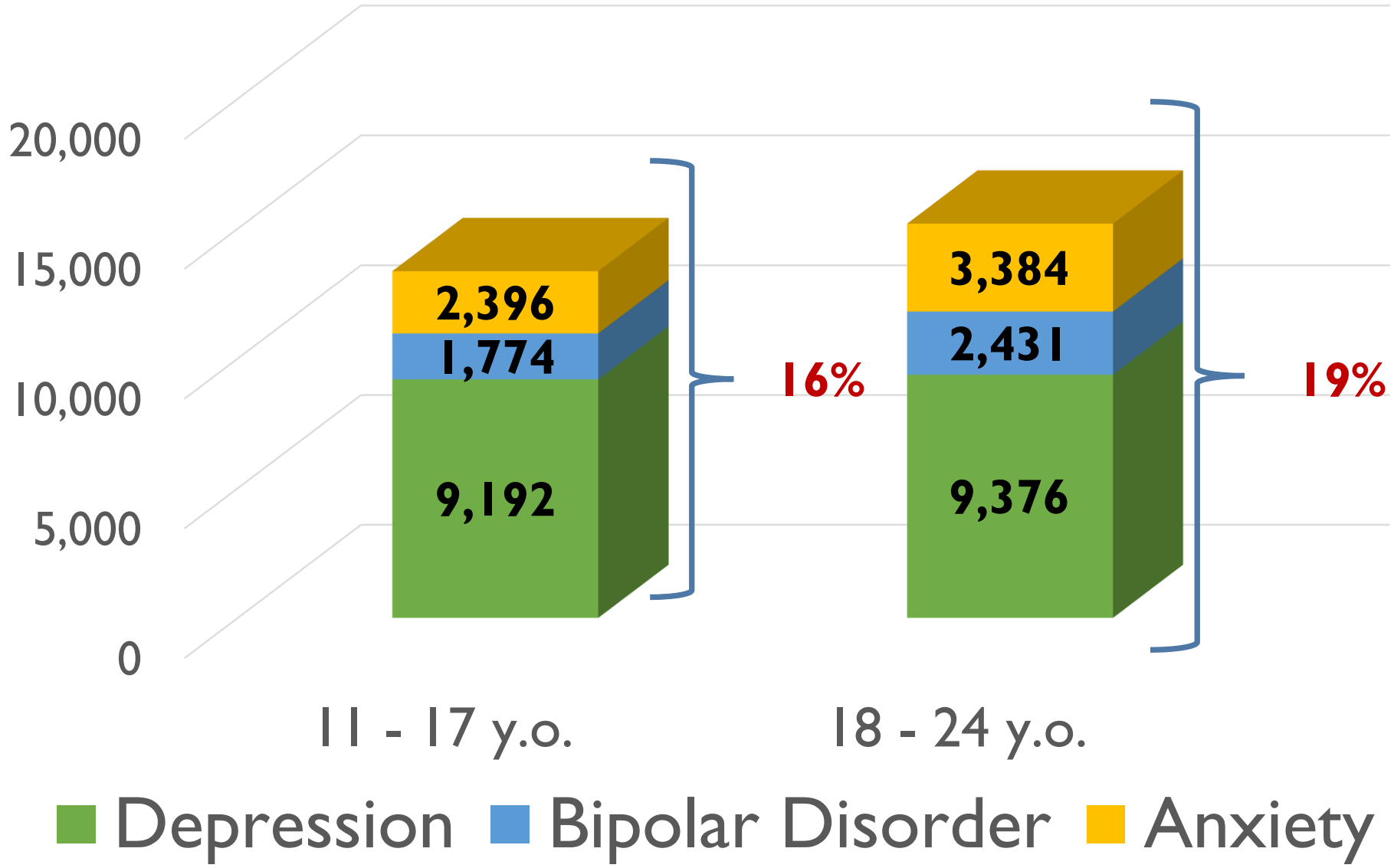
- Positive or Moderate to Severe
- Negative or Minimal to Mild

Native American



- Positive or Moderate to Severe
- Negative or Minimal to Mild

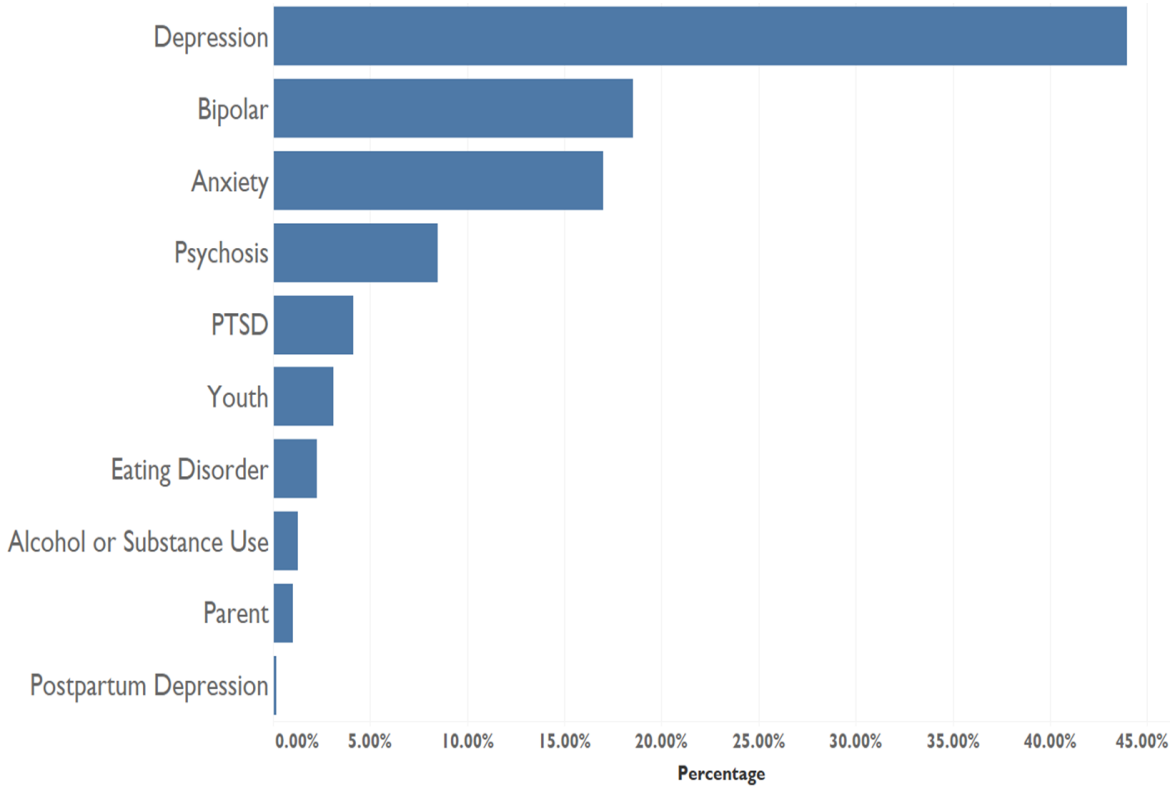
Positive or Moderate to Severe Screening (2015 - 2020)



