



Child and Family Services Reviews

Statewide Assessment Instrument

April 2014



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR
CHILDREN & FAMILIES
Administration on Children, Youth and Families
Children's Bureau

Indiana Child and Family Services Review



**Statewide Assessment
April 6, 2016**

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Introduction

The Child and Family Services Reviews (CFSRs), authorized by the 1994 Amendments to the Social Security Act (SSA), are administered by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The goals of the CFSR are to:

- Ensure substantial conformity with title IV-B and IV-E child welfare requirements using a framework focused on assessing seven safety, permanency, and well-being outcomes and seven systemic factors;
- Determine what is happening to children and families as they are engaged in child welfare services; and
- Assist states in helping children and families achieve positive outcomes.

The CFSR Process

The CFSR is a two-phase process, as described in 45 CFR 1355.33. The first phase is a statewide assessment conducted by staff of the state child welfare agency, representatives selected by the agency who were consulted in the development of the Child and Family Services Plan (CFSP), and other individuals deemed appropriate and agreed upon by the state child welfare agency and the Children's Bureau.

The second phase of the review process is an onsite review. The onsite review process includes case record reviews, case-related interviews for the purpose of determining outcome performance, and, as necessary, stakeholder interviews that further inform the assessment of systemic factors. The onsite review instrument and instructions are used to rate cases, and the stakeholder interview guide is used to conduct stakeholder interviews.

Information from both the statewide assessment and the onsite review is used to determine whether the state is in substantial conformity with the seven outcomes and seven systemic factors. States found to be out of substantial conformity are required to develop a Program Improvement Plan (PIP) to address the identified areas out of substantial conformity. States participate in subsequent reviews at intervals related to their achievement of substantial conformity. (For more information about the CFSRs, see the *Child and Family Services Reviews* at <http://www.acf.hhs.gov/programs/cb.>)

Integration of the CFSP/APSR and CFRS Statewide Assessment

The CFRS process is intended to be coordinated with other federal child welfare requirements, such as the planning and monitoring of the CFSP. We are encouraging states to consider the statewide assessment as an update to their performance assessment in the state's most recent CFSP and/or Annual Progress and Services Report (APSR) rather than a separate assessment process and reporting document. Most of the content for the statewide assessment overlaps with the CFSP/APSR and the same expectations for collaboration with external partners and stakeholders exist across all planning processes. States can use the statewide assessment process to re-engage these partners and stakeholders in preparation for the CFRS.

The Statewide Assessment Instrument

The statewide assessment instrument is a documentation tool for states to use in capturing the most recent assessment information before their scheduled CFRS. Each section, as outlined below, is designed to enable states to gather and document information that is critical to analyzing their capacity and performance during the statewide assessment phase of the CFRS process.

- Section I of the statewide assessment instrument requests general information about the state agency and requires a list of the stakeholders that were involved in developing the statewide assessment.
- Section II contains data profiles for the safety and permanency outcomes. These include the data indicators, which are used, in part, to determine substantial conformity. The data profiles are developed by the Children's Bureau based on the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS), or on an alternate source of safety data submitted by the state.
- Section III requires an assessment of the seven outcome areas based on the most current information on the state's performance in these areas. The state will include an analysis and explanation of the state's performance in meeting the national standards as presented in section II. States are encouraged to refer to their most recent CFSP or APSR in completing this section.
- Section IV requires an assessment for each of the seven systemic factors. States develop these responses by analyzing data, to the extent that the data are available to the state, and using external stakeholders' and partners' input. States are encouraged to refer to their most recent CFSP or APSR in completing this section.

We encourage the state to use this document "as is" to complete the assessment, but the state may use another format as long as the state provides all required content. The statewide assessment instrument is available electronically on the Children's Bureau website at <http://www.acf.hhs.gov/programs/cb/resource/round3-cfsr-statewide-assessment>.

Completing the Statewide Assessment

The statewide assessment must be completed in collaboration with state representatives who are not staff of the state child welfare agency (external partners or stakeholders), pursuant to 45 CFR 1355.33 (b). Those individuals should represent the sources of consultation required of the state in developing its title IV-B state plan and may include, for example, Tribal representatives; court personnel; youth; staff of other state and social service agencies serving children and families; and birth, foster, and adoptive parents or representatives of foster/adoptive parent associations. States must include a list of the names and affiliations of external representatives participating in the statewide assessment in section I of this instrument.

We encourage states to use the same team of people who participate in the development of the CFSP to respond to the statewide assessment. We also encourage states to use this same team of people in developing the PIP. Members of the team who have the skills should be considered to serve as case reviewers during the onsite review.

How the Statewide Assessment Is Used

Information about the state child welfare agency compiled and analyzed through the statewide assessment process may be used to support the CFSR process in a range of ways. The statewide assessment is used to:

- Provide an overview of the state child welfare agency's performance for the onsite review team;
- Facilitate identification of issues that need additional clarification before or during the onsite review;
- Serve as a key source of information for rating the CFSR systemic factors; and
- Enable states and their stakeholders to identify early in the CFSR process the areas potentially needing improvement and to begin developing their PIP approach.

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104–13)

Public reporting burden for this collection of information is estimated to average 240 hours for the initial review and 120 hours for subsequent reviews. This estimate includes the time for reviewing instructions, completing the assessment, and reviewing the collection of information.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Statewide Assessment Instrument

Section I: General Information

Name of State Agency: **Indiana Department of Child Services (DCS)**

CFSR Review Period

CFSR Sample Period: **April 1, 2015 – December 29, 2015**

Period of AFCARS Data: **April 1, 2015 – September 30, 2015**

Period of NCANDS Data: **October 1, 2014 – September 30, 2015**

(Or other approved source; please specify if alternative data source is used): **N/A**

Case Review Period Under Review (PUR): **April 1, 2015 – through date of this review**

State Agency Contact Person for the Statewide Assessment

Name: **Kyle Gaddis**

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Statewide Assessment Participants

Provide the names and affiliations of the individuals who participated in the statewide assessment process; please also note their roles in the process.

State Response:

Insert names and affiliations of statewide assessment participants

External Partners and Stakeholders:

- **Biennial Regional Services Planning Process Participants** - Information compiled from statewide regional stakeholder groups involved in the Biennial Regional Services Planning Process informed the Statewide Assessment. Stakeholder groups included the following categories of individuals:
 - Foster/Adoptive Parents
 - Biological Parents
 - Relatives
 - Caretakers
 - Guardians
 - Prosecutors
 - Youth
 - CASA/GAL
 - Judges
 - Service Providers
- Angela Reid-Brown – Court Improvement Program Director, Indiana Judicial Center
- Natalie Dibner – Operations Manager, KSM Consulting
- Tracy Imburgia – Project Coordinator, Indiana University IV-E Waiver Evaluation Team

Internal Stakeholders:

- Local and Regional DCS Staff
- DCS Central Office Statewide Assessment Team:
 - Doris Tolliver, Chief of Staff
 - Kyle Gaddis, Compliance and Reporting Manager
 - Adam Novotney, Director of Child Welfare Outcomes

- **Lisa Whitaker, Director of Performance and Quality Improvement**
- **Nikki Ford, Application System Analyst/Prog. Senior**
- **LaTrece Thompson, Deputy Director, Staff Development**
- **Sam Criss, Deputy Director, Services & Outcomes**
- **Corinne Gilchrist, Deputy Director, Placement Support & Compliance**
- **Dianna Mejia, Deputy General Counsel**
- **Jane Bisbee, Deputy Director, Field Operations**
- **Reba James, Deputy Director, Permanency & Practice Support**

Section II: Safety and Permanency Data

State Data Profile

Section II data profile deleted in its entirety.

Section II data profile deleted in its entirety.

Section III: Assessment of Child and Family Outcomes and Performance on National Standards

Instructions

Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance on each of the seven child and family outcomes. Review the information with the statewide assessment team and determine if more recent data are available that can be used to provide an updated assessment of each outcome. If more recent data are not available, simply refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each outcome. Analyze and explain the state's performance on the national standards in the context of the outcomes.

A. Safety

Safety Outcomes 1 and 2

Safety outcomes include: (A) children are first and foremost, protected from abuse and neglect; and (B) children are safely maintained in their own homes whenever possible and appropriate.

- For each of the two safety outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the two federal safety indicators, relevant case record review data, and key available data from the state information system (such as data on timeliness of investigation).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Safety Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the safety indicators.

State Response:

Insert state response to Safety Outcomes 1 and 2

Indiana statute and policy ensures that children are first and foremost protected from abuse and neglect. To that end, Indiana statute states the following:

Statute

IC 31-33-7-4 Written report; contents

Sec. 4. (a) The department shall make a written report of a child who may be a victim of child abuse or neglect not later than forty-eight (48) hours after receipt of the oral report required of individuals by IC 31-33-5-4.

(b) Written reports under this section must be made on forms supplied by the administrator. The written reports must include, if known, the following information:

- (1) The names and addresses of the following:
 - (A) The child.
 - (B) The child's parents, guardian, custodian, or other person responsible for the child's care.
- (2) The child's age and sex.
- (3) The nature and apparent extent of the child's injuries, abuse, or neglect, including any evidence of prior:
 - (A) injuries of the child; or
 - (B) abuse or neglect of the child or the child's siblings.
- (4) The name of the person allegedly responsible for causing the injury, abuse, or neglect.
- (5) The source of the report.
- (6) The person making the report and where the person can be reached.
- (7) The actions taken by the reporting source, including the following:

- (A) Taking of photographs and x-rays.
- (B) Removal or keeping of the child.
- (C) Notifying the coroner.

(8) The written documentation required by IC 31-34-2-3 if a child was taken into custody without a court order.

(9) Any other information that:

- (A) the director requires by rule; or
- (B) the person making the report believes might be helpful.

IC 31-33-8-1 Investigations by the department of child services; time of initiation; investigations of child care ministries

Sec. 1. (a) The department shall initiate an appropriately thorough child protection assessment of every report of known or suspected child abuse or neglect the department receives, whether in accordance with this article or otherwise.

(b) If a report of known or suspected child abuse or neglect is received from a judge or prosecutor requesting the department to initiate a child protection assessment, the department shall initiate an assessment in accordance with this section.

(c) If a report of known or suspected child abuse or neglect is received from:

- (1) medical personnel;
- (2) school personnel;
- (3) a social worker;
- (4) law enforcement officials or personnel;
- (5) judiciary personnel; or
- (6) prosecuting attorney personnel; the department shall forward the report to the local office to determine if the department will initiate an assessment in accordance with this section.

(d) If the department believes that a child is in imminent danger of serious bodily harm, the department shall initiate an onsite assessment immediately, but not later than one (1) hour, after receiving the report.

(e) If the report alleges a child may be a victim of child abuse, the assessment shall be initiated immediately, but not later than twenty-four (24) hours after receipt of the report.

(f) If reports of child neglect are received, the assessment shall be initiated within a reasonably prompt time, but not later than five (5) days, with the primary consideration being the well-being of the child who is the subject of the report.

(g) If the report alleges that a child lives with a parent, guardian, or custodian who is married to or lives with a person who:

- (1) has been convicted of:
 - (A) neglect of a dependent under IC 35-46-1-4; or
 - (B) a battery offense under IC 35-42-4; or

(2) is required to register as a sex or violent offender under IC 11-8-8; the department shall initiate an assessment within a reasonably prompt time, but not later than five (5) days after the department receives the report, with the primary consideration being the well-being of the child who is the subject of the report.

(h) If the safety or well-being of a child appears to be endangered or the facts otherwise warrant, the assessment shall be initiated regardless of the time of day.

(i) If a report alleges abuse or neglect and involves a child care ministry that is exempt from licensure under IC 12-17.2-6, the department and the appropriate law enforcement agency shall jointly conduct an investigation. The investigation shall be conducted under the requirements of this section and section 2(b) of this chapter.

In an effort to learn from child fatalities, DCS assesses all deaths of children under the age of 18 that are reported as suspicious for abuse or neglect, and are perpetrated by a parent, guardian or custodian. Indiana state law has two main provisions that help to ensure all child fatalities are reported to DCS. The first is IC 36-2-14-6.3, which requires the county coroner to file an immediate report with DCS on all suspicious, unexpected, or unexplained child deaths. State law also considers all Indiana citizens “mandatory reporters,” by requiring any citizen who suspects child abuse or neglect to make a report to DCS.

When DCS completes a child fatality assessment, the Family Case Manager (FCM) gathers relevant data from a variety of sources, including, but not limited to, law enforcement, hospitals, pathologists, primary care physicians, schools, the state’s vital statistics department and coroners. Indiana state law (IC 36-2-14-18) requires the county coroner to provide child death autopsy reports to DCS to help determine if the child died as a result of abuse or neglect. All data gathered by the Family Case Manger during the child fatality assessment is entered into MaGIK, the State’s child welfare information system. In order for DCS to substantiate allegations of abuse or neglect for any child death, the alleged perpetrator must meet the statutory definition of parent, guardian, or custodian. Indiana pulls data from MaGIK on all substantiated child fatalities to submit for the NCANDS child maltreatment fatality measure.

Indiana also has statutory requirements related to creation of Local Child Fatality Review Teams, whose role is to help provide an additional lens to evaluate child fatality trends and help inform future prevention efforts. As of July 1, 2013, changes to state law mandated that county representatives assume responsibility for creating and maintaining a Local Child Fatality Review Team. Prior to July 1, 2013, DCS was responsible for creating and supporting these multi-disciplinary fatality review teams in each of the Department’s 18 Regions. The law now requires that the local Prosecutor establish a Local Child Fatality Review Committee (Committee) in coordination with representatives from the coroner, health department, DCS and law enforcement. The Committee is responsible for determining whether to create a County Fatality Review Team or a Regional Fatality Review Team and to appoint the team members. In order to support the transition of the child fatality review teams from DCS to the local level the Indiana legislature created a “Statewide Child Fatality Review Coordinator” position under the Indiana State Department of Health (ISDH). The position also supports the State Child Fatality Review Team.

While the responsibility for establishing the teams was amended, the team members and the team responsibilities still remain the same. The teams are required to review all child deaths that are sudden, unexpected, unexplained, assessed by DCS for alleged abuse or neglect, or if the coroner has ruled the cause of death to be undetermined, or the result of homicide, suicide or accident. The goal of the new structure is to create a statewide child fatality review system, where local experts use their knowledge of the area to report information to the State Fatality

Review Team, who will then be able to provide more holistic review of trends in child fatalities. The goal of the teams is to help inform future prevention efforts across the State.

Indiana code clearly reflects the overall need for not only taken written reports of abuse and neglect, but also the methodology and timeliness of investigations into reports of abuse and neglect. Departmental policy further marries the legal aspects of the work with the mechanics of the work itself.

Policy

Policy dictates the following in **Chapter 8, Section 1:**

The Indiana Department of Child Services (DCS) will consider the following factors when identifying placement options for a child:

1. The noncustodial parent's suitability and willingness to care for the child, before considering other out-of-home placements;
2. The possibility of other suitable and willing relatives as a placement, before considering other placement options;
3. The placement type recommendation of the Child and Adolescent Needs and Strengths (CANS) Assessment. See separate policy, 4.32 Child and Adolescent Needs and Strengths (CANS) Assessment;
4. The least restrictive environment available to provide for the child's individual needs;
5. Proximity to his or her own community. Whenever possible a child will be placed within his or her own community and school district and within close proximity to his or her parent, guardian, or custodian;
6. Whether there is a compelling reason that placing siblings together would not be in the best interest of one (1) or more of the children;
7. The child has been identified as a victim of human trafficking and/or domestic violence; and
8. The child is a member of, or eligible for, membership in an Indian (Native American) tribe.

The Child and Family Team (CFT) should identify the best placement option for the child, unless an immediate placement decision must be made due to an emergency removal.

Safety Outcomes Data:

Absence of Maltreatment in Foster Care: 99.68% (November 2015)

The most recent data for the first safety outcome shows Indiana's rate to be at the national standard of 99.68%. It should be noted however, that in the past year Indiana had a prevailing rate which typically hovers just below the national standard and in a few instances, had a rate just above.

Absence of Recurrence of Maltreatment: 93.31% (November 2015)

The most recent data for the second safety outcome shows that Indiana is consistently below the national standard of 94.6%. The highest achievement on this measure within the last year was 93.54% and the lowest at 92.52%.

CHINS Placements remained fairly consistent from November 2014 with 28.5% remaining in home to 28.7% in November 2015.

Indiana's Quality Service Review (QSR)

QSR measures safety in the following ways:

To what degree:

Is the child/youth free of abuse, neglect, and exploitation by others in his/her place or residence and other daily settings?

Is the child/youth free from injury caused by others in his/her daily home, school, and community setting?

Do parents and caregivers provide the attention, actions, and supports necessary to protect the child/youth from known risks of harm in the home?

When looking at data from Quality Services Reviews (QSR) from the most recent round (completed in 2015) there are several applicable factors with regard to safety in the 497 cases reviewed for the round. On the higher scoring end of the spectrum, Indiana found that children and youth were safe in all environments including their homes, schools, and communities broadly. Protective strategies for children and youth were implemented and followed, such as protective orders and safety plans. Children and youth were also found to have been appropriately supervised at all times, including visitations with parents when deemed necessary. The overall QSR Safety Score is rated at 98% with the aforementioned factors involved. With regard to cases which scored lower in the area of safety, it was found that in some instances safety plans were either not developed or not being followed.

The two safety measures were also further broken down for each of the Indiana Department of Child Services eighteen regions. Each region received data on their respective performance along with case and child-level data. The purpose of this was to examine trends of commonality in order to attempt to preempt some of the contributing factors, or at the very least be cognizant of their existence. Each of the regions are further charged with developing their biennial plans to incorporate improvement initiatives in each of the areas; specifically those of repeat maltreatment and repeat maltreatment in foster care.

B. Permanency

Permanency Outcomes 1 and 2

Permanency outcomes include: (A) children have permanency and stability in their living situations; and (B) the continuity of family relationships is preserved for children.

- For each of the two permanency outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the four federal permanency indicators and relevant available case record review data.
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Permanency Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the permanency indicators.

State Response:

Insert state response to Permanency Outcomes 1 and 2

As set forth below, Indiana statute outlines the legal requirements related to permanency, requirements which help ensure that children have stability in their living situations and continuity of family relationships are preserved.

Statute

IC 31-34-21-5.6 Exceptions to requirement to make reasonable efforts to preserve and reunify families

Sec. 5.6. (a) A court may make a finding described in this section at any phase of a child in need of services proceeding.

(b) Reasonable efforts to reunify a child with the child's parent, guardian, or custodian or preserve a child's family as described in section 5.5 of this chapter are not required if the court finds any of the following:

(1) A parent, guardian, or custodian of a child who is a child in need of services has been convicted of:

(A) an offense described in IC 31-35-3-4(1)(B) or IC 31-35-3-4(1)(D) through IC 31-35-3-4(1)(J) against a victim who is:

(i) a child described in IC 31-35-3-4(2); or

(ii) a parent of the child; or

(B) a comparable offense as described in clause (A) in any other state, territory, or country by a court of competent jurisdiction.

(2) A parent, guardian, or custodian of a child who is a child in need of services:

(A) has been convicted of:

(i) the murder (IC 35-42-1-1) or voluntary manslaughter (IC 35-42-1-3) of a victim who is a child described in IC 31-35-3-4(2)(B) or a parent of the child; or

(ii) a comparable offense described in item (i) in any other state, territory, or country; or

(B) has been convicted of:

(i) aiding, inducing, or causing another person;

(ii) attempting; or

(iii) conspiring with another person; to commit an offense described in clause (A).

(3) A parent, guardian, or custodian of a child who is a child in need of services has been convicted of:

(A) battery as a Class A felony (for a crime committed before July 1, 2014) or Level 2 felony (for a crime committed after June 30, 2014);

(B) battery as a Class B felony (for a crime committed before July 1, 2014) or Level 3 or Level 4 felony (for a crime committed after June 30, 2014);

(C) battery as a Class C felony (for a crime committed before July 1, 2014) or Level 5 felony (for a crime committed after June 30, 2014);

(D) aggravated battery (IC 35-42-2-1.5);

(E) criminal recklessness (IC 35-42-2-2) as a Class C felony (for a crime committed before July 1, 2014) or a Level 5 felony (for a crime committed after June 30, 2014);

(F) neglect of a dependent (IC 35-46-1-4) as a Class B felony (for a crime committed before July 1, 2014) or a Level 1 or Indiana Code 2015 Level 3 felony (for a crime committed after June 30, 2014); or

(G) a comparable offense described in clauses (A) through

(F) in another state, territory, or country; against a child described in IC 31-35-3-4(2)(B).

(4) The parental rights of a parent with respect to a biological or adoptive sibling of a child who is a child in need of services have been involuntarily terminated by a court under:

(A) IC 31-35-2 (involuntary termination involving a delinquent child or a child in need of services);

(B) IC 31-35-3 (involuntary termination involving an individual convicted of a criminal offense); or

(C) any comparable law described in clause (A) or (B) in any other state, territory, or country.

(5) The child is an abandoned infant, provided that the court:

(A) has appointed a guardian ad litem or court appointed special advocate for the child; and

(B) after receiving a written report and recommendation from the guardian ad litem or court appointed special advocate, and after a hearing, finds that reasonable efforts to locate the child's parents or reunify the child's family would not be in the best interests of the child.

IC 31-34-21-7 Permanency hearing

Sec. 7. (a) The court shall hold a permanency hearing:

(1) not more than thirty (30) days after a court finds that reasonable efforts to reunify or preserve a child's family are not required as described in section 5.6 of this chapter;

(2) every twelve (12) months after:

(A) the date of the original dispositional decree; or

(B) a child in need of services was removed from the child's parent, guardian, or custodian whichever comes first; or

(3) more often if ordered by the juvenile court.

(b) The court shall:

(1) make the determination and findings required by section 5 of this chapter;

(2) consider the question of continued jurisdiction and whether the dispositional decree should be modified;

(3) consider recommendations of persons listed under section 4 of this chapter, before approving a permanency plan under subdivision (5);

(4) consult with the child in person, or through an interview with or written statement or report submitted by:

(A) a guardian ad litem or court appointed special advocate for the child;

(B) a case manager; or

(C) the person with whom the child is living and who has primary responsibility for the care and supervision of the child; in an age appropriate manner as determined by the court, regarding the proposed permanency plan;

(5) consider and approve a permanency plan for the child that complies with the requirements set forth in section 7.5 of this chapter;

(6) determine whether an existing permanency plan must be modified; and

(7) examine procedural safeguards used by the department to protect parental rights.

(c) If the child is at least sixteen (16) years of age and the proposed permanency plan provides for another planned permanent living arrangement, the court shall, at each permanency hearing, do all the following:

- (1) Require the department to provide notice of the permanency hearing to the child, in accordance with section 4(a) of this chapter.
 - (2) Provide to the child an opportunity to be heard and to make recommendations to the court, in accordance with section 4(d) of this chapter.
 - (3) Require the department to document or provide testimony regarding the intensive, ongoing, and, as of the date of the hearing, unsuccessful efforts made by the department to return the child home or secure a placement for the child with a fit and willing relative, legal guardian, or adoptive parent, including efforts through the use of search technology, such as social media, to find biological or adoptive family members for the child.
 - (4) Ask the child about the desired permanency outcome for the child and document the child's response.
 - (5) Make a judicial determination explaining why, as of the date of the hearing, another planned permanent living arrangement is the best permanency plan for the child and provide compelling reasons why it continues to not be in the best interests of the child to:
 - (A) return home;
 - (B) be placed for adoption;
 - (C) be placed with a legal guardian; or
 - (D) be placed with a fit and willing relative.
 - (6) Require the department to document or provide testimony regarding the steps the department is taking to ensure that:
 - (A) the child's foster family home, group home, secure private facility, or child caring institution is following the reasonable and prudent parent standard; and
 - (B) the child has regular, ongoing opportunities to engage in age or developmentally appropriate activities, including consulting with the child in an age appropriate manner about the opportunities for the child to participate in the activities.
- (d) There is a rebuttable presumption that jurisdiction over the child in a child in need of services proceeding continues for not longer than twelve (12) months after the date of the original dispositional decree or twelve (12) months after the child in need of services was removed from the child's parent, guardian, or custodian, whichever occurs first. The state may rebut the presumption and show that jurisdiction should continue by proving that the objectives of the dispositional decree have not been accomplished, that a continuation of the decree with or without any modifications is necessary, and that it is in the child's best interests for the court to maintain its jurisdiction over the child. If the department does not sustain its burden for continued jurisdiction, the court shall:
- (1) direct the department to establish a permanency plan within thirty (30) days;
- or
- (2) discharge the child and the child's parent, guardian, or custodian. The court may retain jurisdiction to the extent necessary to carry out any orders under subdivision (1).

Permanency Outcome Data

Indiana had a marked decrease in the mean number of placements over the last year. For November 2014, Indiana had a mean number of placements at 2.22 compared to November 2015 decreasing to 2.1 placements.

Indiana's Quality Service Review (QSR)

QSR measures stability in the following way:

To what degree are:

The Child/youth's daily living, learning, and work arrangements stable and free from risk of disruption?

The child/youth's daily settings, routines, and relationships consistent?

Known risks being managed to achieve stability and reduce the probability of future disruption?

When looking at data revolving around stability from the QSR, several things become apparent. In cases which performed well, Indiana sees the children and youth remained in their custodial/non-custodial homes or were places with relatives which allowed for their environments, routines, and relationships to be maintained. Children and youth were stable in their placements and teams had no concerns for future disruptions. Children and youth were maintained in their same placements over the past twelve months. Additionally, team members, both formal and informal, remained consistent throughout the life of the children/youths' cases.

Indiana's QSR measures permanency in the following way:

Is the child/youth living with parents or out-of-home caregivers that the child, parents, out-of-home caregivers, or other stakeholders believe will sustain until the child reaches adulthood and continue onward to provide family connections and supports?

If not, are permanency efforts presently being implemented on a timely basis that will ensure that the child/youth soon will be enveloped in enduring relationships that provide a sense of family, stability, and belonging?

When examining QSR data, some important strengths are present from cases which performed well. Team members were aware of permanency plans and knew the action steps necessary to achieve identified outcomes. Children and youth remained in their own homes or were in their anticipated permanent homes with plans in place to reach permanency. Team members were aware of and agreed with permanency plans for children and youth. Permanency for children and youth had been attained through reunification, adoption, or guardianship. And overall, progress was being made toward permanency goals for the children and youth. In the cases which not did perform as highly, action steps to achieve timely permanency were missing or unclear. Some of the permanency plans also lacked alternative or concurrent plans. Lastly, some team members may have expressed concerns or disagreed on the overall sustainability of current permanency plans. Overall, the scores for permanency are rated at 49% with the above factors considered.

Indiana's QSR also examines how quality family relationships are maintained.

This particular topic is measured in the following ways:

When children/youth and family are living temporarily away from one another, how well are specifically planned strategies and supports working to build and sustain family connections through appropriate visits and other means, unless compelling reasons exist for keeping them apart?

To what degree have strategies and efforts been put into place to support the following between child/youth and his/her parents for:

- (1) Building and maintaining positive interactions?
- (2) Creating and using opportunities for providing emotional support?
- (3) Using varied and creative opportunities for family members to nurture one another?

In the most recent round of the QSR, positive measures occurred to the end of maintenance of quality family relationships. Visitations between mothers and fathers and their children/youth occurred regularly with communication occurring outside the visitations using various methods. Sibling visitations occurred regularly, often in conjunction during parental visitation. However, on the lower end of the performance spectrum, some issues were also noted. At times, contact with parents and children/youth can be limited and inconsistent. Due to incarceration of parents, visitation was again inconsistent or very limited. Moreover, there were some instances of visitation plans not being in place to maintain consistent contact between siblings. Overall, maintaining relationships with the mother and with the father were 63% and 42% respectively, while maintaining relationships with siblings was rated at 64%.

C. Well-Being

Well-Being Outcomes 1, 2, and 3

Well-being outcomes include: (A) families have enhanced capacity to provide for their children's needs; (B) children receive appropriate services to meet their educational needs; and (C) children receive adequate services to meet their physical and mental health needs.

- For each of the three well-being outcomes, include the most recent available data demonstrating the state's performance. Data must include relevant available case record review data and relevant data from the state information system (such as information on caseworker visits with parents and children).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Well-Being Outcomes 1, 2, and 3.

State Response:

Insert state response to Well-Being Outcomes 1, 2, and 3

Well-Being Outcomes Data

Quality Service Review (QSR) Data

The Indiana Quality Service Review groups well-being factors of appropriate living arrangement (covered previously), physical health, emotional status, and learning & development together.

In the QSR, physical health is defined in the following way:

To what degree:

Is the child/youth achieving and maintaining his/her optimum health status?

If the child/youth has a serious or chronic physical illness, is the child/youth achieving his/her best attainable health status given the disease diagnosis and prognosis?

When examining the data from the most current round of the QSR, several factors become readily apparent with regard to high scores and apparent factors for lower scoring cases. Children/youth were up-to-date on immunizations, as well as, routine medical and/or dental care. Children were in good physical health and received routine medical attention. Children/youths' known medical conditions were appropriately monitored and managed by caregivers and/or physicians. The vast majority of cases reviewed scored in the higher areas on physical health, but the lower scores showed that medical needs were not consistently met for the child/youth. The overall physical health rating was 99%.

Emotional status is defined in the following ways:

To what degree:

Is the child/youth presenting age-appropriate emotional development, adjustment, attachment, coping skills, and self-control?

Is the child/youth achieving and maintaining an adequate level of behavioral functioning in daily settings and activities, consistent with age and ability?

The data from the most recent round of the Quality Service Review shows that higher performing cases show children/youth demonstrated age-appropriate emotional development. There were effective uses of therapy and/or medications which led to improved coping skills and decreased behaviors for children/youth. Finally, children/youth exhibited good relationships with their biological parents, peers, siblings, caregivers, and/or other adults. And while the scores for the most recent round show a majority of them with higher performance, several lower performing factors also came to light. Children/youth continued to display inappropriate behaviors due to unaddressed trauma or emotional needs. Services were either delayed or inadequate to meet children/youths' underlying needs. Children/youth were unable to self-regulate their emotions and behaviors, which resulted in their lack of self-control and being unable to use appropriate coping skills. Children/youth put themselves or others at risk as a result of being unable to appropriately express their emotions. Team members were uncertain or lacked understanding of children/youth's diagnoses or past trauma, which lead to their emotional needs being unaddressed. The overall emotional status rating was 88% for the previously completed round of the QSR.

The Indiana Quality Service Review organizes learning & development in the following ways:

To what degree:

Is the young child's development status commensurate with his/her age and developmental capacities?


Is the child's developmental status in key domains consistent with age-appropriate expectations?

Learning and development was measured in the prior round of the Quality Service Review. This is arguably one of the highest performing areas for Indiana in the QSR. Higher performing cases had non-school age children being developmentally on track and meeting developmental milestones or had been assessed for services, when necessary. Services, such as Head Start and First Steps, assisted in addressing children's developmental needs. Children/youth regularly attended school, performed at or above grade level, and were on track for promotion to the next grade. Children/youths' IEPs were well-monitored and effectively addressed their needs. Cases on the rarer, lower end of the performance spectrum showed school-age children/youth had poor attendance and were behind academically. Appropriate interventions needed for children/youths' success in school had not been identified, such as testing for learning disabilities or Individualized Education Plans (IEP). IEPs were in place but were not adequately addressing children/youths' needs. Learning and development saw a 3% increase in the rating, scoring a 91% for the most recently completed round of the QSR.


The increased volume of cases Indiana has seen has been a primary driver for much to do with safety, permanency, and well-being. Indiana has increased the number of Family Case Managers, expanded services, and worked with external partners to address these increases.

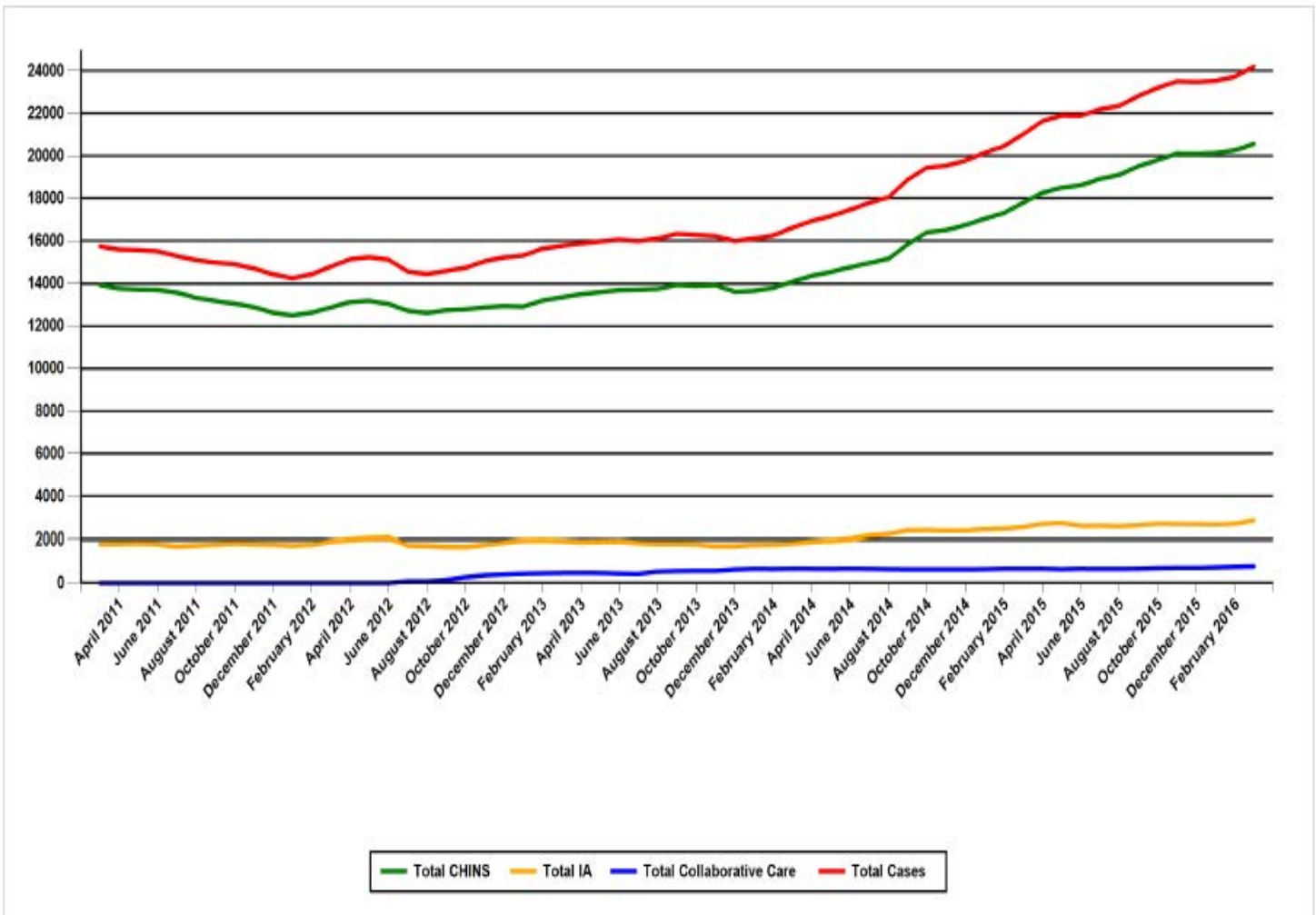
With such a rapid and dramatic increase in case volume, Indiana ensured that the high level of care expended from the agency was maintained at every level.

As seen in the graphic below, an unprecedented and unforeseen increase began in 2013 with an accompanying dramatic rise in volume again in 2014.



Department Of Child Services
Five Year Trend Open Cases
 For March 2011 to March 2016





New CFSR Indicators

In an effort to expand the Quality Service Review indicators to more closely align to the Child and Family Services Review, Indiana has incorporated additional measures into the robust set which already existed. While these measures previously existed in the State’s practice model, having them delineated in such a specific way is still a new method with some time

allotted for adjustment. Moreover, these measures are calculated for a focus on a 12 month timeframe whereas the Quality Service Review measures focus more toward the 90 day timeframe. Below is a chart of the completed scores for the first quarter of implementation prior to the Child and Family Services Review itself. The goal is have indicators measured prior to, during, and following the Child and Family Services Review to allow for longitudinal considerations which lend themselves to continuous quality improvement efforts broadly.