35% of all screenings

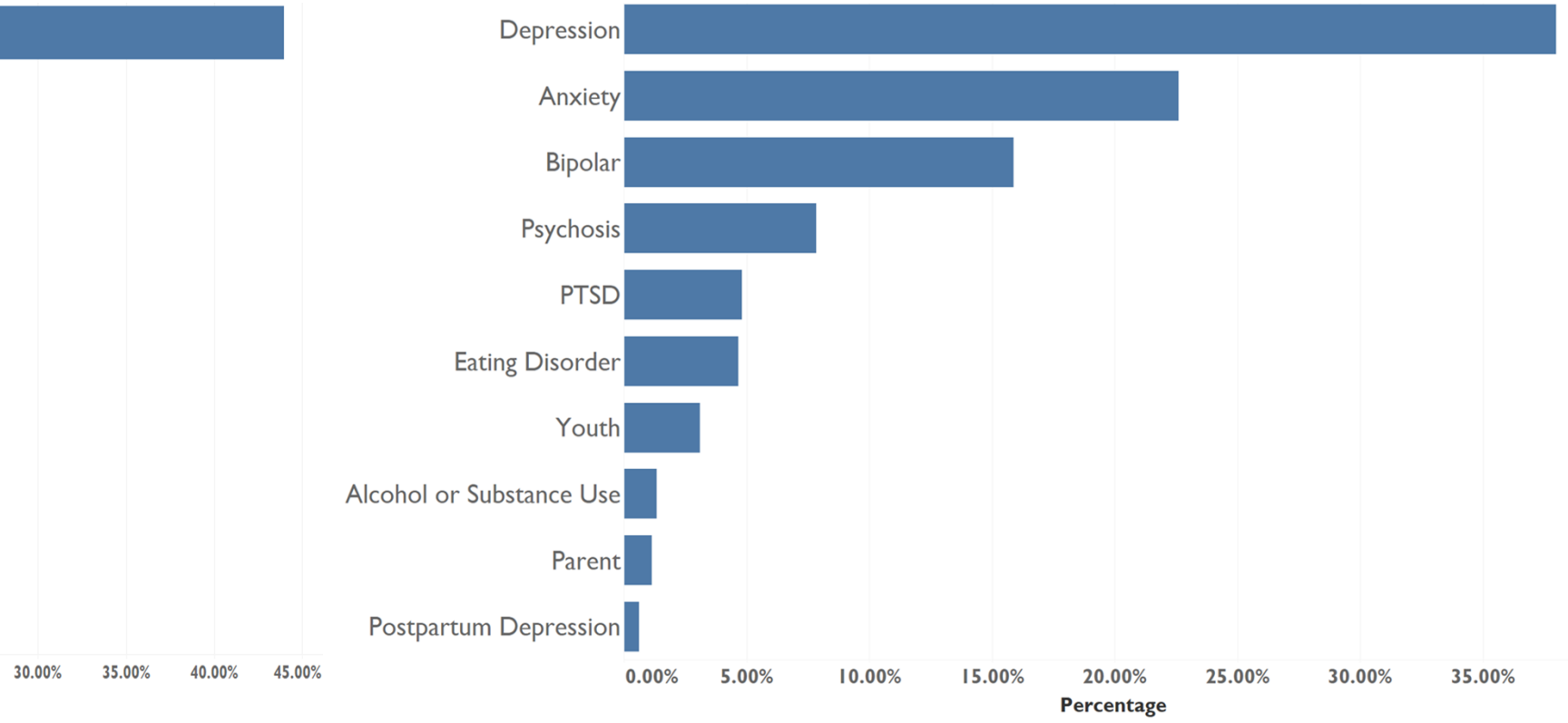
Total Screenings Comparison

2015 - 2020



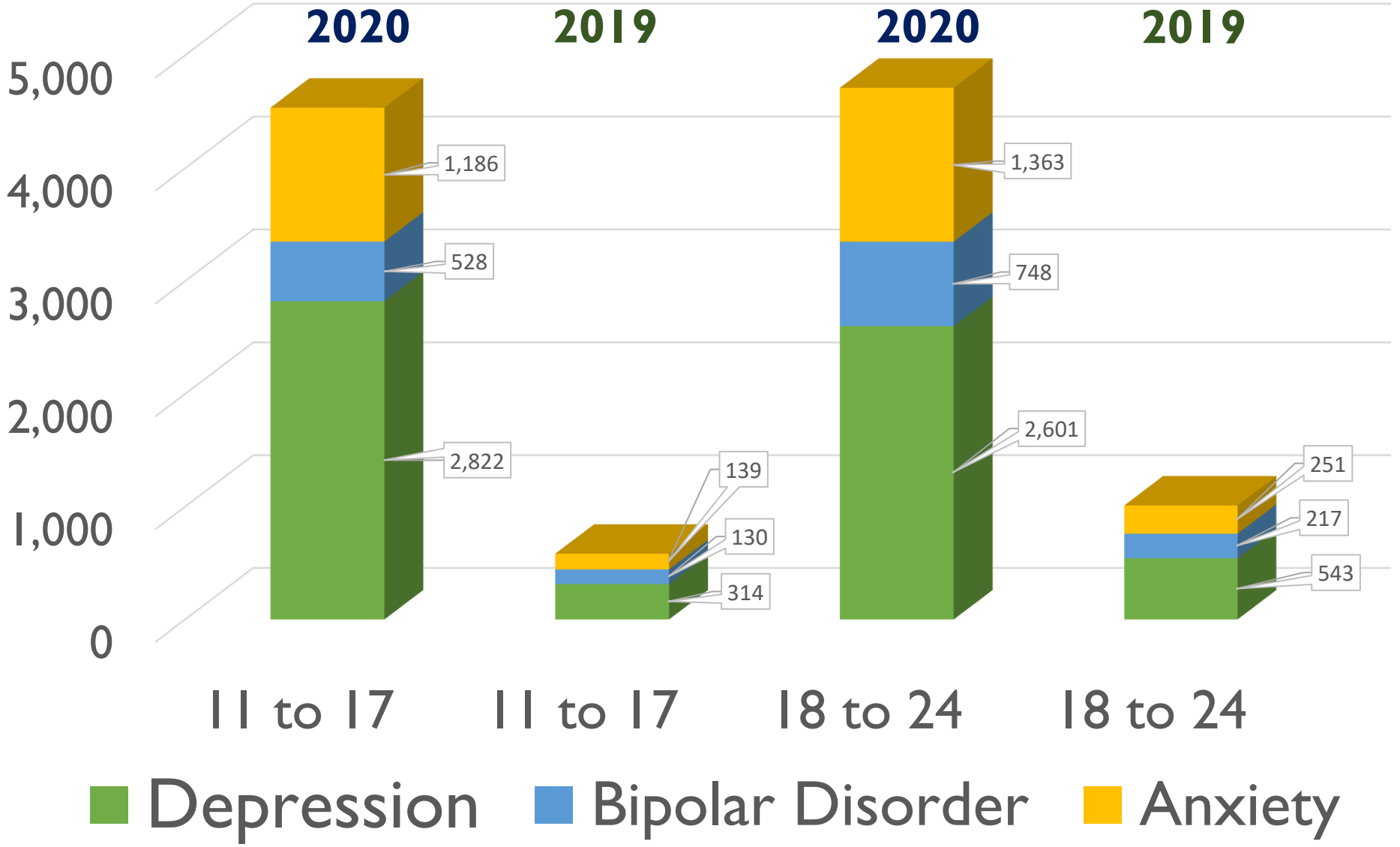
81,755

April 2020 – Nov 2020



27,269 (33% of total)

Positive or Moderate to Severe Screening: 8 Month Comparison (April to November)



480%
increase

Summary of Key Data Points

- Suicide rates in Indiana have consistently increased over the past 50 years, and are higher than the national rate
- U.S. suicide rates for 15–24 year-olds are the highest they have ever been, and Indiana has the 10th greatest percentage increase in the U.S. for suicide rates among 10–24 year-olds over the last 10 years
- There are a significant number of youth in Indiana that are experiencing moderate to severe symptoms of depression, anxiety, and bipolar disorder, all the major precursors to suicidal thoughts and suicide related behaviors, most of whom are self-reporting having no further intention for help-seeking
- Indiana needs an increased focus on suicide prevention and intervention, efforts, especially those related to youth, and racial and ethnic disparities

Questions?

Agenda

3. Mental Health and Substance Abuse
   b) Stephanie Lyons, Indiana University School of Social Work
      Licensed Addictions Counselor Requirements

AMENDMENTS TO THE LICENSED ADDICTION COUNSELOR AND LICENSED CLINICAL ADDICTION COUNSELOR REQUIREMENTS

RECOMMENDATION TO THE COMMISSION ON IMPROVING THE STATUS OF CHILDREN IN INDIANA

DECEMBER 15, 2020

OUTLINE

1. Background
2. Data
3. Experiences
4. Recommendations

BACKGROUND

Shortage of qualified, licensed addictions clinicians in the State of Indiana.

Unnecessary barriers in the Indiana Code (IC) that restrict applicants from applying and supervisors to take on this role.

Inconsistencies between the IC, Indiana Administrative Code (IAC), and the LAC and LCAC Information and Instructions documents.

DATA

Shortage of qualified, licensed addictions clinicians in the State of Indiana.

As there is a significant increase in LMHCs, LCSWs, and LMFTs during the middle of the opioid crisis, there was a minimal increase of LCACs.

Only 537 dual licensed LCACs and 59 LACs in the state (2019).

(Indiana Professional Licensing Agency, 2019)

DATA

LICENSE	2016	2017	2018	2019	INCREASE
LMHC	1846	2021	2250	2514	36%
LCSW	4361	4645	4957	5322	22%
LMFT	843	893	934	986	17%
LCAC	1273	1285	1292	1317	3%

DATA

Disproportionality is evidenced in the clients served.