CFSR Indicator Results At A Glance

Indicators	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Cumulative
Teaming Last 90 Day								
Formation	33%							
Functioning	29%							
Teaming Past 12 Months								
Formation	25%							
Functioning	23%							
Assessing and Understanding Last 90 Days								
Mother	37%							
Father	17%							
Child/Youth	74%							
Resource Parent	51%							
Assessing and Understanding Past 12 Months								
Mother	27%							
Father	13%							
Child/Youth	57%							
Resource Parent	45%							
Intervention Adequacy Last 90 Days								
Mother	38%							
Father	13%							
Child/Youth	73%							
Resource Parent	43%							
Intervention Adequacy Past 12 Months								
Mother	11%							
Father	11%							
Child/Youth	61%							
Resource Parent	40%							
Role & Voice 90 Days								
Mother	49%							
Father	17%							
Child/Youth	75%							
Resource Parent	53%							
Planning 90 Days								
Child & Family Planning Process	33%							

*** Twelve Month Scores are the percentage (%) of cases which scored in refine/maintain over the entire past 12 months.

Section III: Assessment of Child and Family Outcomes and Performance on National Standards

Indicators	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Cumulative
Safety Last 90 Days								
Timely Initiation	85%							
Safety Services	75%							
Safety Plans	53%							
Safety Concerns	76%							
Safety Concerns Visitation	80%							
Safety Past 12 Months								
Timely Initiation	67%							
Safety Services	61%							
Safety Plans	58%							
Safety Concerns	69%							
Safety Concerns Visitation	82%							
Frequency of Contacts Last 90 Days								
Mother	52%							
Father	22%							
Child/Youth	85%							
Frequency of Contacts Past 12 Months								
Mother	42%							
Father	15%							
Child/Youth	80%							
Quality of Contacts Last 90 Days								
Mother	25%							
Father	8%							
Child/Youth	55%							
Quality of Contacts Past 12 Months								
Mother	21%							
Father	5%							
Child/Youth	51%							

*** Twelve Month Scores are the percentage (%) of cases which scored in refine/maintain over the entire past 12 months.

Section IV: Assessment of Systemic Factors

Instructions

The statewide assessment information for systemic factors is used in determining ratings for substantial conformity. Therefore, it is imperative that the statewide assessment team ensures that information in this section speaks to how well each systemic factor requirement functions across the state. To complete the assessment for each systemic factor, state agencies should:

1. Review the *CFSR Procedures Manual* (available on the Children's Bureau Web site at <http://www.acf.hhs.gov/programs/cb>), which elaborates on key concepts and provides examples of data that are relevant to the assessment of systemic factor requirements.
2. Respond to each assessment question using the requested data and/or information for each systemic factor item. Relevant data can be qualitative and/or quantitative. Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance for each of the seven systemic factors. Review the information with the statewide assessment team and determine if more recent data is available that can be used to provide an updated assessment of each item. If more recent data are not available, refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each systemic factor item.
3. Emphasize how well the data and/or information characterizes the statewide functioning of the systemic factor requirement. In other words, describe the strengths and limitations in using the data and/or information to characterize how well the systemic factor item functions statewide (e.g., strengths/limitations of data quality and/or methods used to collect/analyze data).
4. Include the sources of data and/or information used to respond to each item-specific assessment question.
5. Indicate appropriate time frames to ground the systemic factor data and/or information. The systemic factor data and/or information should be current or the most recent (e.g., within the last year).

The systemic factor items begin with #19 instead of #1 because items #1 through 18 are outcome-related items covered in the onsite review instrument used during the onsite review. Items related to the systemic factors are items #19 through 36.

A. Statewide Information System

Item 19: Statewide Information System

How well is the statewide information system functioning statewide to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

Please provide relevant quantitative/qualitative data or information that show the statewide information system requirements are being met statewide.

State Response:

Insert state response to Item 19: Statewide Information System

Overview and Ability to Collect Required Information

An overview of the history, development, and current features of DCS' child welfare information system, the Management Gateway for Indiana's Kids (MaGIK), can be found on page 41 of the 2016 APSR. As further detailed on pages 42-43 of the 2016 APSR, a strength of MaGIK is its functionality that allows DCS to readily identify the status, demographic characteristics, location, and goals for the placement of every child in foster care. Furthermore, as set forth below, an analysis of the data in MaGIK indicates that critical information contained in the system is correct, indicating the statewide information system is a strength.

Accuracy of Data

To evaluate the accuracy of certain data in MaGIK, DCS utilized three groups of employees to verify information and then input the results into an electronic survey. A short description of how each group performed the verification of data and the corresponding results are set forth below.

IV-E Central Eligibility Unit (CEU) Survey: CEU is a division of DCS which is responsible for verifying information necessary to determine IV-E eligibility. CEU utilizes, among other resources, the Indiana Client Eligibility System (ICES) - the central data repository in Indiana for such federal programs as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) – to verify basic demographic information, such as date of birth, gender, and race. Court orders, case notes, and KidTraks (DCS' financial system connected to MaGIK) are also utilized. As part of the survey, CEU staff reviewed a total of 137 cases during the first quarter of calendar year 2016 by verifying that data in MaGIK matched the documents and databases CEU staff use to determine IV-E eligibility. The questions and the results are listed in the table below and demonstrate that no less than 99% of the cases reviewed had information that was accurately reported in MaGIK.

Section IV: Assessment of Systemic Factors

Question (verification source)	Yes	No	Number Corrected if answered "No"?	Unable to verify (not counted in %)
Is youth's date of birth accurately recorded in MaGIK? (ICES)	136 (99%)	1 (1%)	1	0
Is youth's gender accurately recorded in MaGIK? (ICES)	137 (100%)	0 (0%)	N/A	0
Is youth's race accurately recorded in MaGIK? (ICES)	136 (99%)	1 (1%)	1	0
Is involvement/case type accurately recorded in MaGIK to match what is documented in the court order? (court order)	135 (99%)	0 (0%)	N/A	2
Is whether the youth was previously adopted accurately recorded in MaGIK? (KidTraks or case notes)	132 (99%)	1 (1%)	0	4

Family Case Manager (FCM) Supervisor Survey – Over the course of three (3) weeks during the first quarter of calendar year 2016, FCM Supervisors, during their scheduled face to face contact/visits spoke with parent(s)/caregiver(s)/legal guardian(s) and/or youth (if appropriate) in order to obtain answers to the questions listed in the table below. Thereafter, the FCM Supervisor confirmed that the responses given matched the information contained in MaGIK. If information did not match, corrections in MaGIK were requested.

Section IV: Assessment of Systemic Factors

Question	Number of Responses	Yes	No	Number Corrected if answered "No"	Unable to Verify - not counted in %
Are all of the youth's medical conditions properly entered in to the health information section of MaGIK?	1154	1046 (92%)	94 (8%)	63	14
Is the youth's ethnicity accurately recorded in MaGIK?	1153	1134 (99%)	15 (1%)	14	4
Is the location where the youth currently resides and/or placed accurately identified in MaGIK?	1153	1121 (97%)	30 (3%)	23	2
Are all placements in the last year recorded accurately in MaGIK?	1152	1141 (99%)	11 (1%)	3	0

DCS Legal Staff Survey: During the first quarter of calendar year 2016, DCS completed an online survey of statewide legal staff in which DCS staff attorneys and/or administrative staff, as part of the regular preparation of their weekly court dockets, reviewed case files and answered questions regarding the case file. As part of the survey, respondents answered a question about whether the permanency plans entered in MaGIK matched the court's documented permanency goal.

Question	Number of Responses	Yes	No	N/A (Case is an Informal Adjustment or not yet adjudicated) – Not counted in %	N/A (Other) – Not counted in %
After adjudication, do permanency plans (primary and/or concurrent) entered in the Case Plan section of MaGIK match the court’s documented permanency goal?	201	156 (93%)	12 (7%)	27	6

Timely Entry of Data

DCS complies with the federal requirement for timely entry of data as evidenced by the most recent Indiana AFCARS data. For example, the “Date of Latest Removal from Home” had an error rate (i.e. was not entered timely into the statewide information system) of only 0.45% (96 out of 21502). The “Date of Discharge from Foster Care” had an error rate of only 1.36% (62 out of 4547). In addition to meeting the minimum federal requirement, DCS has policies and procedures in place to encourage staff to exceed the federal requirement for timely entry of data.

Verification System Overview

As mentioned above, MaGIK serves as the case file for all DCS cases. By ensuring an electronic file exists where information is securely stored in a single place and readily accessible to the FCM and the FCM Supervisor, the important tools and information an FCM needs to perform his or her administrative functions is provided. For example, in the event of a natural disaster or fire at a local office, the critical case file information would still be retrievable as it is electronically stored securely on off site. MaGIK also enhances the ability of FCM Supervisors to effectively monitor and support their employees.

As the MaGIK system has replaced the traditional paper case file, DCS is mindful of ensuring MaGIK supports DCS’ case practice by promoting the timely entry of accurate information. To that end, DCS instituted– and continues to refine and develop – a multi-layered system of checks and balances that creates an environment of data validation without sacrificing functionality. Such a multifaceted validation system is necessary with over 3,000 individuals interacting with MaGIK and inputting data. These validation efforts continue to


evolve as DCS and its software vendor, Case Commons, make improvements, and add functionality to MaGIK. While the verification system does not guarantee complete accuracy of the data, a byproduct of requiring consistent entry and/or format is the increased likelihood of data being correctly entered, especially after a validation error is identified. Furthermore, a combination of validation points, reminders, and confirmation messages encourage the entry of timely and accurate data. Below is a small sample of the many validations on data entry (with select screenshots) that currently exist within MaGIK.

- People
 - Date of birth cannot be more than 200 years ago, cannot be a future date, and must be in the correct format (mm/dd/yyyy)
 - Location of all people (youth not in placement, adults, and youth starting or moving placements) must have a valid type of location selection and address
- Assessments (information required to submit for supervisor approval)
 - Victims require date of birth, ethnicity, gender, race, living arrangement, and child risk factors
- Case Involvement Types
 - An involvement (for example, a case type that has either been court ordered, an agreement by parents and DCS, or an agreement by older youth and DCS) close date cannot precede the end date of a removal episode (removal episode is the time from first placement until a court outcome is entered that ends DCS's placement responsibility)
 - An involvement type cannot be closed while there is an open removal episode unless there is another active case
 - An alert when a removal episode has ended but the involvement type is still open

CHILD INVOLVEMENT STATUS

Update Involvement Status
Lemon's removal has ended and the child has returned home. Please update the involvement statuses if necessary.

▼ **OPEN INVOLVEMENTS** (1 Child)

 [Lemon Summer](#)
Female, 15 years old (DOB 6/2/2000)
Child in Need of Services (CHINS) since 6/13/2015
1st Removal Ended, 1/11/2016 | Reason: Reunification ([Court Case Closed](#))

- Placements and Locations
 - All child placement locations require a start date and time and a reason for the placement change

UPDATE FOCUS CHILD'S LOCATION



LEMON SUMMER

Female, 15 years old (DOB 6/2/2000)

Child in Need of Services (CHINS) since 6/13/2015

What type of location is this? *

Runaway

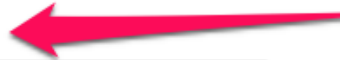
Start Date & Time *

MM/DD/YYYY



HH:MM AM

Why is the location changing? *



- A placement or type location requires the selection of a setting type
- All removal episodes must line up back to back and a valid court hearing outcomes must be present to end a removal episode.
- Court Hearings & Outcomes
 - Outcomes that end a removal episode require a permanency outcome to be selected of either adoption, child is entering the collaborative care program, death of child, emancipation, guardianship, permanent placement with relative, reunification, runaway with wardship dismissed, or transfer of placement and care to another state agency
 - FCM receives dashboard alerts in MaGIK about the next scheduled court hearing and when an outcome is overdue

Hearing Reminder:

CASE NAME ↓	CHILD VISIT WITH PARENT ↑	NEXT SCHED. COURT HEARING ↑	FCM CONTACT WITH CHILD ↑
Dual CHINS Test	45 Days Ago	1/20 Wardship Dismis...	30 Days Ago
0 Action Items		1 Active Focus Child	

Outcome Overdue:

Brandie D. ■■■	2/24 Periodic Review	62 Days Ago Child's Home
4 Action Items — 4 due/overdue		2 Active Focus Children
☆ THV Expiring for Noah C. ■■■ Chayse D. ■■■ — Add Hearing		Due 12/30/15
☆ Case Plan Missing for Chayse D. ■■■ — Add		Due 10/30/15
☆ Case Plan Missing for Noah D. ■■■ — Add		Due 10/30/15
☆ Hearing Outcome Missing for Chayse D. ■■■ Noah D. ■■■ — Add		Due 10/21/15

- FCM gets dashboard alert in MaGIK when a trial home visit order is expiring and needs to get an order if necessary to continue
- Contacts
 - FCM gets dashboard alerts in MaGIK about the last contact with a focus child.

Brandie D. [Avatar]	2/24 Periodic Review	62 Days Ago Child's Home
4 Action Items — 4 due/overdue	2 Active Focus Children	
☆ THV Expiring for Noah C. [Avatar], Chayse D. [Avatar] — Add Hearing	Due 12/30/15	
☆ Case Plan Missing for Chayse D. [Avatar] — Add	Due 10/30/15	
☆ Case Plan Missing for Noah D. [Avatar] — Add	Due 10/30/15	
☆ Hearing Outcome Missing for Chayse D. [Avatar], Noah D. [Avatar] — Add	Due 10/21/15	

- Case Plan
 - FCM gets a dashboard alert in MaGIK when an information adjustment plan or case plan is expiring (three (3) weeks before expiration)

Crystal B. [Avatar]	90+ Days Ago	5/6 Permanency He...	51 Days Ago Other Home
1 Action Item — 1 due/overdue	4 Active Focus Children		
☆ Case Plan Expiring for Tyler B. [Avatar], Jada Lynn H. [Avatar], Kevin H. [Avatar], Jr, William H. [Avatar] — Create New	Due 12/29/15		

- FCM gets a dashboard alert in MaGIK when a case plan is missing

Brandie D. [Avatar]	2/24 Periodic Review	62 Days Ago Child's Home
4 Action Items — 4 due/overdue	2 Active Focus Children	
☆ THV Expiring for Noah C. [Avatar], Chayse D. [Avatar] — Add Hearing	Due 12/30/15	
☆ Case Plan Missing for Chayse D. [Avatar] — Add	Due 10/30/15	
☆ Case Plan Missing for Noah D. [Avatar] — Add	Due 10/30/15	
☆ Hearing Outcome Missing for Chayse D. [Avatar], Noah D. [Avatar] — Add	Due 10/21/15	

- A case plan requires a start date, expiration date, focus child, permanency goal, and at least one caregiver
- A case plan cannot be submitted for FCM Supervisor approval with missing fields in the strength and needs section, safety section, twelve (12) placement questions, four (4) permanency questions, a case plan objectives/activities section, seven (7) health questions, and eleven (11) education questions.
- Case Closure
 - All involvements must be closed in order for an FCM to send a case for closure approval to the FCM Supervisor

Work was completed in August 2015 to improve the syncing of how court hearings, involvement types, removals, and placements are entered and interact with one another within MaGIK. These improvements resulted in the quality of data around these events being more accurate. The validations also help ensure that the data is valid when compared to one another. For example, an involvement type cannot be closed while there is an open removal episode, and a placement cannot be ended without a hearing outcome that would end the removal episode or a new placement for the youth. Similarly, an involvement closed date can no longer be back dated to happen during a removal episode. Placement agreements and subsequent per diem payments and fiscal records are also managed within an integrated component of MaGIK-KidTraks. If the information in MaGIK-Casebook is not correct, a claim for payment cannot be processed timely, prompting supervisory staff and/or the FCM to verify information.

Additional Verification Mechanisms

DCS has also developed the AFCARS checklist tool that FCMs can use to automatically pre-check their data fields. The checklist is an on demand form in MaGIK that workers can access at any time in order to verify the completeness of the various data elements needed for an AFCARS submission.

Lastly, and most importantly, the upcoming implementation of the reconfigured Reflective Practice Survey (RPS) tool to be deployed during the second quarter of 2016 will provide another opportunity for DCS to regularly verify the information contained in MaGIK. The data validation questions will be answered for all surveys scored during each quarter. The revised tool will contain a series of data verification questions that FCM Supervisors will ask parents, children, and/or legal caregivers that will then be cross referenced with information contained in MaGIK. If any data is entered incorrectly, FCMs will be asked to enter the updated and accurate information into MaGIK. Supervisors will then enter whether the data was corrected in the RPS data validation page to ensure when data changes occur, there is justification for the change.

B. Case Review System

Item 20: Written Case Plan

How well is the case review system functioning statewide to ensure that each child has a written case plan that is developed jointly with the child's parent(s) and includes the required provisions?

Please provide relevant quantitative/qualitative data or information that shows each child has a written case plan as required that is developed jointly with the child's parent(s) that includes the required provisions.

State Response:

Insert state response to Item 20: Written Case Plan

A Case Plan is required for each child in need of services who is under the supervision of DCS. The DCS Child Welfare Policy 5.8 – Developing the Case Plan (a copy is attached as **Attachment 1**) instructs Family Case Managers (FCMs) on development of the Case Plan. The Case Plan document includes all of the federally required elements; **a copy of the Case Plan - State Form 2956, is attached hereto as a separate stand-alone document.** Updates to the Case Plan document to reflect the Preventing Sex Trafficking and Strengthening Families Act have also been incorporated. Although Indiana law requires the Case Plan be completed within 60 days under IC 31-34-15-2, DCS Child Welfare Policy 5.8 requires Family Case Managers (FCMs) to complete case plans within 45 days of initiation of the case.

As part of the FCM Supervisors Survey detailed in Item 19 – Statewide Information System, in addition to a list of validation questions, FCM Supervisors answered the following question: “Does the youth have a current case plan entered in MaGIK?” Of the 1150 responses, 799 (77%) had a Case Plan entered in MaGIK, while 244 (23%) did not. If Case Plans were not entered in MaGIK and should have been, FCM Supervisors were asked to upload the Case Plan. 107 (of the 1150) cases were not applicable as they were utilizing the informal adjustment process.

DCS Child Welfare Policy 5.7 – Child and Family Team Meetings (CFTM), directs FCMs to develop the Case Plans jointly with the child's parents and other team members in the Child and Family Team Meeting. By utilizing the CFTM to develop the Case Plan, families have the opportunity to be engaged in the planning process which empowers them to make informed decisions about their own lives, including setting goals and developing strategies to attain them. A copy of DCS Child Welfare Policy 5.7 is attached hereto as **Attachment 2.** An FCM works with the parent, guardian, custodian, extended family, child/youth (if age and developmentally appropriate), and the Child and Family Team in developing the Case Plan. This involvement includes discussing the strengths and needs of the child and family that have been assessed through the ongoing conversations with the family (and their supports) in order to determine appropriate services and develop case plan goals. The FCM also explains the benefits of the

CFTM process to help build a support system or strengthen a pre-existing support system. Additional information on how DCS engages parents and families in the case planning process can be found in DCS Child Welfare Policy 5.3 – Engaging the Family, attached hereto as **Attachment 3**.

To track parent’s involvement, the CFTM section of the Case Plan includes a checkbox that indicates whether parents were involved in the CFTM. The parents are also encouraged to sign the Case Plan. As mentioned above, policy and practice were updated to include children age 14 and older and/or their representatives in the CFTM and in development of the case plans in compliance with the Preventing Sex Trafficking and Strengthening Families Act. Currently, a number of checks and balances are in place to ensure the completion and quality of Case Plans, such as supervisory review and case staffing. The MaGIK dashboard also notifies FCMs when a Case Plan is due and validations (fully described in Item 19 – Statewide Information System) are in place to ensure the Case Plan form is fully completed.

Parent involvement is also tracked using data measuring the role and voice of mothers and fathers as part of the Quality Service Reviews (QSR). Role and voice is described as the degree at which parents are active ongoing participants in decisions made about child/family change strategies, services, and results. For Round 4 of the QSR (from 9/1/2013-7/31/2015), the following chart outlines the number and percent of cases that received a rating of refine/maintain for mothers and fathers.