Black children are 1.65 times more likely to have open CHINS case than white children.

Multiracial children are 2.34 times as likely as white children.

(Kearney, Wilson & Berry, 2019)

In 2018, black children made up 11.2% of the Indiana population (compared to 70.8% being white), but were 17% of the children in foster care (vs. 65.8% being white), and they are 16.6% of the children awaiting adoption (vs. 65.1% being white). And, 6% of black foster youth exit without having achieved family-based permanency vs. only 3% of white children.

(Children's Bureau, 2018)

DATA

Disproportionality is evidenced in the clinicians providing the services.

Cost to become a social worker is higher for Black students than White students.

Nearly half the new social workers are first generation college students.

The majority of MSWs serve high-need populations. 35.1% serve substance abuse disorders and 34.4% work with child welfare system.

(Fitzhugh Mullan Institute for Health Workforce Equity, 2020)

EXPERIENCES

Indiana University School of Social Work assists their graduates (BSWs and MSWs) in the application for the LAC and LCAC.

Alumni who decide after graduation to obtain the LCAC are unable to do so because of the differing MSW practicum requirements.

This may be true for the Licensed Marriage and Family Therapist (LMFT) as the IC states 500 practicum hours to obtain this license.

Licensed Mental Health Counselors (LMHC) are not impacted as IC requires 700 practicum hours.

Community Health Network, Oaklawn Psychiatric Center and Department of Child Services all provided evidence of this barrier.

EXPERIENCES

Clinicians are hesitant to take on the role of supervisor for students due to their workload requirements and the demands of the practicum supervisor role.

Current Supervision hours require 2.9 hours of supervision for a 20 hour/week practicum or 5 hours for a 40 hour/week practicum. Recommendation is to reduce this to 35 hours which is the equivalent of 1 hour per week for a 20 hour practicum.

Implications for the clinician to meet their employer's productivity hours requirement and meeting their own clients' needs.

The ability to provide group supervision assists however it may eliminate some qualified supervisors if there is the requirement for at least 50% of the supervision hours to be in a group setting.

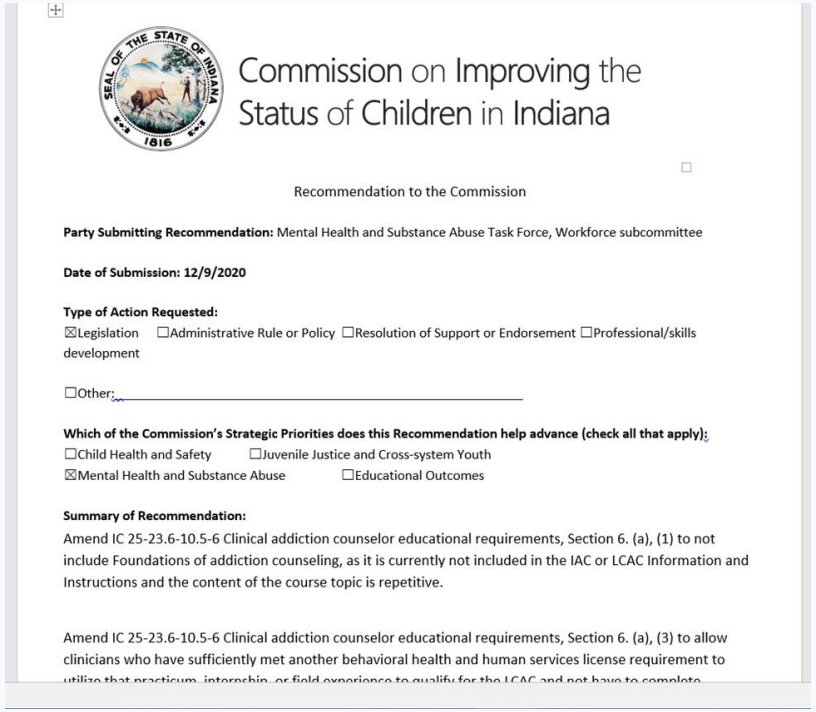
EXPERIENCES

Inconsistencies between IC, IAC, and the Information and Instructions documents.

- LCAC course requirement removal of Foundations of addiction counseling from IC.
- Throughout IC have the supervision requirements state “under the supervision of a qualified supervisor, as determined by the board” in order to be consistent.

RECOMMENDATIONS

RECOMMENDATION TO THE COMMISSION



Commission on Improving the Status of Children in Indiana

Recommendation to the Commission

Party Submitting Recommendation: Mental Health and Substance Abuse Task Force, Workforce subcommittee

Date of Submission: 12/9/2020

Type of Action Requested:
☒Legislation ☐Administrative Rule or Policy ☐Resolution of Support or Endorsement ☐Professional/skills development

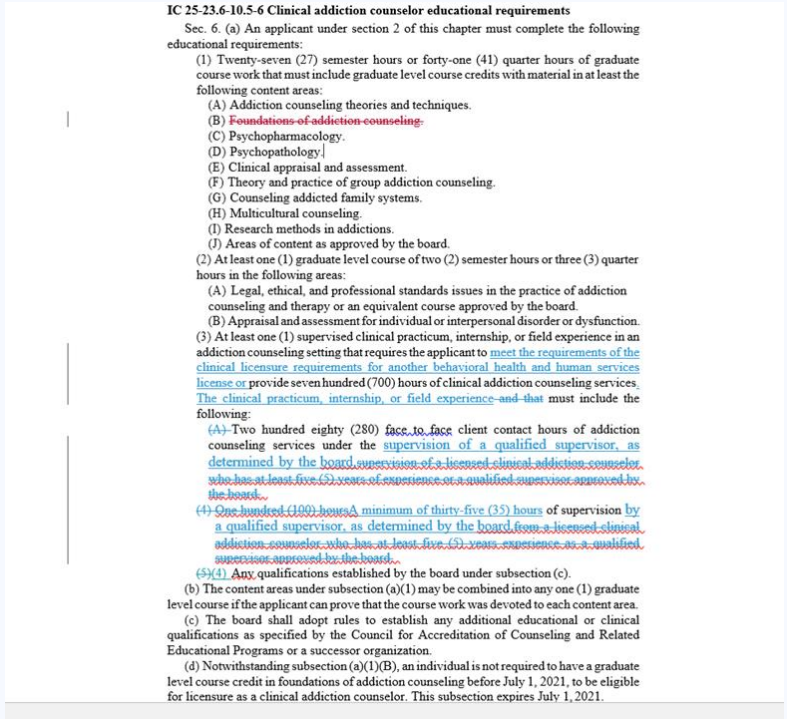
☐Other:_____

Which of the Commission's Strategic Priorities does this Recommendation help advance (check all that apply):
☐Child Health and Safety ☐Juvenile Justice and Cross-system Youth
☒Mental Health and Substance Abuse ☐Educational Outcomes

Summary of Recommendation:
Amend IC 25-23.6-10.5-6 Clinical addiction counselor educational requirements, Section 6. (a), (1) to not include Foundations of addiction counseling, as it is currently not included in the IAC or LCAC Information and Instructions and the content of the course topic is repetitive.

Amend IC 25-23.6-10.5-6 Clinical addiction counselor educational requirements, Section 6. (a), (3) to allow clinicians who have sufficiently met another behavioral health and human services license requirement to utilize that practicum, internship, or field experience to qualify for the LCAC and not have to complete

REDLINED INDIANA CODE



IC 25-23.6-10.5-6 Clinical addiction counselor educational requirements

Sec. 6. (a) An applicant under section 2 of this chapter must complete the following educational requirements:

(1) Twenty-seven (27) semester hours or forty-one (41) quarter hours of graduate course work that must include graduate level course credits with material in at least the following content areas:

(A) Addiction counseling theories and techniques.
(B) ~~Foundations of addiction counseling.~~
(C) Psychopharmacology.
(D) Psychopathology.
(E) Clinical appraisal and assessment.
(F) Theory and practice of group addiction counseling.
(G) Counseling addicted family systems.
(H) Multicultural counseling.
(I) Research methods in addictions.
(J) Areas of content as approved by the board.

(2) At least one (1) graduate level course of two (2) semester hours or three (3) quarter hours in the following areas:

(A) Legal, ethical, and professional standards issues in the practice of addiction counseling and therapy or an equivalent course approved by the board.
(B) Appraisal and assessment for individual or interpersonal disorder or dysfunction.

(3) At least one (1) supervised clinical practicum, internship, or field experience in an addiction counseling setting that requires the applicant to meet the requirements of the clinical licensure requirements for another behavioral health and human services license or provide seven hundred (700) hours of clinical addiction counseling services. The clinical practicum, internship, or field experience ~~and that~~ must include the following:

~~(A)~~ Two hundred eighty (280) face to face client contact hours of addiction counseling services under the supervision of a qualified supervisor, as determined by the board ~~supervision of a licensed clinical addiction counselor who has at least five (5) years of experience or a qualified supervisor approved by the board.~~

~~(1)~~ ~~One hundred (100) hours~~A minimum of thirty-five (35) hours of supervision by a qualified supervisor, as determined by the board from a licensed clinical addiction counselor who has at least five (5) years experience as a qualified supervisor approved by the board.

~~(5)~~(4) Any qualifications established by the board under subsection (c).

(b) The content areas under subsection (a)(1) may be combined into any one (1) graduate level course if the applicant can prove that the course work was devoted to each content area.

(c) The board shall adopt rules to establish any additional educational or clinical qualifications as specified by the Council for Accreditation of Counseling and Related Educational Programs or a successor organization.

(d) Notwithstanding subsection (a)(1)(B), an individual is not required to have a graduate level course credit in foundations of addiction counseling before July 1, 2021, to be eligible for licensure as a clinical addiction counselor. This subsection expires July 1, 2021.

Recommendations

IC be amended to reflect the changes on the Recommendation to the Commission as well as Redlined IC document.

IAC be updated so there is consistency with the IC.

LAC and LCAC Information and Instructions documents be updated so there is consistency with the IC and IAC.

Questions?

Workforce subcommittee of the Mental Health and Substance Abuse Task Force

REFERENCES

Children's Bureau, An Office of the Administration for Children & Families (2018). *Child Welfare Outcomes Report Data*. https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/indiana.html

Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University, (2020, August). *The Social Work Profession: Findings from Three Years of Surveys of New Social Workers.* Council on Social Work Education and The National Association of Social Workers. https://cswe.org/CSWE/media/Workforce-Study/The-Social-Work-Profession-Findings-from-Three-Years-of-Surveys-of-New-Social-Workers-Dec-2020.pdf

Indiana Professional Licensing Agency (2019, November). *State of Indiana's Health Workforce 2019*. https://www.in.gov/pla/files/Health%20Workforce%20Council%20Annual%20Report%202019_10-28-19%20FINAL.pdf

Kearney, A., Wilson, E. & Berry E. (2019) *Racial Disparity in Child Welfare*. Department of Child Services Research and Evaluation Unit.

Agenda

3. Mental Health and Substance Abuse
   c) David Berman, MHAI and Jason Murrey, IDOE
      Suicide Prevention

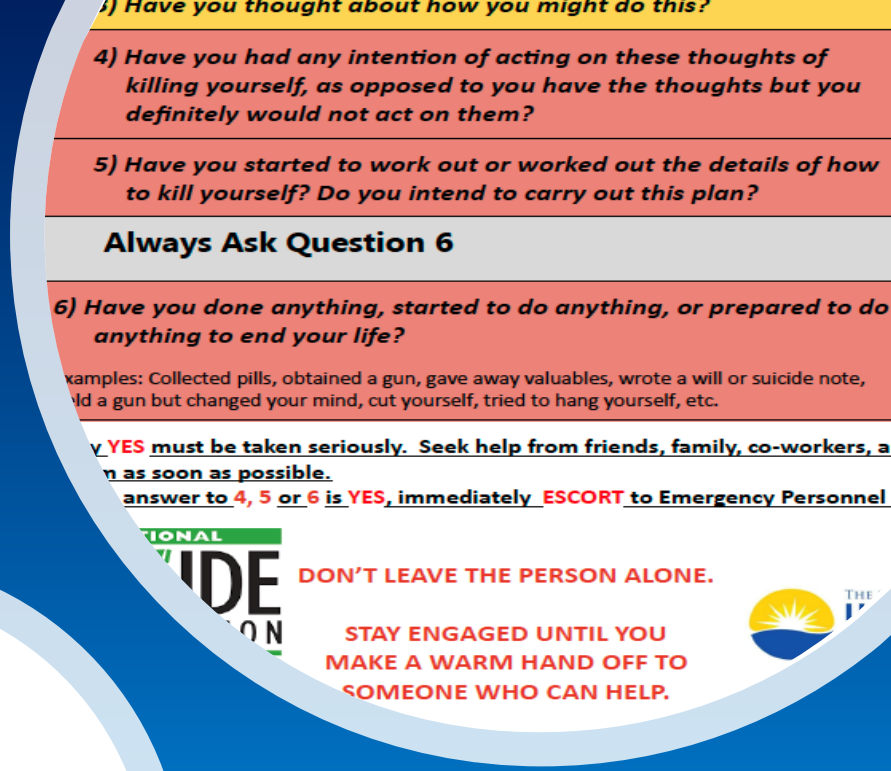
Suicide Prevention Gap Analysis Recommendations

Prepared for the Commission on Improving the Status of Children in Indiana
December 15, 2020

Background:

- Suicide Prevention Gap Analysis subcommittee was formed in 2019
    - Key suicide prevention experts in Indiana
- Identified policy and service needs related to youth suicide prevention in the state
- Recommendations received input from numerous lead suicide prevention entities in Indiana as well as several state suicide prevention coordinators from across the country

1. Suicide Prevention Training in Higher Education Curriculum



QPR INSTITUTE

ASIST

"Competence in the assessment of suicidality is an essential clinical skill that has consistently been overlooked and dismissed by the colleges, universities, clinical training sites, and licensing bodies that prepare healthcare and social service professionals."

Schmitz WM Jr, Allen MH, Feldman BN, Gutin NJ, Jahn DR, Kleespies PM, Quinnett P, Simpson S. Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training.

- **1 in 5 high school students in Indiana have contemplated suicide[1]**
- **1 in 9 high school students in Indiana have made a suicide plan[1]**
- **1 in 10 high school students in Indiana have attempted suicide[2]**

[1] 2020 Indiana Youth Survey, Institute for Research on Addictive Behavior Prevention Insights Department of Applied Health Science, School of Public Health-Bloomington, Indiana University

[2] 2020 Indiana KIDS COUNT Data Book, Indiana Youth Institute

"The typical training of mental health professionals in the assessment and management of suicidal patients has been, and remains, woefully inadequate."

Schmitz WM Jr, Allen MH, Feldman BN, Gutin NJ, Jahn DR, Kleespies PM, Quinnett P, Simpson S. Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training.

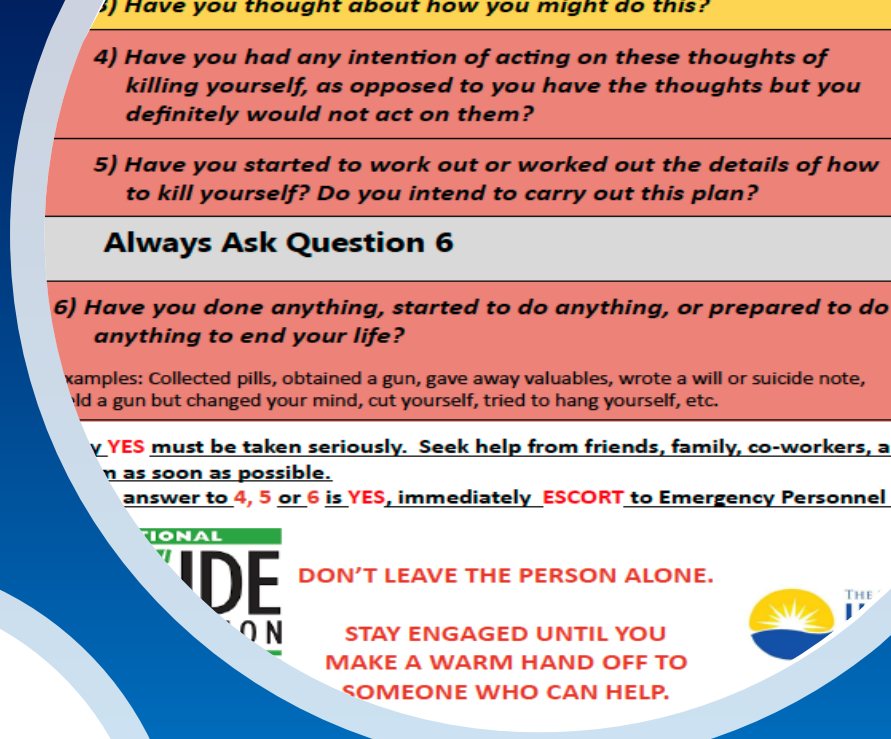
- **Less than half of accredited psychology grad school programs offer didactic training in preventing suicide**
- **Only 40% of social workers report having received instruction on suicide prevention in their graduate school program**

Barry N. Feldman, PhD, and Stacey Freedenthal, PhD, LCSW. The American Association of Suicidology Social Work Education in Suicide Intervention and Prevention: An Unmet Need?