QSR Round 4 Role & Voice – Refine/Maintain

--	Number of cases	%
Mother	256	59%
Father	122	31%

Data revealed that mothers were engaged more than fathers by other team members. Reviewers found that mothers were active in their children’s cases through participation in CFTMs, school meetings, and medical appointments. Further, requests made by mothers were honored by other team members which allowed them to influence the direction of the case. Fathers, however, were passive participants or elected not to participate in their children’s cases. In other cases, stressors, such as substance abuse, mental health needs, legal problems, and incarceration hindered fathers from participating in the case planning process. To improve the participation of fathers, programs, such as Fatherhood Engagement, continue to be utilized throughout all 18 DCS Regions to improve fathers’ participation in their children/youths’ cases. Furthermore, in light of the number of incarcerated fathers, DCS collaborated with the Indiana Department of Corrections (DOC) to develop a documented process for DOC facilities to facilitate communications between DCS and the father and ensure they have access to DCS paid services. A copy of the memorandum of understanding between DCS and DOC is attached hereto as **Attachment 4**.

Additional QSR data is collected to evaluate the child and family planning process. Round 4 QSR data revealed that 227 cases (46%) received the rating of refine/maintain. Data showed that many of the key team members such as parents and children/youth (as well as providers, Court Appointed Special Advocates (CASA), etc.), were included in the Child and Family Planning Process, including the development of the Case Plan. Reviewers indicated team members participated in CFTMs and communicated on a regular basis outside of those meetings. In a large number of cases, team member could also identify the same permanency plan for children/youth. However, team members were unable to identify the action steps needed to achieve sustainable, safe case closure. In addition, many permanency plans and their objectives focused on short-term needs and acute crises rather than long-term plans for sustainability.

To further improve the planning process, as described in more detail in Item 27 – Experienced Worker Training, Staff Development has created and presented several mandatory trainings on mastering skills in CFTMs, including facilitating improvement in the functioning of team members, including parents.

Additionally, in response to the QSR data, DCS' CFSP Plan for Improvement – Objective 2.5 was implemented in order for DCS to evaluate and improve the structure and policy around use of the Case Plan to support development of goals that are in the best interests of children and families, promote engagement with parents, and further timely permanency. In order to assess concerns with the current structure and policy surrounding use of the Case Plan, DCS formed a committee of DCS staff and stakeholders to gather feedback on the effectiveness of DCS case plans. This committee noted the following concerns which will be addressed by the CQI committee assigned to goals involving Case Plans:

- Complexity: the committee had concerns that the Case Plan is too complex and is difficult for some family members to understand.
- Not User Friendly – the case plan committee requested that case plan completion in MaGIK be more user friendly, including capability to download other information into the case plan (like CFTM notes).
- Tracking – the committee identified ways in which DCS could better track case plan completion in MaGIK.
- Parent Involvement – In addition to QSR Sampling, identify other methods to track parent involvement in the CFTM, including whether they were actively engaged. Although DCS Policy requires a signature of the parent(s) on the Case Plan, a signature alone does not demonstrate a parent was actively involved in planning.

Item 21: Periodic Reviews

How well is the case review system functioning statewide to ensure that a periodic review for each child occurs no less frequently than once every 6 months, either by a court or by administrative review?

Please provide relevant quantitative/qualitative data or information that show a periodic review occurs as required for each child no less frequently than once every 6 months, either by a court or by administrative review.

State Response:

Insert state response to Item 21: Periodic Reviews

Each child's case must be reviewed at least once every six (6) months through a formal court hearing under IC 31-34-21-2. The first periodic case review must occur at least six (6) months after the date of the child's removal or at least six (6) months after the date of the dispositional decree, whichever is first.

Supervisors can monitor the status of periodic reviews utilizing the Child Data Summary in MaGIK, an auto-generated report that includes a field for the date of the last review and for the next scheduled periodic review. Dashboard ticklers in MaGIK also alert FCMs of the date of the next periodic review hearings. Information addressed in periodic review hearings include the child's safety, the continuing need for foster care, the extent of compliance with the case plan, progress made to alleviate or mitigate the causes necessitating placement in foster care, and a likely date for reunification or other permanency. This information is also included in the child's Case Plan and the Periodic Review Orders issued after the hearings. DCS staff attorneys also review this information with FCMs in preparation for the periodic review hearings and ask these questions during examination of the FCM. The FCM enters the results of the hearings in MaGIK and then uploads the order when it is received.

In practice, many Indiana courts hold periodic reviews every three (3) months. The inclusion of a mechanism for ongoing tracking and reporting of periodic review hearings is an area being reviewed. Nevertheless, as part of the Legal Survey detailed in Item 19 – Statewide Information System – DCS attorneys and administrative staff reviewed case files and answered questions regarding the timeliness of periodic reviews. The below chart demonstrates that out of the 201 cases that were reviewed, 95% of initial periodic reviews and 98% of subsequent periodic reviews were held timely.

Question:	Yes	No	N/A (case is not yet at this point, reviewed as informal adjustment, or other) - not included in %
Was the first periodic case review held within six (6) months after the date of the child/youth's removal or date of dispositional decree, whichever occurred first?	157 (95%)	8 (5%)	36
Were subsequent periodic case reviews held at least every six (6) months?	118 (98%)	3 (1%)	80

DCS collaborates with the Indiana Judicial Center to prepare bench book forms for judges to use in the periodic hearings to ensure that all of the necessary findings are addressed at hearings and included in court orders. As part of the survey mentioned above, DCS staff attorneys also reviewed the case file to answer a question about whether statutory determinations and findings required for periodic reviews were included in the court's order. As detailed in the table below, results indicated that 150 (99%) of court orders contained the required findings.

--	Yes	No	N/A (case is not yet at this point, reviewed as Informal Adjustment, court order not yet issued, etc.) not included in %
Were the statutory determinations and findings required for periodic reviews pursuant to I.C 31-34-21-5 included in the Court's order?	150 (99%)	1 (1%)	50

The above survey results indicate that the practices that DCS has put in place, such as the MaGIK tickler system and the collaboration with the courts on bench books, are having a positive impact on the periodic review process, resulting in this item being a strength of DCS.

Item 22: Permanency Hearings

How well is the case review system functioning statewide to ensure that, for each child, a permanency hearing in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter?

Please provide relevant quantitative/qualitative data or information that show a permanency hearing as required for each child in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter.

State Response:

Insert state response to Item 22: Permanency Hearings

Permanency hearings are tracked in MaGIK and through court orders. The MaGIK Child Data Summary Report includes a field for the date of the last permanency hearing and a field for the next scheduled hearing for tracking and scheduling purposes. Based on the court date of the last permanency hearing, MaGIK will send a notification to the FCM when it is time for the next hearing. Indiana statute requires courts to hold permanency hearings timely and Indiana courts and DCS local office attorneys monitor permanency hearings to ensure they are held timely. Indiana's law is more expansive than the federal requirement in that it applies to all children under DCS care, whether in foster care placement or in home with a parent. It also includes a provision that permanency hearings may be held more often if ordered by the court. Indiana code IC 31-34-21-7(a) requires the first permanency hearing be held within 12 months of removal or disposition, whichever occurs first.

To track the timeliness benchmarks listed above, DCS has a Memorandum of understanding with the Indiana Judicial Center to exchange information and reports related to judicial cases and permanency as part of the Court Improvement Program (CIP). Below are the 12 month timeliness measures and median data for the first and subsequent permanency hearings from the Indiana Judicial Center for Federal Fiscal Years 2013 – 2015.

--	FFY 2013	FFY 2014	FFY 2015
Time to First Permanency Hearing – median number of days from filing of the original petition to first permanency hearing	323	306	324
Time to Subsequent Permanency Hearings – median number of days from the first permanency hearing to the second, second to third, etc.	140	138	119

Corresponding percentages for the above timeliness measures are provided in the charts below and indicate that the majority of permanency hearings are held timely. The percentages reflect Federal Fiscal Year 2015 only.

Time to First Permanency Hearing	FFY 2015
Length of Time	Percent of Cases
365 Days and Under	83.1%
366 - 547 Days	14.9%
548 - 730 Days	1.2%
731 - 910 Days	0.4%
911 - 1095 Days	0.2%
1096 Days or More	0.1%

Time to <u>First</u> Subsequent Permanency Hearing	FFY 2015
Length of Time	Percent of Cases
365 Days and Under	92.7%
366 - 547 Days	5.8%
548 - 730 Days	0.9%
731 Days or More	0.6%

As part of the DCS Legal Survey - detailed in Item 19 – Statewide Information System - DCS surveyed legal staff statewide that, in the process of preparing the cases on their weekly docket, reviewed the case file and answered questions regarding the timeliness of permanency hearings and whether the permanency court orders contained the required findings. Results from the survey found that nearly all cases reviewed held timely permanency hearings and those hearings all made the necessary statutory findings. Results from the survey are detailed in the chart below.

--	Yes	No	N/A (case is not yet at this point, reviewed as Informal Adjustment, other) not included in %
Was the permanency hearing held at least once every 12 months after the date or removal or the date of the original dispositional decree, whichever occurred first?	95 (98%)	2 (1%)	104
Were the statutory determinations and findings required for a permanency hearing pursuant to I.C. 31-34-21-5 included in the Court's order?	96 (100%)	0 (0%)	105

The Court Improvement Program CHINS Timeliness Data and the DCS Legal Survey indicate that permanency hearings are regularly occurring timely and courts are making the required findings and determinations, demonstrating this item to be a strength. DCS will continue to collaborate with the Indiana Judicial Center to review timeliness measures and work with courts to improve practices and avoid issues that may consistently cause delays for permanency.

Item 23: Termination of Parental Rights

How well is the case review system functioning statewide to ensure that the filing of termination of parental rights (TPR) proceedings occurs in accordance with required provisions?

Please provide relevant quantitative/qualitative data or information showing that filing of TPR proceedings occurs in accordance with the law.

State Response:

Insert state response to Item 23: Termination of Parental Rights

A petition for termination of the parent-child relationship can be filed if one of the following occurs: (1) the child has been removed from the parent for six (6) months under a dispositional order; (2) a court has entered a finding that reasonable efforts for family preservation or reunification are not required; or (3) the child has been removed from the parent and has been under the supervision of a local office or probation department for at least fifteen (15) months of the most recent twenty-two (22) months.

Indiana law requires the Termination of Parental Rights (TPR) hearing to be commenced within 90 days and completed within 180 days, or the case shall be dismissed (IC 31-35-2-6). As part of the Court Improvement Program (previously described in Item 22 – Permanency Hearings), the Indiana Judicial Center tracks the median number of days from filing a Child In Need of Services (CHINS) petition to the filing of a TPR petition as well as the median number of days from filing a TPR petition to the completion of a TPR proceeding. The table below sets out the median time for Federal Fiscal Years 2013-2015.

--	Federal Fiscal Year 2013	Federal Fiscal Year 2014	Federal Fiscal Year 2015
Time to Termination of Parental Rights (TPR) Petition – The median time from filing of the CHINS petition to filing the TPR petition	468	470	476
Time to Termination of Parental Rights – The median time from filing of the CHINS petition to termination of parental rights	619	604	646

The Indiana Judicial Center is looking into expanding the timeliness measures it tracks, and one of those measures is the percentage of cases in which there is a final TPR order within 90, 120, and 180 days of filing of the TPR petition.

As part of the DCS Legal Survey (detailed in Item 21-Periodic Reviews), DCS surveyed legal staff statewide regarding the timeliness of TPR hearings and whether the court orders contained the required findings. Out of the 201 cases reviewed, a TPR petition had been filed in 42 cases. As further detailed in the chart below, of those 42 cases where TPR petitions had been filed, 85% were commenced within 90 days and 83% were completed not more than 180 days after the TPR petition filing.

--	Yes	No	N/A (TPR dismissed, not yet occurred, etc.)
If a TPR petition has been filed, was a hearing on the petition commenced not more than 90 days from the date of filing the petition?	28 (85%)	5 (15%)	9
If a TPR petition has been filed, were the hearings on the petition completed not more than 180 days after the filing of the TPR petition?	20 (83%)	4 (17%)	18
If a TPR order has been completed, were the statutory determinations and finding required for termination of parental rights pursuant to I.C. 31-35-2-8 included in the court's order?	18	0	2

For the 42 cases where a TPR had been filed, a TPR Order had been issued in 18 of the cases (2 TPRs had been dismissed). Out of those 18 TPR Orders, a review of the case file by legal staff determined that all had the required statutory determinations and findings.

Historically, DCS ran a monthly report to track children out of home for 15 out of 22 months. This report was not created at the time of MaGIK implementation and was not available when the CFSP was completed but has since been recreated. DCS Executive Staff closely review the 15 of 22 report and other reports relating to children for whom parental rights have been terminated to continually monitor the length of time they are in care after termination. The timeliness measures and survey data support this item being a strength of the agency. Nevertheless, DCS is in the process of reviewing all reports related to permanency to determine additional relevant quantitative and qualitative data to measure performance and show that TPR proceedings are occurring in accordance with required provisions. Timely filing of TPR is also

being reviewed as part of the Case Load Committee. Improved tracking of timelines associated with TPR filings is incorporated in CFSP Plan for Improvement Objective 2.5.

Item 24: Notice of Hearings and Reviews to Caregivers

How well is the case review system functioning statewide to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are notified of, and have a right to be heard in, any review or hearing held with respect to the child?

Please provide relevant quantitative/qualitative data or information that show foster parents, pre-adoptive parents, and relative caregivers of children in foster care (1) are receiving notification of any review or hearing held with respect to the child and (2) have a right to be heard in any review or hearing held with respect to the child.

State Response:

Insert state response to Item 24: Notice of Hearings and Reviews to Caregivers

DCS complies with IC 31-34-21-4, which requires it to provide notice of hearings at least seven (7) days prior to the hearing to the following individuals:

- Child's parent, guardian, or custodian;
- Any attorney that has filed an appearance on behalf of the child, parent or guardian;
- Any prospective adoptive parent named in a petition for adoption of the child;
- Tribal representatives;
- Foster parents;
- Any other person that DCS knows is providing care for the child; and
- Any other suitable relative or person whom the department knows has had a significant or caretaking relationship to the child.

Courts also include most of the above individuals on their distribution list for court orders and hearing notices. In addition to formal written notification, courts also require notice of service at some hearings and inquire as to the reason for non-attendance of parents or other key participants in the case, as this information is included in hearing orders. Lastly, courts also frequently schedule hearings during other proceedings and notify attendees of the next hearing date. FCM's also remind interested parties of hearings during their conversations and interactions such as Child and Family Team Meetings. DCS also has developed a form for children to submit to the court if they are not able to attend the hearing to advise the judge of their wishes.

Over the course of three weeks in early 2016, DCS surveyed resource (foster) parents during regularly scheduled resource and adoptive parent (RAPT) trainings across the state to ask them whether they received notice of court hearings and whether they were given the opportunity by the court to be heard. The survey was completed via hard copy and then transferred and input electronically by a DCS Staff Development team member. As set out in the table below, DCS received 210 responses to the survey and found that 162 (77%) of resource (foster) parents received notice of a hearing and/or review and 130 (62%) believed they were given the opportunity to be heard by the court.

--	Yes	No
Did you receive verbal or written notice of the next court hearing?	162 (77%)	48 (23%)
Were you given the opportunity by the court to be heard (i.e. share thoughts and concerns regarding a child placed with you)?	130 (62%)	80 (38%)

The survey results, along with the multiple mechanisms DCS has in place to assure foster parents receive notice and have an opportunity to be heard, point to this item being a strength. Nonetheless, DCS is in the process of reviewing methods to improve data collection and tracking in order to regularly measure performance in this area. For example, DCS is considering adding a question to the QSR related to whether parents, foster parents, and/or caregivers were in fact timely notified of hearings and reviews and felt they had input. An additional option being discussed is incorporating questions in to the Reflective Practice Survey (RPS) on this issue. Potential questions include the following:

- Did all individuals involved in the case, including the parent, foster parent, and/or caregiver receive a letter or document notifying them of hearings which occurred regarding the child?
- Were these individuals aware that they could attend the hearing?
- Did they attend the hearings? If so, did they feel they were provided an opportunity to provide input at the hearing?

DCS will also continue to work with the courts to help ensure foster parents not only receive notice, but are also given a meaningful opportunity to be heard.

C. Quality Assurance System

Item 25: Quality Assurance System

How well is the quality assurance system functioning statewide to ensure that it is (1) operating in the jurisdictions where the services included in the CFSP are provided, (2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety), (3) identifies strengths and needs of the service delivery system, (4) provides relevant reports, and (5) evaluates implemented program improvement measures?

Please provide relevant quantitative/qualitative data or information showing that the specified quality assurance requirements are occurring statewide.

State Response:

Insert state response to Item 25: Quality Assurance System

The Indiana Quality Assurance System includes the following: Quality Service Reviews (QSR); Quality Assurance Reviews (QAR); and Reflective Practice Surveys (RPS). Additionally, activities relating to ongoing evaluation and reporting of Indiana's IV-E Waiver play a role in the continuous quality improvement system DCS has in place. An overview of the foundational administrative structure of DCS' quality assurance system is described in-depth on page 47 of the 2016 APSR submittal. Furthermore, detailed information and background on the quality assurance systems mentioned above is also provided on pages 49-55 of the 2016 APSR submittal. Due to the investment in resources and continued improvement of quality assurance procedures, including an ongoing commitment to implement a high functioning continuous quality improvement system that informs all levels of staff statewide, DCS believes its statewide quality assurance system is a strength.

The following sections outline how all of the above quality assurance mechanisms operate statewide to evaluate services and identify strengths and needs to produce reports and information that are funneled to the various DCS regions statewide via the Biennial Regional Services Planning Process. Lastly, how those DCS Regions act on those reports and information to create action plans to meet the unique needs of their communities and how those action plans are monitored.

IV-E Waiver Activities

DCS and the IU Evaluation Team have conceptualized how CQI will be organized and executed within the agency. CQI efforts have been focused on aligning the Biennial Regional Services Strategic Plan Process (BRSP) with the CQI team, which allowed DCS and the Indiana University (IU) Evaluation Team to collect data from community members who need to be represented within the BRSP. From Evaluation Team discussions over the last service provider survey in 2013, it was clear that three distinct groups were answering the past service provider survey: foster parents, service providers, and the court. Since these are different

populations with different insights into cases, the decision was made to separate them to better direct improvement efforts. During the summer months of 2015, the Evaluation Team and Central CQI Team met 3-5 times a week for multiple hour sessions to create three new data instruments aimed at three different populations: 1) caregiver/youth (includes bio parents/foster parents/relative caregivers), 2) community service providers, and 3) court (includes judges/CASA/GAL/prosecutors/probation). The surveys asked respondents to answer questions using a 1 to 5 scale.

The following is a summary of how each survey was distributed, the number and categories of respondents, and an overview of the results/sample graph.

The Caregiver and Youth Survey was administered for the first two weeks of August where FCMs on their monthly visit had the biological parent, foster parent, relative, or older youth fill out the survey. Data collection began on August 3, 2015. A letter was sent to all FCMs with language stating:

“DCS is dedicated to the principles of Continuous Quality Improvement (CQI), a cycle of problem solving activities that require the deliberate use of evidence. Given that shared responsibility, as our CQI efforts continue to expand, DCS wants to give a voice to those who receive our services. In order to complete this, we need your help over the next two weeks.”