Suicide Prevention Training in Higher Education Curriculum

Recommendation:

Legislatively mandate training on screening for suicide risk and implementation of appropriate intervention practices in all pre-professional schooling programs, including social work, education, and all healthcare professions.



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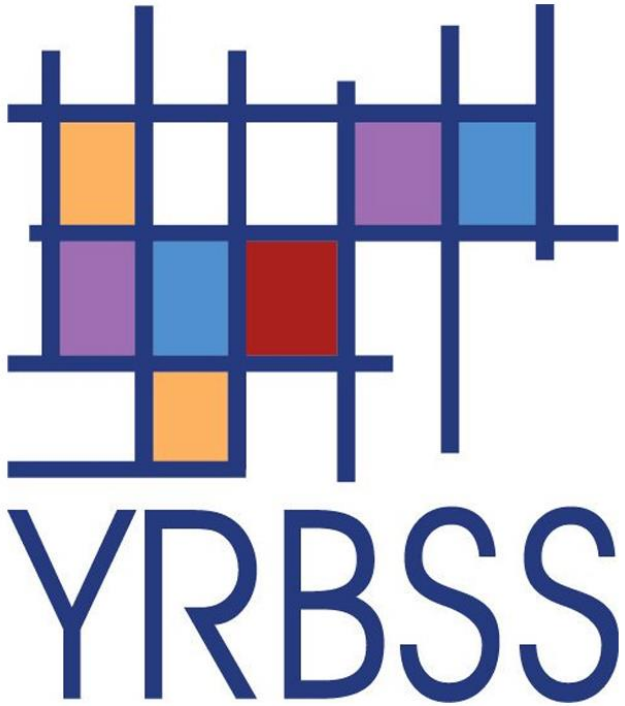
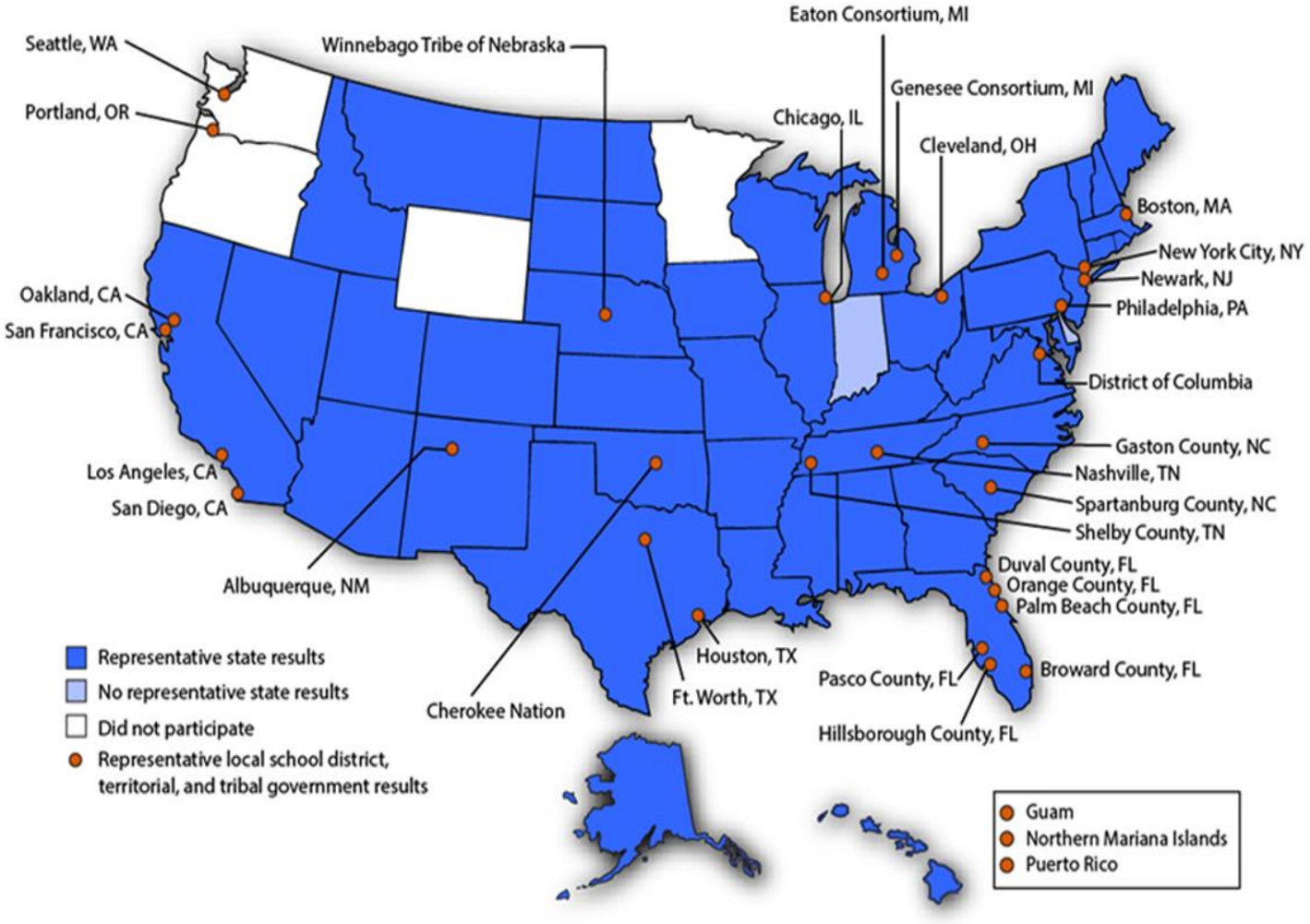
ASIST

2. Youth Risk Behavior Surveillance System (YRBSS)



The Youth Risk Behavior Surveillance System (YRBSS) is an anonymous school-based survey that collects deidentified data about six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults.



Indiana has not had data represented in the last two YRBSS, as the state has not provided the minimum required data sample for participation since 2015. Indiana was one of only five states that did not have data included in the 2019 survey, and one of ten in 2017.

- **Indiana has consistently been denied CDC suicide prevention funding – a common factor of those states funded has been participation in the YRBSS**

- **Participation ensures that the state receives annual suicide related survey data that complements the Indiana Youth Survey, as the IYS does not ask questions regarding youth suicide attempts**

"Require schools to participate in the CDC Youth Risk Behavior Surveillance System Survey"

2018 Indiana School Safety Recommendations: Working group included representatives from IN Dept of Homeland Security, IN DOE, FSSA, IN Dept of Health, ISP, ICJI, Integrated Public Safety Commission

Youth Risk Behavior Surveillance System (YRBSS)

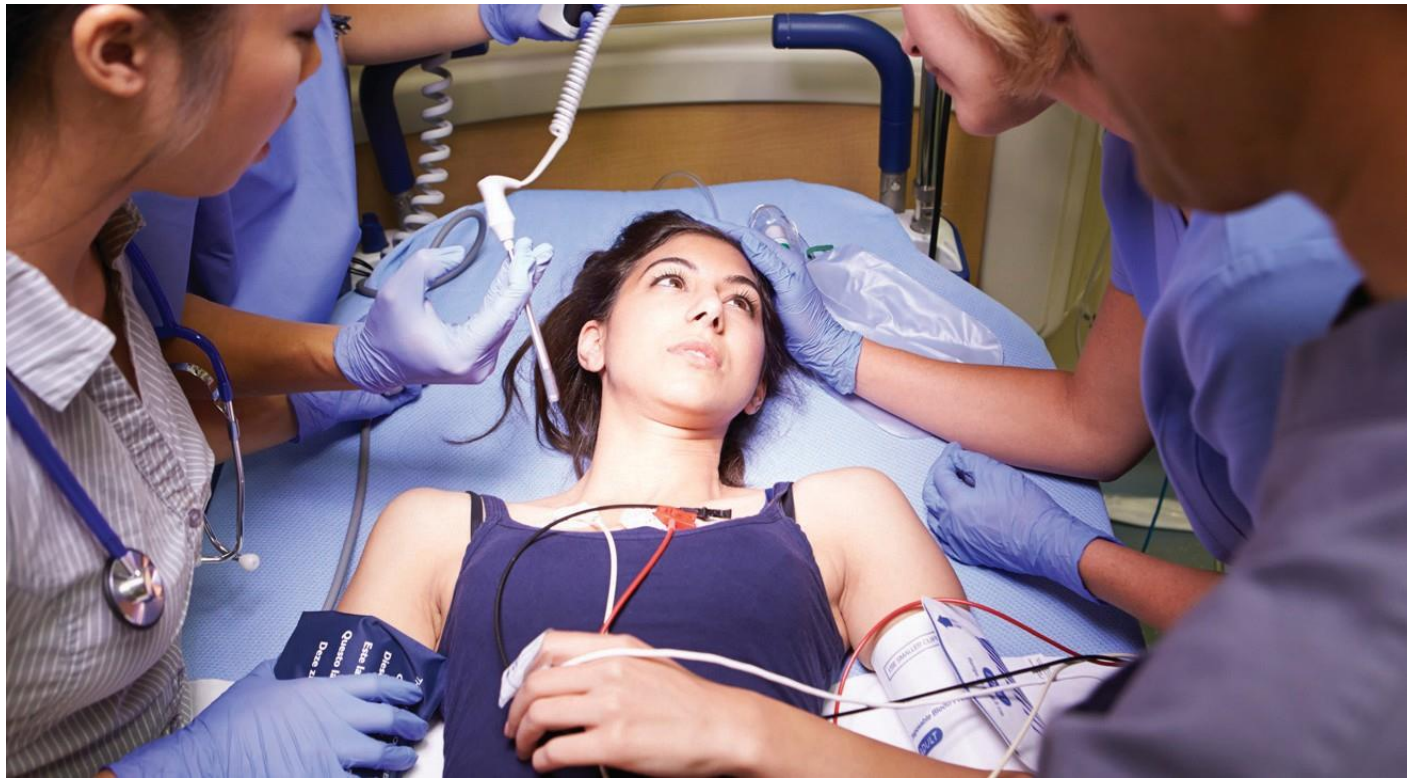
Recommendation:

Legislatively mandate that schools selected by the CDC participate in the YRBSS every 2 years (alternating with the Indiana Youth Survey)

3. Coordinated Crisis Response

Indiana lost one hub for the state's National Suicide Prevention Lifeline in March 2020 (4 remaining) with the possibility of additional losses pending, yet there is an expectation of an increase in callers once the transition to 9-8-8 occurs.

An increase continues to occur in Emergency Department visits for individuals with suicidal ideation or suicide related behaviors, which limits the bandwidth of these facilities to address more acute needs.



Phoenix, AZ Case Study

There is a potential for significant cost savings utilizing Coordinated Crisis Response.

- **Reduced state inpatient spend by $260 million**
- **Saved hospital emergency departments $37 million in avoided costs/losses**
- **Saved the equivalent of 37 FTE law enforcement officers**

BJA presentation at ISMICC (2017), Madison Wisconsin data

Coordinated Crisis Response

Recommendation # 3:

Advocate for a comprehensive and integrated crisis network including:

- Sufficient infrastructure for statewide crisis call centers coordinating in real time
- Centrally deployed, 24/7 mobile crisis
- 24-hour crisis receiving and stabilization programs

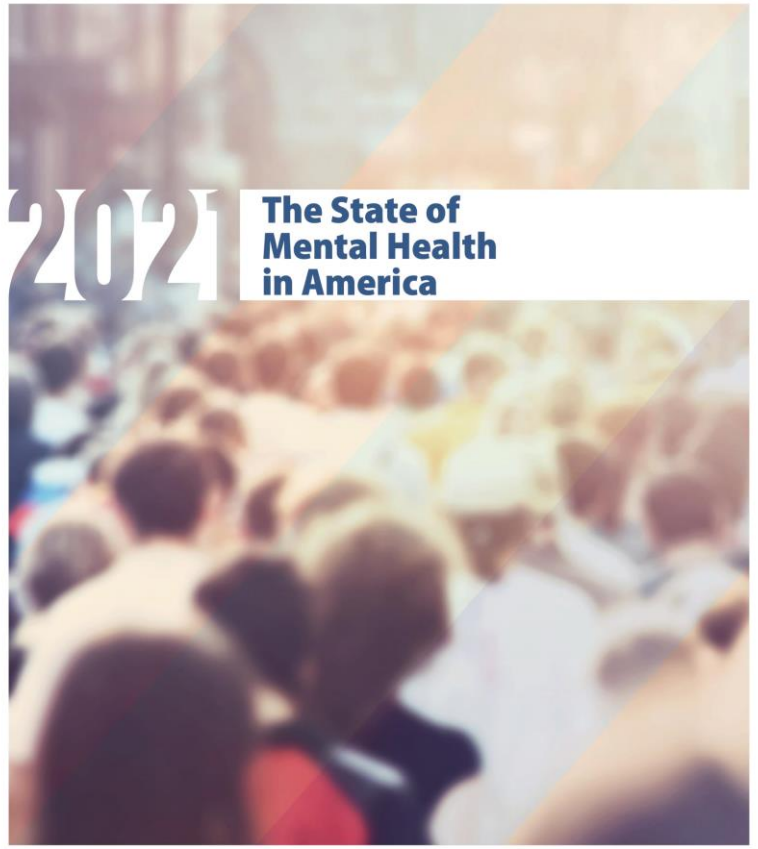
4. Ensuring Prioritization of Mental Health

Scale: 1 Best → 51 Worst

- Indiana ranks 33 out of 51 states (includes District of Columbia) overall, indicating higher prevalence of mental illness and lower rates of access to care

- Indiana's overall ranking is currently 7 spots lower than that listed in the 2020 report (26th), and over the past 10 years, has dropped 14 spots (19th in 2011)

- Indiana ranks 45 for youth with at least one major depressive episode in the past year



4. Ensuring Prioritization of Mental Health

<u>Recommendation:</u>

Advocate for Mental Health Programs and Awareness, and Suicide Prevention to be prioritized across all branches of government

Questions?

Agenda

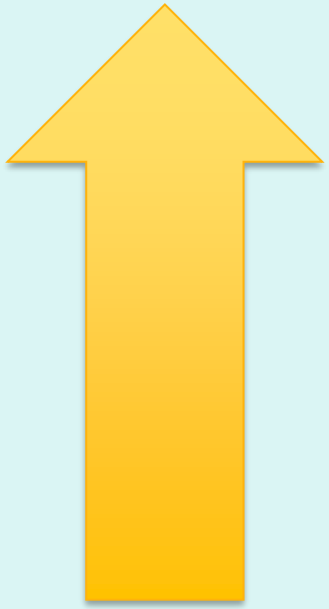
3. Mental Health and Substance Abuse
   d) Sirrilla Blackmon, DMHA, and Jennifer Tackitt-Dorfmeyer, Choices Mobile Response and Stabilization Services for Youth

CISC Mental Health & Substance Abuse Task Force

Mobile Response Stabilization Services Subcommittee

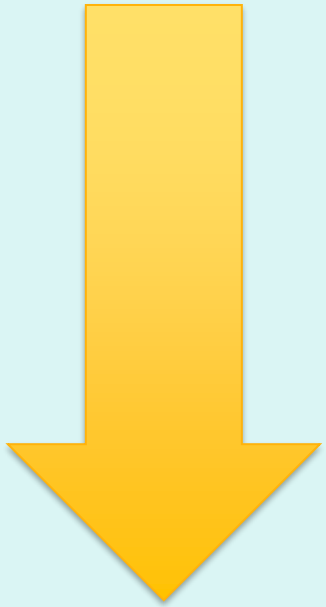
choices®
COORDINATED CARE SOLUTIONS

Impact of Mobile Response Services



- Parent/caregiver/family member empowerment to respond in crisis
- Youth and Family Voice
- Linkage into more appropriate, longer-term care
- Supports to families in times of disaster or trauma
- Collaboration with law enforcement for policing/trauma response
- Access to BH services in the community
- Connections between child serving systems