Respondents were able to rate DCS and the services that they have used. In addition, questions were asked about the teaming process and concrete services. To complete the survey, FCMs informed the caregiver and youth (3CM/CHINS or Collaborative Care) that they were selected as a possible participant because they are an individual that receives services from DCS and then asked if he/she would be willing to fill out a survey. The FCM filled out the name of the focus child whose first name was first in alphabetical order. The Caregiver and Youth Survey stopped collection on Friday, August 14th, 2015. Respondents consisted of biological parents (n=121), foster parents (n=123), relative caregivers (n=56), and youth (n=56).

In general, both adult caregivers and youth agreed or strongly agreed with most questions of satisfaction about DCS services and case managers. For adult caregivers, the questions with relatively higher average scores include: “I know what my DCS Family Case Manager (FCM) expects me to do” (M = 3.52), “the services DCS provides to my family respects our culture” (M = 3.45), and “my DCS FCM helps me get the services my family needs” (M = 3.45). There was one question that showed a significant difference between types of adult caregivers. Relative caregivers were more likely than biological parents to perceive that “my family is better off after receiving DCS services (3.52 vs. 3.22, $p < .05$).

Once the Caregiver and Youth surveys had been collected, the decision was made to continue to collect data using the caregiver and youth survey during the QSRs (more information regarding this effort is found in the QSR section below – Survey of Parent/Caregiver/Youth). Since the QSR collects rich data on a particular case, now the service recipients are able to provide additional information about their experiences with services provided by DCS staff as well as external providers. Complete data from this effort will be reported with Round 5 of the QSR.

The Community Service Provider survey was directed at CEOs, therapists, and administration. The Community Service Provider survey mirrored the FCM survey, asking them to rate the need, availability, utilization and effectiveness of services as well as some questions on teaming and specific questions about their facility. This survey was distributed by DCS

through an existing service provider list. The majority of respondents were frontline workers (n=181), followed by program managers (n=161), agency CEO (n=114), and central/administrative operations (n=85).

Respondents generally perceived that the most effective service was trauma focused-cognitive behavioral therapy (M = 3.8), followed by case management (M = 3.76), home-based services (M = 3.74), and home-based casework (M = 3.73). The interesting findings is that the effectiveness of mental health services was relatively ranked lower although it was consistently ranked higher in all other components of services. Furthermore, agency CEOs reported a significantly lower effectiveness than did central/administrative operations for home-based services and home-based therapy, and also a significantly lower effectiveness than did frontline workers for older youth services. There was also significant difference in the effectiveness of dental services between central/administrative operations (M = 4.11) and frontline workers (M = 3.47) at the .05 level.

The Court survey was comprised of questions directed at six (6) groups: judges, prosecutors, attorneys, law enforcement, CASA/GAL, and probation. Director Bonaventura sent out the survey to judges via an email list. Probation, law enforcement, prosecutors, attorneys, and CASA/GAL surveys were sent out on a listserv put together by the DCS Executive Team. This population was asked about service effectiveness and teaming. Additionally, they were asked to rate DCS employees in regards to court processes. Similar to the Community Service Provider survey, the snowball sampling method resulted in the data collection period being extended to Saturday, August 22nd. The majority of respondents were GAL/CASA (n=478), followed by probation (n=87), prosecutor (n=39), and judge (n=31).

In general, both groups indicated that most services were at least “somewhat” effective. More specifically, more than ninety percent of both groups commonly reported that dental services, first steps, health care services, and respite were “somewhat” and “completely” effective. On the other hand, judges showed that housing services (21.4%), mental health services (17.2%), and substance abuse services (16.7%) were “not effective at all”. Other court respondents also indicated that employment training services (27%), substance abuse services (25.5%), and father engagement services (24.8%) were “not effective at all”.

Information from the above described surveys was shared in the Statewide Data Presentation in September 2015 (detailed below) as well as provided to regional teams as part of the BRSP process.

Quality Service Review (QSR)

One of the most robust pieces of DCS’ quality assurance system is QSR. An overview of QSR, including the standards used to evaluate quality of services and how it identifies strengths and needs can be found on page 49 of the 2016 APSR.

The QSR process takes place across the state, as evidenced by the upcoming schedule of QSRs posted on the DCS website and attached hereto as **Attachment 5**. As presented on page 50 of the 2016 APSR submission, QSR Indicators that align with the Child and Family Service Review (CFSR) Onsite Review Instrument (OSRI) were added to the QSR starting with Round 5 in September 2015 and will continue throughout the upcoming rounds. A quarterly report on these indicators is in the process of being developed for submission to the agency

Director, Chief of Staff, and IU Evaluation Team. Thereafter, as part of the CQI effort, the quarterly reports will be pushed to field management for development of strategies to improve indicators in their region. Results of implementation of those strategies will be reported back to the Central CQI Team.

QSR indicator results play a critical role in measuring the progress toward DCS' Plan for Improvement as listed in Indiana's CFSP. A list of the categories and relevant indicators include:

Safety (CFSP Goal #1):

- Safety
- Behavioral Risk

Permanency (CFSP Goal #2):

- Placement Stability and Permanency Child Status
- Parent/Caregiver Status
- Role and Voice of Family Members
- Long Term View and Intervention Adequacy Planning Indicators

Well-Being (CFSP Goal #3)

- Appropriate Living Arrangement
- Physical Health
- Emotional Status
- Learning and Development
- Pathway to Independence

Information obtained from Round 4 of the QSR provides context around both system and child/parent/caregiver indicators. For example, overall the Child Status Indicators illustrated well-matched services and interventions for children/youth were employed. In addition, children/youth with identified needs received appropriate services, such as Individual Educational Plans (IEP), Para Education Teachers, First Steps services, and Head Start.

The QSR also identified trends to explain the decrease in several other important System Indicators. For example, some parents were not engaged in permanency planning for their children/youth by choice, due to incarceration, or were not engaged by system partners. Also, permanency plans were stalled for children/youth due to many reasons, such as team members being unclear of action steps for goal completions, parents' substance abuse not being fully addressed, untimely service referrals, or a wait list for services.

QSR results and analysis similar to those mentioned above are distributed in regional reports and then presented in the BRSP/RS meeting forum for community and providers to view and give feedback. The local stakeholders and RSC members utilize the information and connect it to their BRSP and any new information is applied to their existing plans. The information is also shared with the CQI work committees.

Survey of Parent/Caregiver/Youth: As mentioned above, as part of the QSR process, a survey of parent/caregiver/youth (SPCY) was administered beginning with the current round of the QSR. The SPCY will assist DCS and system partners in understanding the perception of those who are actually receiving services. Reviewers ask bio parents, caregivers, and youth

(14 years and older) if they would like to participate in the survey during their interview. Respondents can refuse to answer questions at any point during the survey. QSR reviewers give the respondents a password (their QSR ID), and they fill out the survey.

The survey includes questions about what services are implemented. Parents, caregivers, and youth are given the opportunity to rate those services on how well the services meets the unique needs of the child/youth and how well they support the ability to maintain the child/youth in their home (for unlicensed relatives and resource parents) on a 3 point Likert type scale consisting of not at all, somewhat, or completely. The caregivers and youth are also provided an opportunity to rate their experience with DCS and how engaged they were in the teaming process using a 4 point Likert type scale from Strongly Disagree to Strongly Agree. These types of data can provide an alternative perspective from the viewpoints of the service recipients.

Sixty-one (61) people completed the SPCY survey in the first two regions reviewed in round 5 of the QSR. Services most often used were case management services, followed by home-based services and health care services. Services were rated fairly high (2.64 overall out of 3), but due to the low number of responses in each category, mean scores should be used with caution. When the respondents rated DCS, respondents agreed that DCS respected their culture (>90% agreed), they had the opportunity to give their opinions about the case (78% agreed), their FCM helped get the services families needed (88% agreed), and DCS has improved their situation (77% agreed). Finally, most of the respondents participated in CFTMs in the last year (76.3%) and had favorable ratings regarding teaming such as they were positively encouraged to participate, time/location was convenient, and their opinion is valued during the CFTMs.

Feedback from initial implementation in the first two regions found that not all QSR participants were offered a survey due to internet accessibility, equipment malfunctions, time constraints, or reviewers who unintentionally omitted the survey from the process. Some respondents who were interviewed by phone were sent a link to the survey to their stated email address. All survey results were compiled by Indiana University. Additionally, some data entry errors may have occurred during the participant's role selection.

Distribution of Results: Each region received the SPCY data as part of their regional report which is shared with the RSC in BRSP planning. The DCS Administration also will receive a quarterly report (currently in development) that is shared with the Director, Chief of Staff, and other members of the Executive Staff. DCS continues to improve in distributing the QSR data in conjunction with other data reports in order to make informed decisions and implement improvements throughout the agency. For example, as mentioned in Item 27 – Ongoing Staff Training, training needs were identified based off of the past rounds of QSR data on team formation struggles in including fathers and resource parents in Child and Family Team Meetings. DCS revised and instituted new in-service training to improve the teaming ability of DCS staff.

As discussed on page 55 of the 2016 APSR, a list of several strengths of DCS' quality assurance system(s) - specifically QSR - were listed following a review by the Region V Administration of Family and Children (ACF) in January 2014. Below is a description of the steps DCS has taken to address areas in which ACF identified as opportunities for improvement:

1. Define in written policy what constitutes a conflict of interest for internal and external reviewers.
 - Action Taken: Policy was developed to define what constitutes a conflict of interest.
2. Consider developing ongoing training opportunities for provider reviewers, similar to current DCS reviewer practice (Advanced QSR reviewer training) and including this standard in future RFPs.
 - Action Taken: This option has been explored by DCS. Barriers that DCS is working to overcome are identifying funding sources as well as creating spots for providers while ensuring an adequate number of DCS employees are able to have access to the qualified reviewer training. Currently, funding does not allow providers to become qualified reviewers; therefore, advanced training is limited to DCS employees.
3. Develop and share an on-going case review schedule which includes representation of populations served, including the largest metropolitan areas.
 - Action Taken: An on-going case review schedule is posted online that provides dates through 2017.

Quality Assessment Review (QAR)

An overview of QAR is provided on page 52 of the 2016 APSR. For ongoing cases, QAR automatically collects information in the following categories:

1. Safety Assessment and Risk Reassessments are completed at least every 180 days until case closure for children in the home.
2. A Child and Adolescent Needs and Strengths (CANS) assessment was completed prior to developing the case plan.
3. A CANS assessment was completed in the last 6 months.
4. For all unlicensed placements, criminal history checks and child protection history checks within Indiana and nationwide were completed within 3 days of placement, for household members.
5. The first case plan was approved within 45 days of the removal date or disposition, whichever comes first.
6. Current case plan includes a safety plan for the child.
7. A female with a relationship of parent or guardian has a visitation plan that was created within five days of removal and/or covers the dates of the report period.
8. A male with a relationship of parent or guardian has a visitation plan that was created within five days of removal and/or covers the dates of the report period.
9. CHINS hearing has been completed within 60 days of removal or before the completion of the Initial hearing, whichever occurs first.
10. A Dispositional Hearing was completed 30 days after CHINS adjudication.

DCS continues to work toward meeting objective 4.2(b) from the CFSP to develop automated QAR reports for distribution. To that end, real time and quarterly reports became available in the fall of 2015 and are being validated by Field Operations. These reports will enable FCM Supervisors to more effectively manage FCMs in identifying strengths and areas needing improvement. Statewide and regional data trending reports are being developed and refined which will assist in making adjustments in strategies.

Discussions have already been initiated with Regional Managers and Executive Managers to identify strategies for improvement with the newly developed report. Field management has focused on two areas for immediate improvement and are developing strategies to address them. For example, field management recognized that safety plans are not always included in the Case Plan section of MaGIK; rather they are often located in other sections within system, such as CFTM notes, contact logs, and uploaded attachments, preventing them from being collected in the QAR (and indicating artificially low numbers). Another area identified for improvement is the area of background checks for unlicensed homes. Dialogue with Regional Managers and Central Office recognized background checks are routinely completed; however, not always documented in MaGIK giving false results in this area. Strategies are being discussed at the regional level to ensure corrective action occurs.

Reflective Practice Survey (RPS)

Data analyzed from RPS thus far has proven to be unreliable as scores remain artificially high, as evidenced by an analysis of corresponding QSR scores for the same DCS Regions. In order to identify reasons, focus groups were conducted with Supervisors and Local Office Directors. Results from these groups indicated a collective aversion to being penalized for unfavorable results. The results from the focus groups further support the need for DCS' goal of promoting a culture of learning.

The RPS will process through two phases of updates in the coming months. The first phase will involve moving the RPS from Intake to the KidTraks database. The RPS will be accessed from the Gateway portal home page but will not have any new functionality at the time of the move. The second phase of updates will involve adding a data validation page to the RPS where the accuracy of federal systemic factors can be verified. A list of the data validation questions are attached hereto as **Attachment 6**. The data validation questions will be answered for all RPSs scored during each quarter. The target roll-out for data validation being added to the RPS is the 2nd quarter of 2016. The data validation questions will be answered by the parent, child/youth, or legal caregiver during the FCM Supervisors' RPS visit with the family. Following the visit, Supervisors will verify that the answers given during the home visit match the data that is entered in MaGIK. If any of the data is entered incorrectly, FCMs will be asked to enter the updated and accurate information into MaGIK. Supervisors will then enter whether the data was corrected in the RPS data validation page to ensure when data changes occur, there is justification for the change.

Biennial Regional Services Strategic Plan Process

As mentioned above, key components of the CQI efforts being funneled down to the local stakeholders took place in the form of a statewide data presentation and the Biennial Regional Services Strategic Plan Process (BRSP). In 2015, the BRSP began with a statewide data presentation held on September 18, 2015, that included statewide and region specific data. For this BRSP, Indiana developed the data through an extensive planning process that involved obtaining feedback and recommendations from all DCS divisions. Following the presentation of the statewide data where attendees were educated on the types of data being collected and trends to look for, each region participated in a regional data workgroup facilitated by a data expert. The data package used in the regional work groups included the following:

- general information on service utilization;
- results from the Service Needs, Utilization and Effectiveness survey delivered to FCMs in Spring 2015 and service providers in Summer 2015 (described above);
- in depth analyses of the characteristics of children who had a second instance of maltreatment within 12 months of an initial incident;
- in depth analyses of the characteristics and permanency outcomes of children who had been in out of home care 24 months or more on July 1, 2014;
- Quality Service Review indicator summaries;
- Quality Service Review stress factor summaries;
- prevention programs outcomes and client characteristics; and
- financial and budget projection data.

Each region was tasked with reviewing the above data sets and including action items in their BRSP that addressed how DCS services may help address three key agency objectives:

1. The reduction of repeat maltreatment;
2. The increase in the proportion of children who have been in out of home care for 24 months or more who reach permanency within 12 months; and
3. The improvement in outcomes for families with substance use issues.

The Central CQI Team is comprised of key executive staff representing all areas of DCS, from field to fiscal staff. The Central CQI Team currently meets monthly with additional meetings scheduled when necessary. The Central CQI Team desires a two-way exchange, whereby CQI needs and efforts are brought from the field to the Central CQI Team, and decisions and efforts at the Central CQI level are funneled down to the field (see the Biennial Regional Services Strategic Plan Process below). The Central CQI Team is committed to formally disseminating findings and information to mid-level and field staff in an effort to be more transparent within the agency and to support data-driven decisions in practice. To that end, the survey results for each region were included in the regional reports which are utilized in ongoing BRSP meetings and integrated into their plans for improvement.

The next CQI initiative will be to pioneer CQI principles in the regions. The CQI Team is currently in discussions about what regions will lead these efforts, what they will be, who will train, and how the CQI efforts will be evaluated. Currently, the CQI team is investigating the possibility of implementing Six Sigma training to evaluate whether implemented strategies were effective. Indiana's CFSP Plan for Improvement Goal #4 revolves around CQI implementation and promoting a culture of learning whereby staff at all levels of the agency consider ways to improve practice, programs and policy.

Additional Quality Assurance Mechanisms

Service Mapping

Indiana implemented a pilot for the service mapping enhancement to the KidTraks service referral and provider portal in April 2015 and expanded the application statewide on July 1, 2015. The Service Mapping function uses data collected from the Child and Adolescent Needs/Strengths Assessment and a short set of questions answered during the service mapping session to provide recommendations for comprehensive services, including Medicaid paid services, Comprehensive Home Based Services (including Trauma Focused Cognitive Behavioral Therapy, Motivational Interviewing, Alternatives for Families Cognitive Behavioral Therapy, Intercept, and others), Family Centered Treatment and Cross System Care Coordination.

In addition to ensuring that service recipients are offered the best comprehensive services to meet their unique needs, the service mapping enhancement also allows Indiana to systematically track the needs and gaps in services statewide by collecting information on services that would otherwise be recommended but are not currently available in a particular location. The DCS Research and Evaluation Team has been actively tracking the use of service mapping and what it reveals about service availability throughout the state.

Service Evaluation Reports

Indiana's Research & Evaluation Team is dedicated to evaluating the services and programs offered to DCS service recipients. The team regularly produces reports examining the utilization of services at the state, region and county level and supports the Services & Outcomes administrative team by producing ad hoc reports detailing billing and delivery of services.

Additionally, the Research & Evaluation team produces formal, on-going evaluations of Indiana pilot projects and evidence based practices. Some of the on-going evaluations include:

- The Family Centered Treatment (FCT) service intensity and model fidelity tracker. The FCT tracker is used for internal decision making processes, provider oversight and is used to support the FCT Workgroup that includes DCS, FCT providers and representatives from the FCT foundation.
- Sobriety Treatment and Recovery Teams (START) model implementation and outcomes reporting. The DCS Research & Evaluation team produces semi-annual reports examining the implementation of the START pilot program. Additionally, the team is working with consultants to begin a formal evaluation of START outcomes.
- Father Engagement Retention and Outcomes Survey. Father Engagement providers complete a quarterly survey on all father engagement clients that is used by DCS to determine the effectiveness of the program in engaging and retaining fathers.

- Service Log Evaluation. The DCS Research & Evaluation team is developing analyses that will use service log data to create more detailed reports on the utilization and effectiveness of comprehensive services.

D. Staff and Provider Training

Item 26: Initial Staff Training

How well is the staff and provider training system functioning statewide to ensure that initial training is provided to all staff who deliver services pursuant to the CFSP that includes the basic skills and knowledge required for their positions?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

- staff receive training pursuant to the established curriculum and time frames for the provision of initial training; and
- how well the initial training addresses basic skills and knowledge needed by staff to carry out their duties.

State Response:

Insert state response to Item 26: Initial Staff Training

Overview

The initial staff training program is a strength of the agency. All newly hired family case managers (FCMs) must complete pre service training, including a pre and post-test prior to being assigned a case load. DCS does not hire contracted staff for case management responsibilities. New FCMs begin their training in cohort classes with defined starting dates that occur roughly every two weeks. As of February 22, 2016, DCS will begin its 226th cohort class. DCS created its comprehensive new FCM training program in 2006 and since that time, it has been continually updated and improved to reflect the feedback of graduates, practice improvements, and evaluations of the training. DCS also receives quarterly reports from Indiana University (IU) as part of the Child Welfare Education and Training Partnership (CWETP) for the purpose of aiding in continuous quality improvement in the cohort training program. Via the CWETP, DCS has the opportunity to utilize the expertise of scholars and researchers to analyze and refine its training curricula.