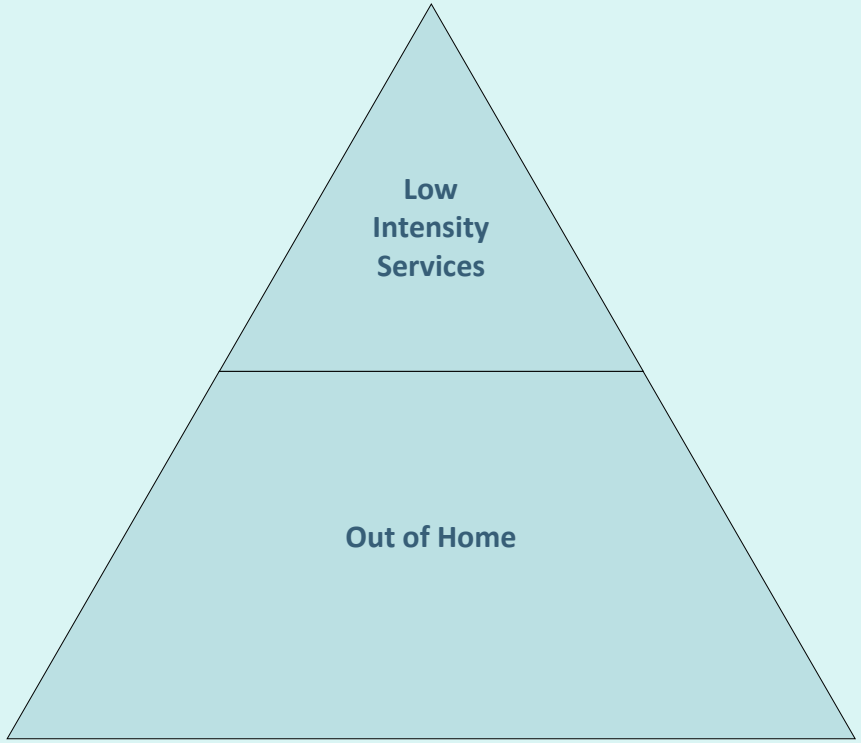
SAMHSA
TA Network 2019

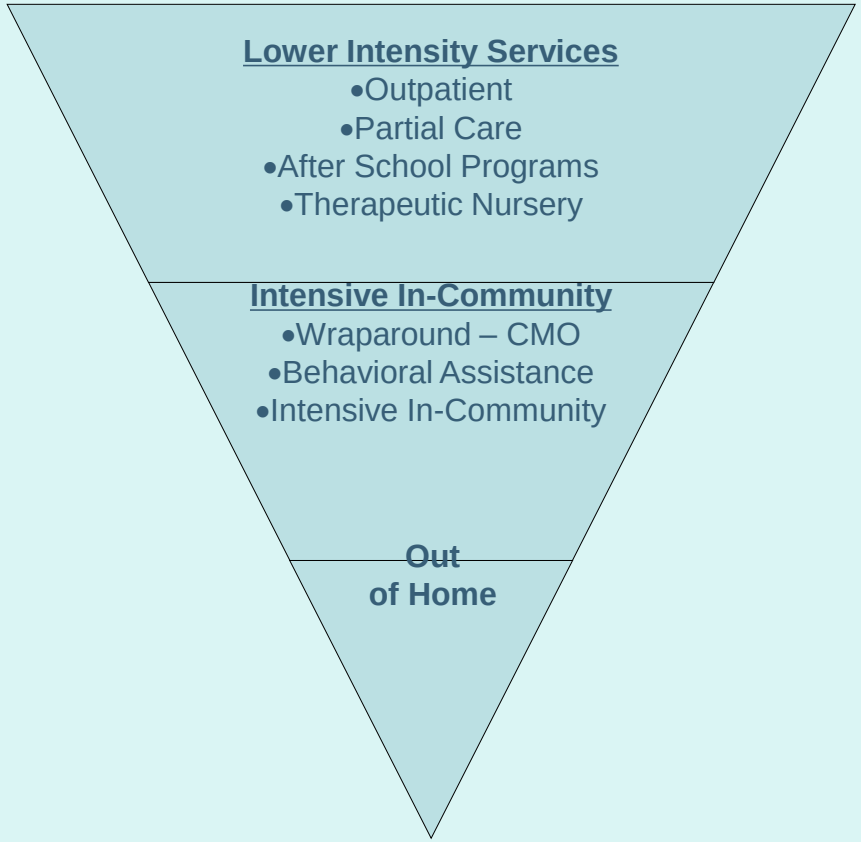


- Need for higher levels of care
- Youth in the juvenile justice system
- Placement disruptions in child welfare

Overuse of Deep-End Services

E. Manley NWIC 2018





MRSS Subcommittee

The Subcommittee built a representative membership and accomplished the following :

- **Reviewed several Indiana mobile response programs.**
- **Examined Medicaid claims data for a period from 2014 through 2018 which provided a preliminary overview of the issues of youth presenting in the ED.**
- **Developed and distributed a statewide survey that reviewed the interest around a mobile response program for Indiana.**

Indiana Medicaid Data
Key Findings

Increases since 2014:

- **Number of youth who went to ED because of MH crisis: 10.1%**
- **Annual Medicaid total amount: 12.7%**
- **Youth utilization of inpatient services after an ED visit for MH crisis: 25.1%**
- **Annual Medicaid total amount for inpatient: 11.8%**

Indiana Medicaid Data
Key Findings

In 2018, 24,630 youth went to the Emergency Department (ED) because of Mental Health (MH) crisis. Specifically:

- Visits were on average 3.6 times per year for 1.5 days per visit and 5.3 episode-days per year.
- 18.1% (n=4,465) utilized inpatient services following an ED visit for an average of 20.6 days in care throughout the year.

Indiana Medicaid Data
Key Findings

Utilization of ED visit for MH crisis by race

- White youth – significantly overrepresented
- Hispanic youth – significantly underrepresented
- Black youth – significantly underrepresented
- Asian youth – significantly underrepresented

The group also reviewed the top 10 zip codes with the highest number of youth who visited the ED for MH crisis in 2018. Howard (n=571) and Cass (471) counties had the highest count, representing 46% and 57% of their MH crisis visits, respectively.

Indiana Needs Assessment

- **Survey Respondents**
  - N=58 Caregivers: White/Caucasian (74%), Prefer not to answer (16%), More than one race (5%), Black/African American (5%)
  - N=1158 Community Members: White/Caucasian (80%), Prefer not to answer (7%), More than one race (3%), Black/African American (7%), Hispanic or Latino (2%), Other race (1%)

Community Respondents

- Department of Child Services staff (33%)
- Behavioral health professional (19%)
- School personnel (10%)
- Community or faith-based organization staff/volunteer (9%)
- Law enforcement or youth justice professional (9%)
- Other (8%)
- Community Mental Health Center or Federally Qualified Health Center professional (6%)
- Systems of Care member (5%)
- Medical professional, including pediatric or emergency services (2%)

Opportunities for MRSS in Indiana

Where is the biggest need for services according to caregivers?

Caregivers' needs are related to resources and guidance. They need:

- *Support to know when to seek services*
- *Access to behavioral health resources*
- *In-home help with planning if hospitalization needed*

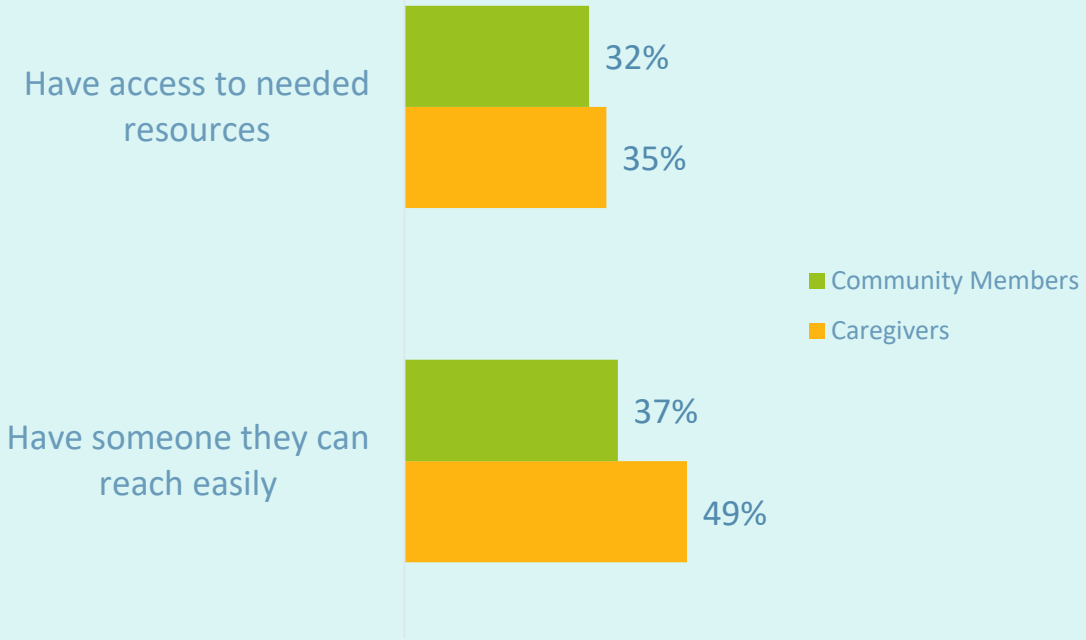
Opportunities for MRSS in Indiana, continued

Where is the biggest need for services according to community members?

- Most community members believe families will benefit from MRSS and would refer families to the resource. Their needs include:
  - *Access to support they can easily reach*
  - *Access to behavioral health resources*

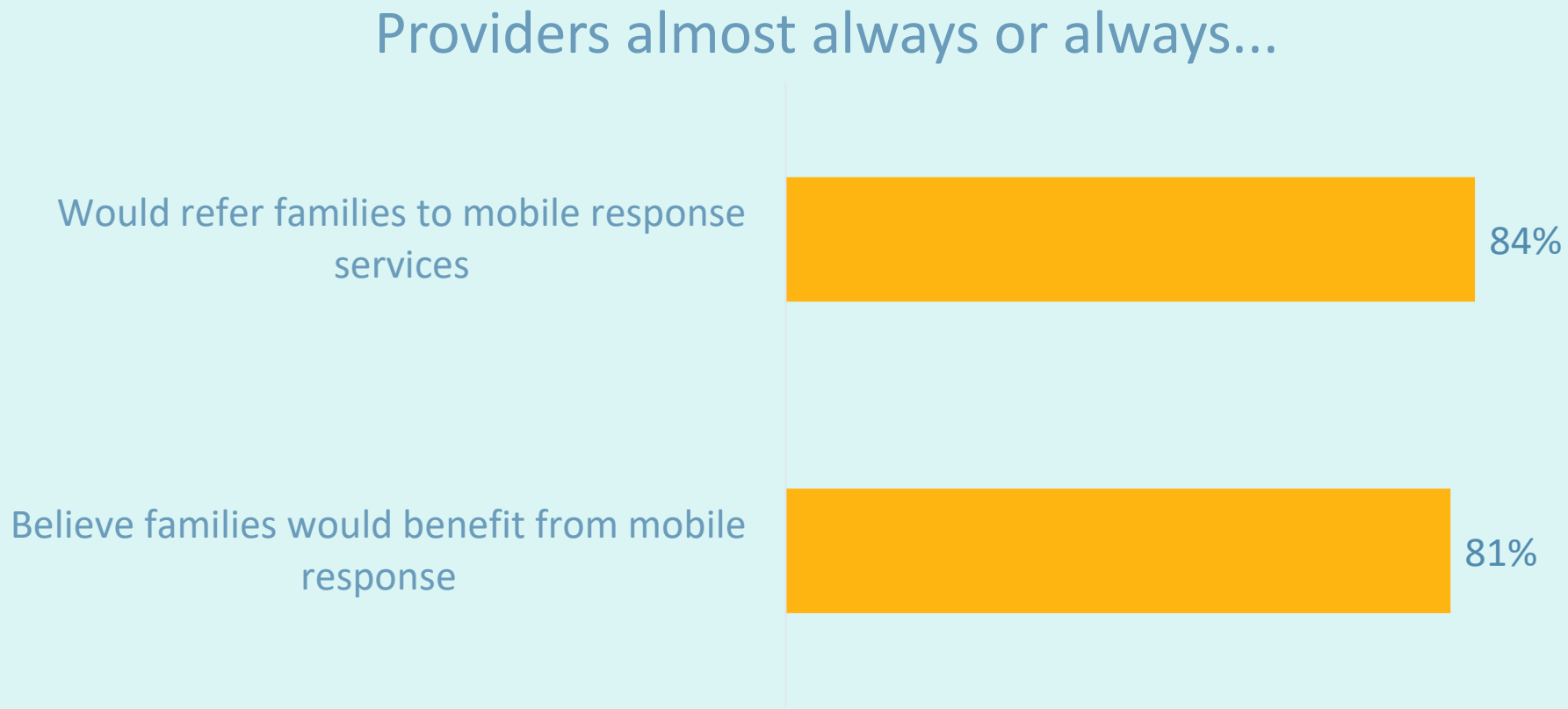
When a child experiences a mental or behavioral health crisis

Respondents almost always or always



Caregivers almost always or always

When a child experiences a mental or behavioral health crisis



Subcommittee Recommendations

Recommendation # 1: ***Request OMPP to conduct a deeper dive regarding cost and care utilization for Indiana children who experience crisis and have intensive needs. This would include all insurers; Medicaid, Medicare and Commercial.***

Recommendation # 2: ***Garner cross-state agency commitment and collaboration in the development of the state's crisis continuum.***

Subcommittee Recommendations, continued

Recommendation #3: ***Engage one of the Manage Care Entities to pilot MRSS for their members.***

Recommendation #4: ***Partner with local organizations to plan implementation, including addressing unique needs for people of color and immigrant populations.***

Subcommittee Recommendations, continued

Recommendation #5: ***Indiana team to engage in technical support from National Association of State Mental Health Program Directors and other states. Currently there are multiple successful MRSS programs across the country nearby states include:***

- ***Illinois***
- ***Ohio***
- ***Wisconsin***
- ***Kentucky***
- ***Tennessee***

References

NASMHPD, Meet-Me Here Webinar March 21st, 2019

E. Manley, MRSS Collaborative Webinar February 8th, 2019

Mobile Response and Stabilization Services and High-Fidelity Wraparound: Foundational Elements of a Children's System of Care SAMHSA TA Network April 22nd, 2019

Agenda

4. Equity, Inclusion, and Cultural Competence
   a) Calvin Roberson, IMHC, and Marshawn Wolley, Black Onyx Management Equity to Action Resource Packet

Equity Positional Leadership Guidance

A Recommendation for Consideration

Overview

- The recommendation presented to the Indiana Commission on Improving the Status of Children is to consider the adoption of a framework whereby entities (departments and/or corporations) develop selection criteria for staff leading equity initiatives.

Recommendation Objectives

- Provide protective factors to ensure successful equity integration
- Identify essential skills that the leader(s) should have or develop as they are collaboratively working with entity leadership and staff to best integrate equity principles into practice
- Provide tools for entities (departments and corporations) to use to evaluate their current and progressive status towards becoming an equity friendly entity

Equity Centered Protective Factors

- Diverse composition of governance
- Equity training from governance to volunteers
- Organizational position statement(s) on equity
- Accountability: SMART goals and objectives imbedded in organizational strategic plan and operational (management) plans

Equity Centered Protective Factors

- Dedicate part of the budget to support equity initiatives (training, entity events, etc.)
- Institute an equity team and organizational campaign
- Equity Leader reports directly to President/CEO, Executive Director, or equivalent

Positional Leadership Attributes

- Visionary: casts overarching vision, identity, and strategy throughout enterprise for equity inclusion
- Leader and Manager: works closely with programmatic and administrative teams to adopt a culture of equity

Positional Leaders Attributes

- Communicator and Diplomat: coalesces the corporation at all levels in guiding protocols and practices that integrates principles of equity, both verbally and in writing, and holds the collective accountable

Organizational Readiness Assessment Tools and Resources

Recommendation List

Questions and Answers

Agenda

4. Equity, Inclusion, and Cultural Competence
   a) Latrece Thompson, DCS
      Equity Curriculum Guide

Equity and Inclusion Curriculum Resource Guide

Equity and Inclusion Curriculum Resource Guide

- EICC Curriculum Workgroup
- Key Terms identified by Common Language Committee
- Research of Key Terms/Resources
- Rubric developed for scoring of resources
- Scoring of Resources

Agenda

5. Executive Director Updates
    - 2021 Meeting Dates
    - Youth Engagement Summit

Agenda

6. Legislative Preview
   All Commission Members

Agenda

7. Future Meeting Topics or Other Items
   All Commission Members

Agenda

8. Next meeting: February 17, 10 a.m. – noon