Cohort Training Process and Curriculum

The cohort training process has a defined start date and end date (graduation). Upon completing the pre-hire process, a new FCM matriculates into a cohort class with other new hires that lasts approximately twelve (12) weeks. Each cohort has a sponsor that acts as a

trainer and a resource for trainees. The curriculum includes scheduled classroom sessions with facilitated discussions and small group activities that use real case examples to develop critical thinking skills. Foundational learning pieces are provided through computer assisted trainings (CATs) which new FCMs can view on their own schedule within the deadlines provided, enabling initial viewing and re-viewing according to each individual learner's needs.

As a result of the research and feedback further detailed below, the FCM cohort training model has continued to be updated to reduce the number of days in the classroom and increase the days of on-the-job training. Additional days spent in the local office accelerates acclimation to the actual work environment with increased opportunities at an earlier stage to build relationships with peers, management, law enforcement, courts, and service providers/community partners.

Curricula has been built to accommodate all types of learners, including: using small and large group activities; visual, auditory, and motor skills; relevant/practical; task/goal oriented; and self-directed learning opportunities. In its current form, new workers complete 35 classroom days, 28 computer assisted trainings, and 29.5 transfer of learning (TOL) days prior to graduation. On day 1 of FCM cohort training, all new workers must complete a pre-test prior to their first class and then complete a post-test and evaluation at graduation.

Each new FCM worker completes the below training topics to ensure they have the knowledge necessary to perform their duties. The current new worker FCM curriculum is as follows:

Unit 1

- 1 Day – **Orientation in Central Office-HR presentation** (ID, Finger Printing, info on location of training, parking, etc.)
- 1 Day – **Getting to Know DCS** (Introduction to agency mission and values, agency structure, position roles and responsibilities, and essential processes at DCS)
- 1 Day – **Laptop & Introduction to MaGIK** (laptop distribution and set-up, introduction to MaGIK, and on-line policy manual)
- 1 ½ Days – **Worker Safety** (Introduction to risk management & safety awareness, cycle of escalation, universal precautions, substance identification, and car seat installation)
- ½ Day – **Job Skills Building** (introduction to DCS Hotline)
- 5 Days – **Orientation in County Office & Transfer of Learning (TOL) in County Office** (Introduction to field office supervisor, director, and family case managers, completion of initial new hire paperwork, begin TOL activities)

Unit 2

- 1 Day – **Overview of Legal Concepts** (introduction to legal aspects of the job)
- 1 Day – **Culture & Diversity I** (cultural learning continuum, disproportionality, norms, and power)
- 2 Days – **Engagement & Interviewing** (introduction to engagement skills needed to create and maintain trust based relationships with children & families, focus on cycle of need, process of change, working with resistance, Johari's window, core conditions, challenge model, functional strengths, etc.)
- 1 Day – **Child and Family Teaming** (introduction to the child and family team meeting process, preparation of parents, identification of team members, discussion of formal and informal supports, etc.)
- 2 Days – **Facilitation Training Session** (Practice Team trainers will begin CFTM certification training)
- 2 ½ Days – **Transfer of Learning in County Office** (continue TOL activities and CFTM certification process)
- ½ Day – **Facilitation Training Debrief** (video conference call with Practice team to discuss CFTM certification process and activities completed during the week)

Unit 3

- 1 Day – **Culture & Diversity II** (cycle of oppression, hidden rules, communication, poverty, and cultural aspects of Indiana and working with diverse families throughout state)
- 2 Days – **Effects of Abuse & Neglect on Children and Families** (introduces participants to normal child development, effects of abuse and neglect on development, reactive attachment disorder, impact of separation on child and family, importance of placement identification and stability, and focuses on tracking and monitoring child well-being from initial contact through case closure. Car Seat installation is at the end of day 2)
- 2 Days – **Transfer of Learning in County Office**(continue TOL activities and CFTM certification process)

Unit 4

- 1 Day – **MaGIK Training** (how to properly document family data in it throughout the life of a case. Capturing data in the assessment, case planning, and case closure phases)
- 4 Days – **Assessing Child Maltreatment** (introduction to assessment process and impact on safety, stability, permanency, and well-being from the first contact with family through case closure. As well as introduction to abuse & neglect scenarios, utilization of agency forms, planning & techniques of interviewing, and how to document the assessment process)
- 4 Days – **Case Planning & Intervening for Permanence** (introduction to the case planning process, the importance of DCS intervention, development of goals, objectives, and activities, as well as tracking and monitoring for goal achievement. It addresses family issues related to mental health, substance abuse, and domestic violence.)
- 1 Day – **Legal Roles & Responsibilities** (responsibilities of the FCM including knowledge of CHINS statutes, timelines, legal reports, etc. Trained in conjunction with a DCS attorney)
- 22 Days – **Transfer of Learning in County Office**(continue TOL activities and CFTM certification process)
- 1 Day – **Cohort Evaluation & Graduation** (half the day is spent on post-test, collection of training feedback, and recommendations, other half is focused on graduation ceremony)

The new worker FCM curricula in its current form reflects updates which incorporate 1) relevant changes to the Indiana Practice Model; 2) the training evaluation and pre/post-test process (described below); 3) continuous feedback from the Quality Service Reviews (QSRs); and 4) legislative or policy changes.

Changes and improvement to curricula are initiated and implemented with the assistance of the CWETP and the 75 DCS Staff Development employees who all work to develop and deliver high quality, relevant training content. Due to the approval of new FCM positions, DCS has had a substantial increase in the number of participants in the new hire training which has resulted in an increase in the number of training classes and class sizes. In response to an increase in new hires, DCS Staff Development has had to add trainers and adjust locations to accommodate the increase in participants.

Timeliness/Compliance

As mentioned above, a cohort completes the 12 week training together as a class. To ensure the new worker training is tracked, each participant is required to sign in and out on an

attendance form for classroom trainings. Upon the conclusion of a class, the attendance information is entered in DCS' comprehensive training records tracking database, the Enterprise Learning Management (ELM) System, by staff from IU. As IU staff input the attendance, an additional check is done by making sure the number of evaluations they receive matches the attendance sheet. Due to cohort classes being staggered, if a trainee misses a classroom training, they are able to make it up by attending the same class in another cohort. Computer Assisted Trainings (CATs) are tracked and uploaded automatically to ELM upon successful completion. Lastly, with respect to the transfer of learning (TOL) days, new workers must complete TOL tasks in the local office and have their participation approved and signed off by both the cohort sponsor (trainer) and supervisor in addition to affirming their attendance by signing their certification as well. The new worker then submits the approved TOL sheet with the requisite signatures to DCS Staff Development. Thereafter, prior to graduation, Staff Development checks the ELM system and the TOL certifications to ensure all of the requirements have been met. Once the requirements have been met, including all of the requisite pre and post testing and evaluations, Staff Development notifies the MaGIK team to grant access to the new employee following the cohort graduation so they can begin work on a limited caseload. A new worker who does not complete the cohort process and/or graduate is hired. Attached as **Attachment 7** is a learning plan transcript, which is an example of a training report that is used to verify the training of a new worker. The report lists the name of the new worker, title of the training, type of training, status, and date completed.

Evaluation of Training

There are three primary tools used to assess the functionality of DCS training initiatives and ensure new workers have the knowledge and training to successfully carry out their duties:

- 1) The CWETP utilizes a formal training evaluation that is completed by new workers following each class. The evaluation is sent to IU where it is compiled and analyzed with summarized results sent to DCS quarterly. The evaluations have twenty questions that range in topics from knowledge, skill, and curriculum to classroom environment. A copy of the evaluation is attached **Attachment 8**.

For calendar year 2015, a total of 360 new worker classes were evaluated (99.7% response rate) with 9,206 evaluations received (92.9% response rate). Overall, on a 1-5 scale, the evaluations from the classes were given a mean overall rating of 4.32, indicating that new workers rated the training that they received as "exceeds" expectations. Moreover, the mean scores for the below selected questions in the new worker evaluation demonstrate that trainings provide them with the knowledge and skills necessary to carry out their duties.

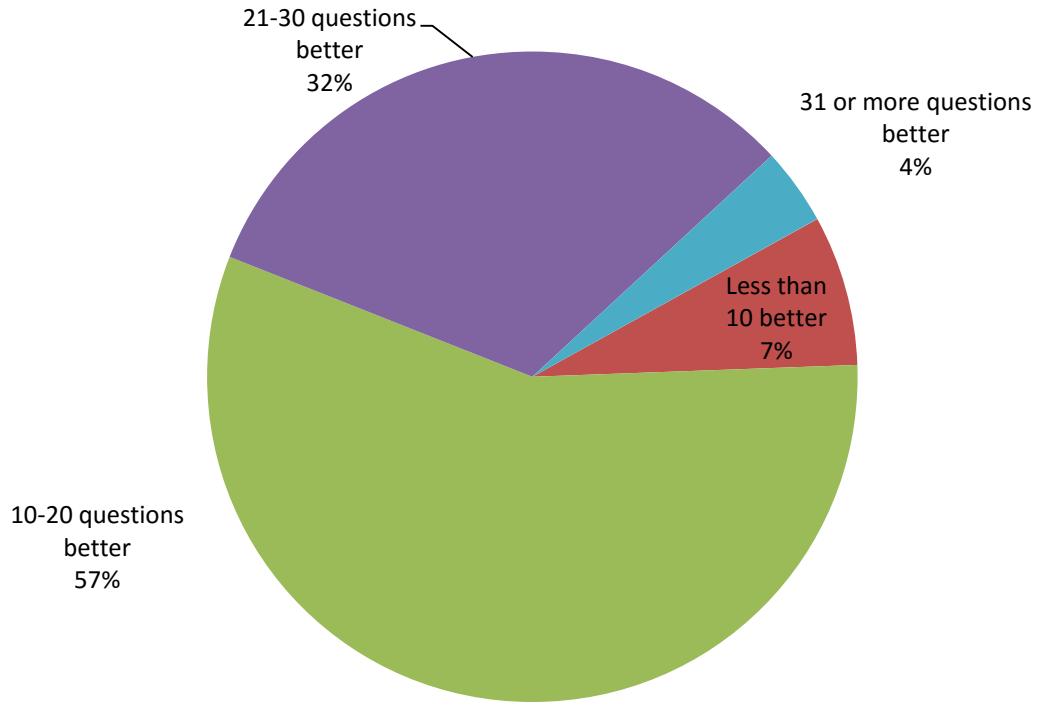
Question	Mean	Number of evaluations
14a. Practical (1= not at all, 5= very)	4.57	9115
14b. Important (1= not at all, 5= very)	4.66	9078
14c. Increased knowledge (1=did not, 5=greatly)	4.45	9096
14d. Increased skill (1=did not, 5=greatly increased)	4.38	9088
14e. Increased confidence (1=did not, 5=greatly)	4.33	9050

- 2) As mentioned above, each cohort begins and ends with a required pre and post-test for each new worker. The pre and post score data is designed to assess the knowledge gained from training. In calendar year 2015, 23 cohorts completed pre-test and 21 post-test. Participants improved 17.7% on average from pre-test to post-test but most importantly, all trainees (n=633) improved. As indicated in the pie chart below, almost ninety-three percent improved by 10 or more questions. About seven percent improved by ten questions or fewer.

Calendar Year 2015 Test Results

<u>Quarter</u>	<u>N (posttest)</u>	<u>Pre-Test Score</u>	<u>Post-Test Score</u>	<u>% change</u>
1st	183	53.6	72.6	19.0
2nd	117	53.7	71.0	17.3
3rd	101	53.9	70.5	16.6
4th	232	53.2	70.5	17.4
Annual	633	53.5	71.2	17.7

Figure 1. Pre-Post Test Trainee Question Performance



The below chart breaks down the categories in which new worker trainees improved, including:

- At least 30% on the Getting to Know DCS and Legal Overview curriculums
- At least 20% on Assessing Child Maltreatment and Case Planning & Intervening.
- Less than 10% on Permanency and Time Management.

Category	N=(633) Change %
Getting to Know DCS	30.7
Laptop	18.5
Culture & Diversity	10.8
Legal Overview	31.4

Category	N=(633) Change %
Engagement	25.0
Teaming	15.8
Assessing Child Maltreatment	20.5
Case Planning & Intervening	26.9
Worker Safety	13.0
Legal Roles	17.2
Effects of Abuse & Neglect	14.9
Permanency	8.5
Time Management	4.9
Test	17.6

- 3) The Individual Training Needs Assessment (ITNA) report identifies training needs as reported by FCMs and FCM Supervisors. An ITNA allows staff to develop a training/employee development plan with their supervisor. Information from the ITNAs are also used to develop new curricula if there is a common need identified. Results from the completion of an ITNA performed in the 4th quarter of 2015 will soon be available for DCS to review.

Information from these evaluation methods led to the creation of Objective 1.3 in the CFSP – Re-evaluating and Updating Training Curriculum for New Family Case Managers. For example, to improve teaming scores identified from QSR data and needs identified from ITNAs, Objective 1.3(a) was developed to incorporate enhanced Child and Family Team Meeting training prior to cohort graduation where Peer Coach Consultants are able to provide more oversight and focused training.

Additional New-Worker Training Initiatives

To better support staff transitioning into the challenging work of case management, a Field Mentor Program is also utilized. This program matches a trainee with an experienced, trained, FCM in the local office to provide one-on-one support. When challenges are noted, training can be adjusted to better facilitate the transfer of learning from classroom to the actual practice of child welfare. In collaboration with Dr. Anita Barbee from the University of Louisville, a

comprehensive Skills Assessment Scales tool was developed to assist the Field Mentor with providing feedback to the trainee based on established, research-based competencies. Supervisors receive a copy of this assessment and can use it to help identify the strengths of the newly hired staff. Three months after graduation, the new employee's supervisor also completes the Skill Assessment to assist Staff Development with analyzing any additional training needs during the pre-service period and evaluating the knowledge and skills new workers are equipped with. Feedback from this process is used as a framework for developing additional training assistance, if needed, as well as to provide necessary modifications to the new worker curriculum. When challenges are noted, training can be adjusted to better facilitate the transfer of learning from classroom to actual practice. This project is on the cutting edge of national best practices in training and supervision of frontline child welfare workers.

FCMs who express an interest in focusing their work in certain areas (for example, becoming a Foster Care Specialist) are able to receive specialized training (see Item 27 – Ongoing Staff Training). However, the worker must have completed the new hire FCM training prior to being able to specialize.

An example of the feedback mechanisms being implemented by DCS is the current iteration of the pre-services training for newly hired FCM's in 2015. Most of the training content was retained; however, the training delivery was altered to replace many of the classroom sessions with computer assisted training in order to provide the foundational knowledge on each of the training topics. Classroom sessions moved toward facilitated discussion and small group activities, using more real case examples to develop critical thinking skills at a higher level. The redesign changed the model from that of primarily instructor led to that of learner based facilitation, focusing on the development of critical thinking skills.

Item 27: Ongoing Staff Training

How well is the staff and provider training system functioning statewide to ensure that ongoing training is provided for staff that addresses the skills and knowledge needed to carry out their duties with regard to the services included in the CFSP?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Staff, for purposes of assessing this item, also include direct supervisors of all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

- that staff receive training pursuant to the established annual/bi-annual hour/continuing education requirement and time frames for the provision of ongoing training; and
- how well the ongoing training addresses skills and knowledge needed by staff to carry out their duties with regard to the services included in the CFSP.

State Response:

Insert state response to Item 27: Ongoing Staff Training

Overview

Ongoing training of staff was identified as an area needing improvement in DCS' Round 2 CFSP. Throughout the course of the 2010-2014 CFSP plan period, DCS devoted significant resources to develop a robust training plan for all levels of staff. As a result of this investment and as further detailed below, DCS believes the ongoing staff training program is now a strength.

Ongoing/Experienced Staff Training Requirements

DCS recognizes that staff expertise is a critical component of achieving positive outcomes for children and families and to that end, has established an expectation that staff professional development remain a priority. DCS currently offers 103 classroom and 67 computer-assisted trainings (CAT) in order to support the training of the over 3,400 current staff in meeting their training requirements. Experienced worker trainings are scheduled in regional locations to maximize participation by minimizing the travel time away from casework for children. Training topics are individualized to regional needs as identified by Individual Training Needs Assessments, Quality Service Review (QSR) data, and regional manager requests (as discussed in more detail below).

DCS Policies GA 10 and GA 11 (available at <http://www.in.gov/dcs/2516.htm>) require all levels of staff (DCS does not contract for case management services) to satisfy certain annual training requirements (combination of classroom and computer assisted trainings). DCS designates a certain number of trainings that are required to be a part of the annual training hour requirement and are scheduled in regions throughout the year when necessary. Currently, the required trainings are as follows:

- Human Trafficking
- Allowances for Children in Care
- Lesbian, Gay, Bi-sexual, Transsexual, Questioning (LGBTQ) Youth
- Worker Safety Refresher (every two years)
- Trauma Informed Care
- Substance Abuse *(See CFSP Objective 1.4(d))*
- Domestic Violence
- Caregiver Mental Illness

In calendar year 2015, the list of experienced worker trainings that were completed/revised were:

- Caregiver Mental Illness
- Introduction to Adoption for Experienced Workers
- Developmental Disabilities
- Dealing with Substance Abuse
- Making Visits Matter
- Culture and Diversity for Experienced Workers
- Forensic Interview Techniques
- Domestic Violence and the Child and Family Team Meetings
- Experienced Worker Trauma Informed Care and Secondary Trauma
- Experienced Worker Safety

Timeliness/Compliance

The mechanisms for monitoring completion of the ongoing training requirements is similar to those discussed in Item 26 – Initial Staff Training. For classroom trainings, an attendance sheet is maintained and then sent to Indiana University (IU) where a staff member enters the attendance information into the Enterprise Learning Management (ELM) System. In addition to the attendance sheet, evaluations are also completed at the conclusion of each class and sent to IU. The attendance sheet and evaluations act as a secondary check to ensure the number of evaluations match the attendance. CATs are tracked and uploaded automatically to ELM upon successful completion. To verify attendance at an approved external training (i.e. a training outside the CWETP) that is not cataloged in ELM, a hardcopy form is utilized and must be signed by the trainer and maintained in each employee file as part of the annual employee appraisal. Additionally, as part of an employee's annual evaluation, the annual training requirement is verified by the applicable FCM Supervisor. The employee's direct supervisor will document in the employee's file if there are extenuating circumstances preventing an employee from completing the required annual training requirements (e.g. FMLA leave).

Evaluation of Training

There are four primary tools used to assess the functionality of DCS training initiatives and ensure experienced workers have the knowledge and training to successfully carry out their duties:

- 1) Evaluations: Similar to new hire FCM evaluations discussed in Item 26 – Initial Staff Training, experienced workers participating in classroom trainings complete a training evaluation at the conclusion of each class. The evaluation is substantially similar to the evaluation new workers complete.

The 2015 Calendar Year Training Evaluation Report indicates that 178 experienced worker classroom trainings were evaluated (92.3% response rate) with 2,859 evaluations being submitted (97.7% response rate). Overall, the experienced worker classroom trainings were given a mean overall rating of 4.19, indicating that new workers rated the training they received as “exceeds” expectations. The questions from the evaluation listed in the table below provide insight as to whether the training provides experienced workers with the skills and knowledge needed to perform their job tasks. The below selected questions and mean scores in the experienced worker evaluation demonstrate that classroom trainings provided them with the knowledge and skills necessary to carry out their duties.

<u>Question</u>	<u>Mean</u>	<u>N</u>
14a. Practical (1= not at all, 3=somewhat, 5= very)	4.40	2845
14b. Important (1= not at all, 3=somewhat, 5= very)	4.50	2797
14c. Increased knowledge (1=did not, 3=somewhat, 5=greatly)	4.00	2824
14d. Increased skill (1=did not, 3=somewhat, 5=greatly increased)	3.94	2817

- 2) Individual Training Needs Assessment (ITNA): ITNAs are used to identify training needs for experienced worker training classes. Following identification, those topics are then scheduled into DCS regions to meet their identified training needs. The ITNAs that were completed in 2011 demonstrated a need for the following training topics among field staff:
 - Teaming in the First 30 days
 - Advanced Engagement & Crisis Management
 - Advanced Cultural Competency

- Protective Factors
- Advanced Developmental Disabilities
- Trauma Informed Care
- Experienced Worker Safety
- Introduction to the Attachment Continuum

Following the ITNA, a strategic planning meeting was held in November 2012, and identified the following curricula which were developed and implemented in 2013 based on the ITNA results:

- Understanding Culture and Embracing Diversity for all DCS Staff, Both Field Staff and Non-Field Staff
- Servant Leadership
- Clinical Supervision
- Engaging Challenging Clients
- Trauma Informed Care
- Presentation and Facilitations Skills Training.

The new round of ITNAs completed in November 2015 will give DCS Staff Development a new opportunity to evaluate its current training curriculum and make further improvements.

- 3) Quality Service Review: An additional method for identifying training needs is data from the Quality Service Reviews (QSR). For example, recent QSR data around team formation revealed struggles in including fathers and resource parents in the Child and Family Team Meetings (CFTM). DCS revised and instituted new in-service trainings to improve the teaming ability of DCS staff. Trainings on these topics were provided in quarterly workshops for all experienced workers to complete.
- 4) Child Welfare Education and Training Partnership (CWETP): DCS is also utilizing its established training relationship with IU to work with a researcher that will assist DCS (and the DCS Data Management Team) in correlating the trainings to outcomes. For example, Indiana University is currently examining how years of experience influence the following factors:
 - Child and Adolescent Needs and Strengths (CANS) Assessment
 - Placement moves and types
 - Child and Family Team Meetings
 - Contacts by FCM
 - Length of Case
 - Removals
 - Key Performance Indicators-Maltreatment
 - Visits

Special attention is being given to years of experience of FCMs before and after the practice model change in the training to see how the training changes have impacted the above factors.

Supervisor Training

All new FCM Supervisors receive a comprehensive training over a five (5) month period covering five modules. The first module is an orientation module which provides an overview of clinical supervision and information about servant leadership and leadership behaviors. This is followed by four (4) three (3) day training modules covering the areas of (1) personnel and technology issues (2) administrative supervision (3) educational supervision and (4) supportive supervision. Recognizing that well-prepared and competent supervisors are a key to successful outcomes for children, the new supervisor curriculum that was piloted was implemented with the assistance of experienced trainers from the Butler Institute for Families working with Indiana trainers to develop competency in delivering the curriculum. Results have been very positive and Indiana trainers are now delivering this training to all new supervisors who are hired. This training continues to be offered based on need.

Initially, quarterly workshops were conducted using video conferencing equipment, however, feedback from the supervisors indicated that this type of training was difficult for the supervisors to fully become engaged and understand the material, so the training was modified to become a classroom type training day held on two (2) different days in their region or in a neighboring region to minimize travel. This format has been very well received and will continue quarterly with the topics chosen based on results of assessments and feedback from focus groups. A training held in March of 2013 on “Managing Change” received very positive feedback. In December 2013, training was also held on “Reflective Practice Surveys” as well as in March 2014, which covered “The Role of the Supervisor in the CFTM Process”; they both received very positive feedback.

The Supervisor Core training was redesigned effective March 2015 to begin with a Supervisor On-boarding session that includes content that the new supervisor will need immediately. This three (3) day on-boarding session is occurring monthly in order to meet the immediate needs of the supervisors that are hired during that month. The information presented during on-boarding includes:

- Payroll and Travel Supervisory Review and Approvals
- Data Reports
- Human Resources for Supervisors
- Ethics
- Eligibility Determinations
- Background Checks
- Funding Appeals and Fiscal Approvals
- Supervisory Functions in KidTraks and MaGIK

The remainder of the Supervisory Core Modules (Servant Leadership, Clinical Staffing, Administrative Supervision, Educational Supervision and Supportive Supervision) continue to be facilitated to new Supervisors and are currently under review for redesign which will begin in 2016.

Evaluations: Evaluations of FCM Supervisor training is the same as the new and experienced worker trainings. For calendar year 2015, a total of 66 new worker classes were evaluated (93.9% response rate) with 1229 evaluations received (98% response rate). Overall, the evaluations from the classes were given a mean overall rating of 3.86, indicating the average response was slightly above “meets expectations”.

Individual Training Needs Assessment (ITNA): An ITNA for Supervisors was developed and completed by all Family Case Manager Supervisors in July 2013 and have shaped the priorities for 2014/2015/2016. A sample ITNA for Family Case Manager Supervisors is attached as **Attachment 9**. Common themes expressed in the ITNA included:

- developing the skills to better manage staff as both individuals and as a group
- becoming more familiar with DCS policies and procedures
- learn how to plan and conduct team and unit meetings, as well as making these meetings more productive
- assistance with working with the many different unique styles and personalities of their staff (requests ranging from tools to address difficult and insubordinate staff all the way to developing tools to praise accomplishments and encourage career development for outstanding staff)
- how to work with staff that are passive aggressive and encouraging these staff to clearly express their needs and concerns and how to encourage these staff members to maintain a positive outlook on their job

As a result of the ITNA, two quarterly supervisor workshops were developed, *The Supervisor Toolkit for Implementing Change and Resiliency*.

Professional Development/Leadership Trainings

In addition to providing numerous trainings to meet the mandatory minimum training requirements, DCS also supports continued professional development for all staff, including an extensive array of leadership trainings. One such training is the Leadership Academy for Supervisors, which is inclusive of the National Child Welfare Workforce Institute model. Local Office Directors and Central Office Middle Managers continue to be trained in the Leadership from within training, which focuses on leadership styles and concepts. Leadership training is also available for middle management staff aspiring to promote into executive level positions and is known as the Child Welfare Management Innovations Institute. This training is an intensive six (6) month training program where participants are trained on various aspects of leadership and complete a change management project during the course of the training.

A Supervisor Mentor program has also been established following a process similar to that of the Field Mentor. A series of Skill Assessment Scales were developed based on the modules described above and identified supervisors who are assigned to new supervisors complete the scales approximately one month after each module. These scales were updated in 2012 to reflect the many changes that have occurred throughout DCS the last three years. The completion of these scales provides additional information to both the new supervisor regarding strengths and needs as well as to the Staff Development area to identify additional training

needs. A manual is provided to the supervisor mentor that includes information about learning styles, the program protocol and a description of the scales. A CAT was also developed in 2012 to assist Supervisor Mentors with understanding expectations related to their mentoring role and continues to be available for all newly appointed supervisors.

DCS also offers additional specialized trainings for FCMs, including additional/enhanced assessment training, foster parent specialist training and intensive family preservation training.

Item 28: Foster and Adoptive Parent Training

How well is the staff and provider training system functioning to ensure that training is occurring statewide for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities (that care for children receiving foster care or adoption assistance under title IV-E) that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children?

Please provide relevant quantitative/qualitative data or information with respect to the above-referenced current and prospective caregivers and staff of state licensed or approved facilities, that care for children receiving foster care or adoption assistance under title IV-E, that show:

- that they receive training pursuant to the established annual/bi-annual hourly/continuing education requirement and time frames for the provision of initial and ongoing training.
- how well the initial and ongoing training addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children.

State Response:

Insert state response to Item 28: Foster and Adoptive Parent Training

DCS has a training system in place that provides foster and adoptive parents the necessary skills and knowledge to effectively carry out their duties with regard to foster and adoptive children. Based on the comprehensive curriculum and positive evaluation scores, the foster and adoptive parent training system is a strength of DCS.

Foster (Resource) Parent Training Overview

A brief history of the evolution of Resource and Adoptive Parent Training (RAPT) can be found on page 60 of the 2016 APSR submittal. DCS Staff Development has a staff of 9 trainers, 2 trainer supervisors, 5 program coordinators and 1 program coordinator supervisor that are dedicated to implementing and facilitating RAPT. All prospective foster parents (DCS and Licensed Child Placement Agency (LCPA)) must complete a minimum of 10 hours of pre-service training prior to initial licensure. These classes include the following:

- RAPT I-Introduction to DCS—3 hours
- RAPT II-Effects of Child Abuse and Neglect—4 hours
- RAPT III-Discipline, Attachment and Effects of Care Giving on the Family—3 hours

1. RAPT I – Introduction to DCS - includes the following topics:
 - An overview of the Indiana Department of Child Services
 - The CHINS (Court) Process
 - Definitions of Common Terms
 - Fiscal Benefits for Children in Care and Family Per Diems
 - Licensing Procedures
 - Indiana Practice Model
 - Transitions from a Child’s Point of View
 - Supports Available to Resource Parents

2. RAPT II – Effects of Child Abuse and Neglect - includes the following topics:
 - Descriptions of Abuse/Neglect
 - Characteristics of Maltreating Families
 - The Continuum of Parenting
 - Empathy
 - Recognizing and Reporting Maltreatment
 - Impact of Abuse/Neglect on Child Development

3. RAPT III – Attachment, Discipline, Effects of Care Giving on the Family Overview - includes the following topics:
 - Negative Effects of Separation for the Child and Family
 - Child Developmental Level Effects on Out-of-Home Placement
 - Strategies to Help a Child Handle Feelings
 - The Appropriate Goal of Discipline
 - Effective Strategies to Promote Healthy Development and Attachment
 - Selecting Discipline Strategy Based on Age and Development Level
 - Potential Effects on the Resource Family of Providing Care
 - Coping Strategies and Using Support Systems

Timeliness/Compliance

All foster families must complete the minimal training requirements listed above before they can be licensed to provide care and receive a placement. Trainings are available throughout all of the DCS regions and are available a minimum of every 60 days, with an increased frequency in larger regions. Additionally, potential foster parents can attend any training available throughout the state if they miss one in their home region/county. Subsequent to licensing, foster parents have online trainings and in-service classroom trainings that can be taken to prepare for the specific needs that some foster children may have. 15 hours of in-service (up to 8 hours of online training or using videos or books and 7 hours in the classroom) training annually is required for ongoing licensees. DCS requires each licensee who has a therapeutic certificate to successfully complete 20 hours of training annually, which includes 10 hours of training as required in order to be licensed as a resource parent and 10 hours of additional therapeutic training to meet the child’s specific needs. A list of current approved RAPT class schedules can be found at <http://www.in.gov/dcs/2307.htm>. DCS also maintains a list of approved alternative in-service trainings; however, the alternative in-service training must be related to the roles of the resource parent(s) in working with families and children and be approved by the DCS Staff Training Management. Training hours will be

not be given nor will they be accepted for quality assurance purposes if they are not on the approved alternative in-service training list. The licensing specialists, as part of an Annual Review. Checklist for Foster Family Homes, maintain a record of the training hours to ensure that the annual requirement is met.

Indiana is proactive in ensuring that there are not barriers to access for pre-service trainings as it is in the best interest of all parties to get individuals licensed (either directly by DCS or through an LCPA) as expediently as possible. To accomplish that, DCS does the following:

- RAPT I curricula is trained by the Regional Foster Care Specialists within each DCS region. They are able to set the class schedule to meet the needs of their region.
- RAPT II curricula is offered as an online class which individuals can access twenty-four hours a day at their convenience. For those individuals who are not comfortable with computer technology or have a religious barrier to using technology, the course is available for delivery in a classroom setting.
- RAPT III curricula is scheduled a minimum of once every 60 days in the smaller regions and at least once every 30 days in the larger regions. DCS will add classes upon request if the numbers indicate a need to train more individuals; this flexibility meets the ebb and flow of the demand for the curricula.

Below is a chart that identifies the number of classes and evaluation responses (surveys) received for RAPT trainings that took place across the state in calendar year 2015. All of the below trainings are available to resource/adoptive parents who are licensed directly by DCS or through an LCPA.

2015 RAPT Classes and Evaluations (Surveys)

RAPT	<u>Classes</u>	<u>Surveys</u>
	# (%)	# (%)
Adoption Legal Overview	20 (2.5%)	261 (2.4%)
Attachment	15 (1.9%)	226 (2.1%)
Developmental Disabilities	18 (2.3%)	226 (2.1%)
Educational Advocacy	17 (2.1%)	185 (1.7%)
Fostering Older Youth	21 (2.6%)	258 (2.4%)
RAPT III Attachment, Discipline, & Effects of Care Giving	240 (30%)	3246 (30.3%)
RAPT IV Adoption	100 (12.5%)	1524 (14.2%)
Language of Power (CC II)	23 (2.9%)	273 (2.5%)
Nuts & Bolts	14 (1.8%)	131 (1.2%)
My Family, Your Family	25 (3.1%)	337 (3.1%)
Poverty & Race/Ethnicity (CC I)	16 (2%)	177 (1.7%)
Preparing for Family Change	3 (0.4%)	56 (0.5%)
Power of Peers	16 (2%)	218 (2%)
Resource Family Self-Care	21 (2.6%)	271 (2.5%)
Sexual Abuse	18 (2.3%)	161 (1.5%)
Substance Use Disorders (CC III)	25 (3.1%)	274 (2.6%)
Supporting LGBTQ Youth (CC IV)	20 (2.5%)	189 (1.8%)
Teaming with Families—the CFTM	25 (3.1%)	289 (2.7%)
Training of Trainers	19 (2.4%)	409 (3.8%)
Trauma-Informed Care I	40 (5%)	579 (5.4%)
Trauma-Informed Care II	37 (4.6%)	504 (4.7%)
Trauma-Informed Care III	31 (3.9%)	427 (4%)
Understanding & Managing Challenging Behaviors	36 (4.5%)	495 (4.6%)
Total	800 (100%)	10716 (100%)

Additionally, the chart below identifies the number of RAPT classes that took place in each DCS region for calendar year 2015 is below.

Region	Classes # (%)	Surveys # (%)
Region 01	67 (8.4%)	1124 (10.5%)
Region 02	37 (4.6%)	396 (3.7%)
Region 03	51 (6.4%)	786 (7.3%)
Region 04	57 (7.1%)	996 (9.3%)
Region 05	42 (5.3%)	477 (4.5%)
Region 06	35 (4.4%)	364 (3.4%)
Region 07	36 (4.5%)	371 (3.5%)
Region 08	41 (5.1%)	494 (4.6%)
Region 09	33 (4.1%)	382 (3.6%)
Region 10	148 (18.5%)	2433 (22.7%)
Region 11	34 (4.3%)	388 (3.6%)
Region 12	26 (3.3%)	194 (1.8%)
Region 13	35 (4.4%)	409 (3.8%)
Region 14	32 (4%)	431 (4%)
Region 15	27 (3.4%)	177 (1.7%)
Region 16	43 (5.4%)	650 (6.1%)
Region 17	26 (3.3%)	285 (2.7%)
Region 18	29 (3.6%)	359 (3.4%)
Total	799 (100%)	10716 (100%)

Adoptive Parent Training

RAPT IV training is dedicated to adoption training. This six (6) hour class addresses common adoption issues for children, parents, and families and communicates to them about resources that are available in the community. There were 100 RAPT IV trainings that took place across the state in calendar year 2015. These trainings are attended by prospective adoptive families who come to DCS either directly or through an LCPA provider. The RAPT IV curriculum includes:

- Pre-adoptive tools and services
- Children and adoption issues
- Issues for adoptive families
- Talking About Adoption
- Eligibility
- Post-adoptive services
- Introduction to the Special Needs Adoption (SNAP) Program is also provided.

Evaluation responses for the RAPT IV Adoption Training in calendar year 2015 indicated the training scored well that reflected the utility of the training were the following (using a 1-5 scale):

- How likely will you be able to apply the knowledge you have learned in this training?
 - Mean 4.75 (1510 responses)
- Practical
 - Mean 4.77 (1509 responses)
- Increased knowledge
 - Mean 4.64 (1470 responses)
- Increased skill
 - Mean 4.54 (1466 responses)

An additional stand-alone training (for example, to satisfy annual training requirements) for prospective adoptive parents is the Adoption Legal Overview. This training covers the four types of adoption assistance, the steps to complete an application for adoption assistance, understand how adoption subsidy is negotiated, and understanding the administrative review and hearing process.

Evaluation of Training

DCS assesses the functioning of foster and adoptive parent training to ensure foster and adoptive parents whether licensed through an LCPA or directly by DCS, have the knowledge and training to successfully carry out their duties. Similar to other DCS trainings, each foster and adoptive parent class completes evaluations (surveys). A sample of the RAPT evaluation form is attached as **Attachment 10**. In calendar year 2015, a total of 800 RAPT trainings were evaluated (98% response rate) with 10,716 evaluations received (98.3% response rate). These classes were attended by 2,862 of prospective foster/adoptive parents in pre-service training and 6,909 licensed foster and adoptive parents who were completing their annual training requirements. Overall, the evaluations from the trainings were given a mean overall rating of

4.69, indicating that foster/adoptive parents rated the trainings that they received as “exceeds” expectations.

The below selected questions and mean scores in the RAPT evaluation regarding the importance, practicality, and knowledge increase received the highest mean scores on the evaluation. These evaluation results include feedback from resource/adoptive parents licensed either directly by DCS or through an LCPA.

Question	Annual Mean	Annual N	Annual Rank
14a. Practical (1= not at all,5= very)	4.71	10612	3
14b. Important (1= not at all,5= very)	4.75	10597	2
14c. Increased knowledge (1=did not,5=greatly)	4.77	10258	1
14d. Increased skill (1=did not,5=greatly)	4.53	10342	11

DCS Staff Development and trainers continue to monitor feedback from foster and adoptive parents to make adjustments and improvements to the foster and adoptive parent training system. Furthermore, DCS recognizes that a renewed focus on foster and adoptive parent training is important to improve Indiana’s maltreatment in foster care scores.

DCS and Licensed Child Placing Agency (LCPA) Collaboration

DCS collaborates and meets quarterly with LCPAs to develop and refine trainings for both DCS and LCPA foster parents. As noted above, in the survey results, LCPA foster parents are able to attend DCS trainings upon request. As both DCS and LCPA foster parents are required to meet the same training requirements, these collaborations lay the foundation for all foster parents in Indiana to have consistent, quality training. The only difference in training requirements between DCS and LCPA foster parents would be if a foster parent is receiving a certification for a specific therapeutic purpose. DCS, in partnership with the LCPAs, has now completed the development of additional curricula for foster parent pre-service. These courses include Trauma Informed Care, Sexual Abuse, Managing Challenging Behaviors and Cultural Competencies. This uniform curriculum was provided to the LCPAs by a series of “train the trainer” classes that occurred from December 2014 through March 2015, with the goal that the LCPAs would begin to use the new curricula subsequent to training the trainers. Train the trainer classes for LCPA staff are now completed on a quarterly schedule; these included train the trainer on RAPT I, RAPT II, RAPT III, RAPT IV, Trauma Informed Care, Sexual Abuse, Managing Challenging Behaviors and Cultural Competencies. DCS also receives feedback and recommendations regarding training from the Resource and Adoptive Training Advisory Board, which is made up of both DCS staff and external stakeholders (including foster parents).

Provider Training:

Development of Core Competencies and Training Resources

The Home Based Provider Workgroup and DCS collaborated to develop core competencies and training resources for providers. The training is recommended for all home based staff and required for clinicians who do not yet have sufficient experience in the field of child welfare. Training resources are available on the below listed topics and can be found online at <http://www.in.gov/dcs/3493.htm>.

- Agency Orientation/Confidentiality
- Review Service Standard
- Professionalism
- Boundaries
- Abuse/Neglect/Hotline Reporting
- Worker Safety
- Environmental Safety
- Verbal De-escalation Techniques
- Responding to Suicidal Clients
- DCS 101
- DCS Legal and Testifying
- First Aid
- Safe Sleep
- Car seat Training
- Vehicle/Driving Safety
- Protective Factors
- Critical Thinking Skills
- Family Engagement/Rapport Building
- Domestic Violence
- *Process Trainings*

The Regional Child Welfare Service Coordinators, Training Staff and Older Youth staff routinely train provider staff throughout the state on topics, such as:

- Service standards and what to look for in the referral
- Qualification for new therapist coming in without 2 years' experience
- Training providers on supervision – core competency
- Training providers on best practice centered around target populations (older youth)
- Father engagement
- Older Youth Services
- Authentic Youth Engagement
- Healthy risk taking when working with older youth.
- Children's Mental Health Initiative
- Best practice for working with youth who identify as LGBTQ
- Quality Service Reviews
- Continuous Quality Improvement (PDSA Model)
- National Youth in Transition Database

DCS pays for external training for:

- Forensic Interviewing
- Training providers on evidence based models (trauma informed, TF-CBT, CPP)
- Homebuilders© training

Probation Staff Training:

DCS collaborates with probation officers in the juvenile delinquency/juvenile status cases which fall under the scope of this review. With respect to the training of probation officers in Indiana, all are required to have at least twelve (12) hours of continuing education in each calendar year after certification. At least six hours of annual continuing education shall contain information on evidence-based practices in community supervision. Each chief probation officer and supervising judge certifies to the Indiana Judicial Center (IJC) those probation officers who have met the requirement.

At the Probation Annual meeting held on May 6-7, 2015, 779 probation officers received 9.8 hours of training, with many of the topics presented applying to youth. Topics that incorporated child welfare and DCS included Confidentiality in Probation, IDOC Division of Youth Services and Juvenile Detention Alternatives Initiative (JDAI): Programs, Services, and Collaboration Opportunities, Title IV-D Child Support Division and Probation, Human Trafficking, Effectiveness of Modeling and Skill Building with Youth (Presenter was from one of our contracted residential facilities), and Juvenile Legislation and Appellate Opinions. There was a session on Indiana Drug Trends.

A second training conference held in calendar year 2015 was the Probation Officers Professional Association of Indiana's Fall Conference. For that conference, DCS gave a presentation on the HEA 1434-15 (the Department of Child Services state bill) and HEA 1196-16 (dual system youth bill). In addition, JDAI also had a presentation at this conference.

Residential Facility Staff Training:

Direct care staff of residential facilities are required to receive an orientation within two weeks of employment. Thereafter, annually each direct care staff must receive twenty (20) hours of pertinent training if they are full time and ten (10) hours if they are part-time. Training is required in the following categories:

- Administrative procedures and overall program goals
- Principles and practices of child care
- Family relationships and the impact of separation
- Behavior management techniques
- Emergency and safety procedures
- Identification and reporting of child abuse and neglect

All direct care staff are required to maintain current certifications in first aid and CPR as well. As listed in 465 Indiana Administrative Code 2, rules 9-13, the training requirements are slightly different due to the nature of the type of license, whether it be for child caring facilities (residential), child caring facilities (residential)/emergency shelter care, private secure facilities, group homes, and group homes/emergency shelter care. A sample of employee files in

residential facilities are checked for compliance during audits by Residential Licensing. If a pattern of significant non-compliance is found, the residential facility is asked to submit a plan of correction which specifies how the deficiency will be corrected.

E. Service Array and Resource Development

Item 29: Array of Services

How well is the service array and resource development system functioning to ensure that the following array of services is accessible in all political jurisdictions covered by the CFSP?

- Services that assess the strengths and needs of children and families and determine other service needs;
- Services that address the needs of families in addition to individual children in order to create a safe home environment;
- Services that enable children to remain safely with their parents when reasonable; and
- Services that help children in foster and adoptive placements achieve permanency.

Please provide relevant quantitative/qualitative data or information that show:

- The state has all the above-referenced services in each political jurisdiction covered by the CFSP;
- Any gaps in the above-referenced array of services in terms of accessibility of such services across all political jurisdictions covered by the CFSP.

State Response:

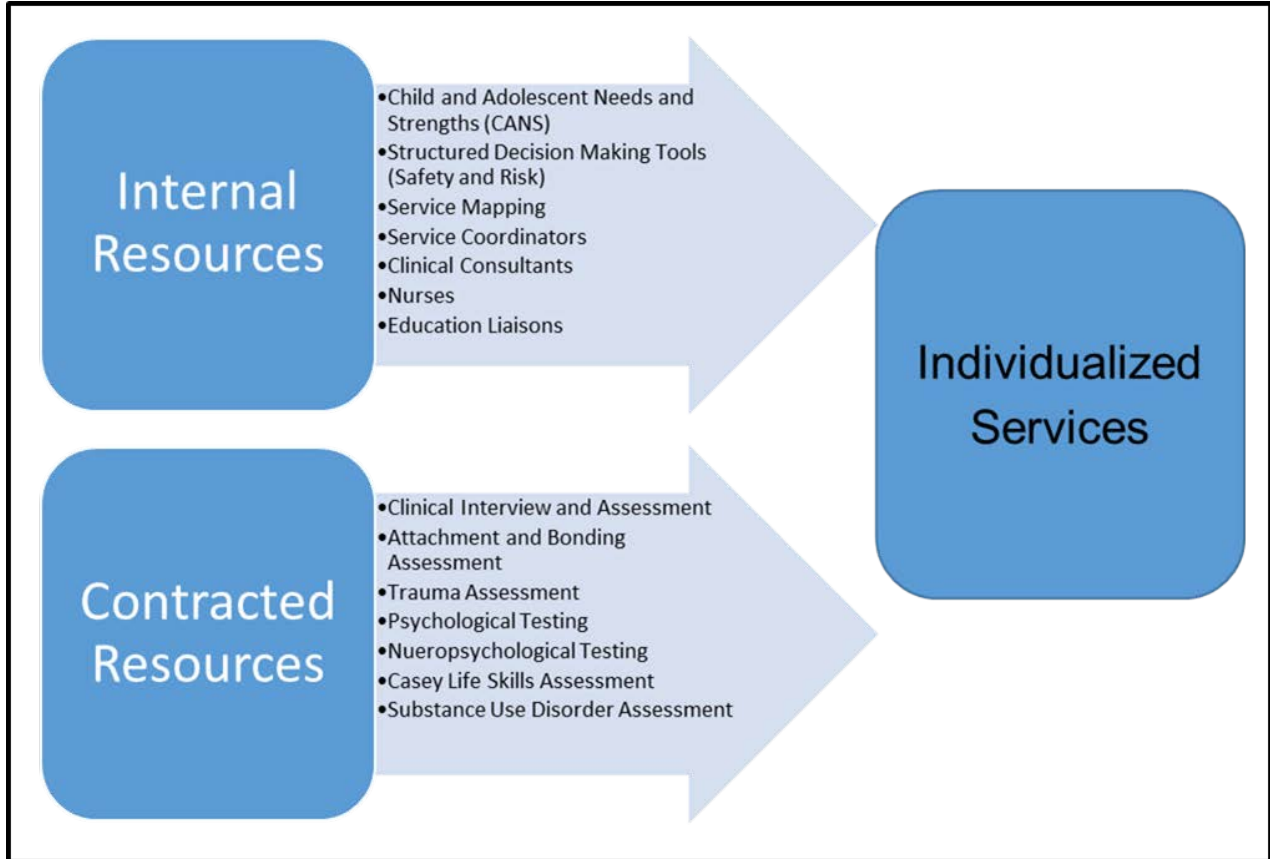
Insert state response to Item 29: Array of Services

The array of services Indiana offers is a strength. As set out below, DCS has a comprehensive statewide system of services that identifies the strengths and needs of children and families as well as multiple resources to identify service gaps statewide, including the DCS Service Mapping Tool, Regional Service Providers, and a regional services planning process.

Services that assess the strengths and needs of children and families and determine other service needs

DCS' service array includes assessment tools and specialized teams internally as well as through contracted providers. The following is a description of the resources available to determine the individual service needs of the children, youth and families DCS serves.

Figure 1: Assessment Resources



Internal Resources

Child and Adolescent Needs and Strengths

DCS utilizes the Child and Adolescent Needs and Strengths (“CANS”) assessment tool to aid family case managers in identifying the individualized strengths and needs of a child and his/her family. A score of 3 or higher on the CANS behavioral health recommendation indicates supportive community-based services, intensive community home-based services, or high intensity services are needed to address concerns around mental health issues in the child. It is also important to connect the child and family to the local community health center to ensure continuity of care after DCS involvement ends. DCS utilizes the CANS extensively as part of the Service Mapping project (see below) to ensure services are provided that are individualized to the child and family’s needs.

The CANS Report also indicates the placement CANS recommendations that are used to identify the level of care as well as services and funding for contracted placements/foster care if

the child requires placement outside of the home. These CANS reports can also be used during case supervision with the case managers to ensure the child and family are being connected to appropriate services.

Each month, the MaGIK system provides reports for field staff to review the Child and Adolescent Needs and Strengths (CANS) tools that were completed the prior month for that region. Within the region's report, viewers of the report can drill down to county and case level information. This detailed report provides information to the regional managers and local office directors on those cases that could be referred for Medicaid services (if the child's behavioral health CANS recommendation is 3 or higher) as well as other diagnostic and evaluation services.

Structured Decision Making Tools (Safety and Risk)

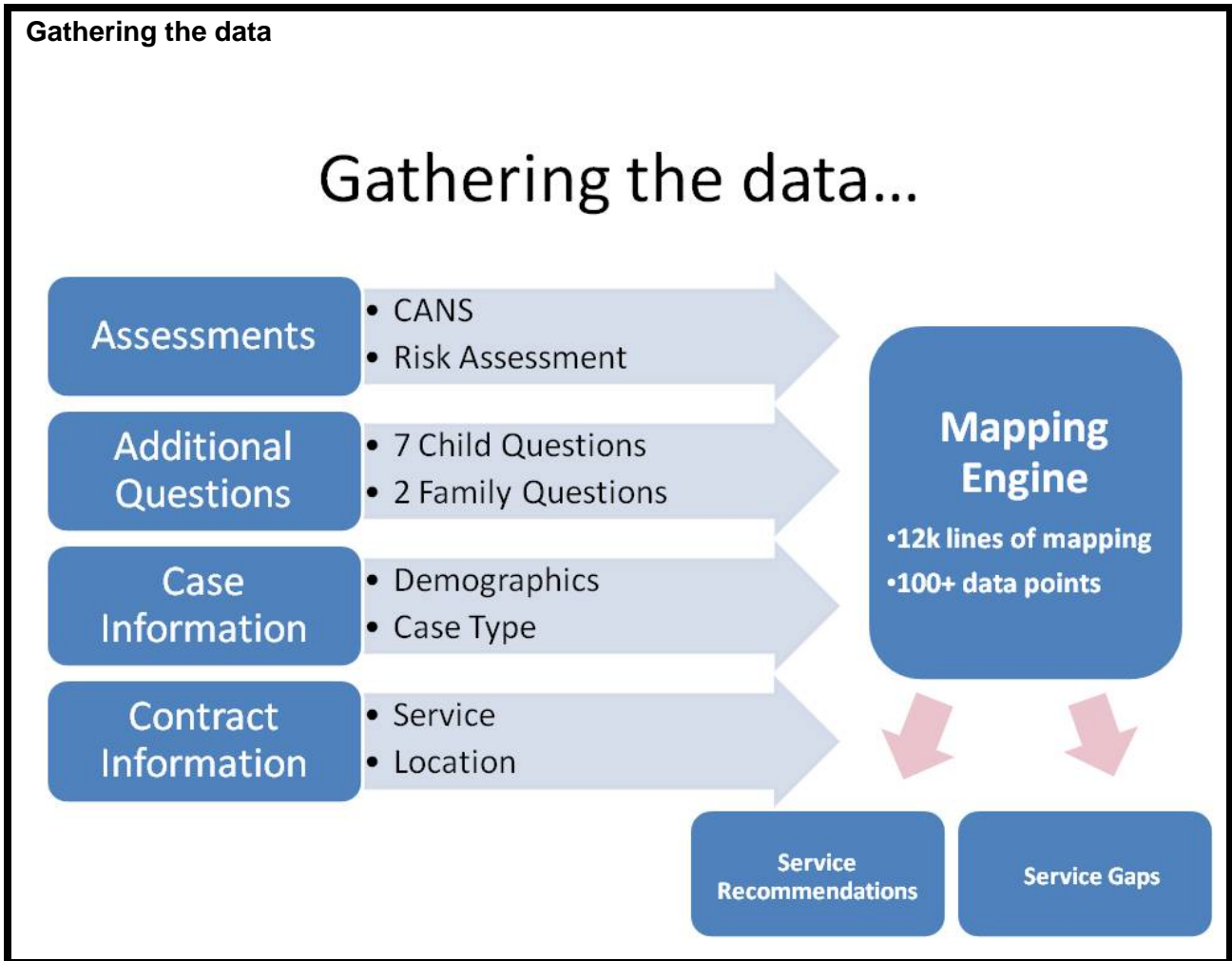
The Standardized Decision Making (SDM) Safety and Risk Assessments measure the strengths and needs of a family as they become an open case with DCS. Following an initial assessment by a case worker, safety and risk assessment tools (SDM tools) are completed that include the child's characteristics including age; medical diagnosis or mental disorder; school age but not attending school; diminished mental capacity; and diminished physical capacity. Twelve safety threats are assessed along with protective factors if safety threats are present. Using both safety threats and protective factors information, the case worker assesses if specific safety responses can control the safety threat. Safety decisions are categorized as safe, conditionally safe, or unsafe, in which case the number of children placed outside of the home is indicated.

For the risk assessment, parental/caregiver risk factors were assessed including previous child protective services (CHINS or informal adjustments); history of abuse or neglect as a child; mental health problem; alcohol or drug problem; criminal arrest history; domestic violence in household in the past year; excessive/inappropriate discipline; domineering; and current housing situation. The risk assessment is scored as low, moderate, high, or very high and based on both the overall safety and risk levels, result in either a plan to either open a case or not. The SDM risk assessment tool states that when unresolved safety threats are still present at the end of the assessment, the assessment should be opened as a case regardless of risk level.

Service Mapping

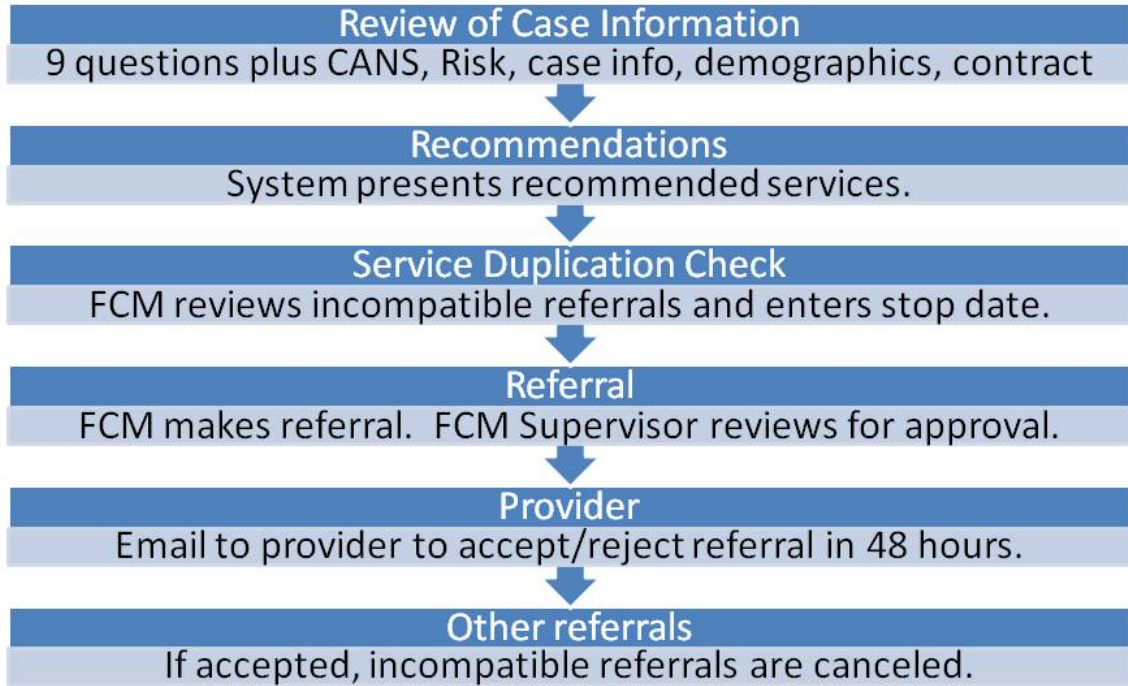
One of the most important products that has been developed as a result of the Title IV-E Waiver is Service Mapping. Indiana is in the fortunate position, as a result of the Title IV-E Waiver, of being able to greatly enhance its community based service array. Indiana has chosen to do this by enhancing the service array with multiple evidence-based practice (EBP) models. With this expansion and each EBP having a specific target population, the service array had become too complex to utilize traditional service referral methods, thus necessitating a more complex system of making referrals. Service mapping provides an electronic service consultant, allowing even inexperienced FCMs to make quality service decisions. The system reduces the use of cookie cutter services by utilizing assessment and other information to

recommend services for families based on their individual circumstances, improving the chances for positive outcomes.

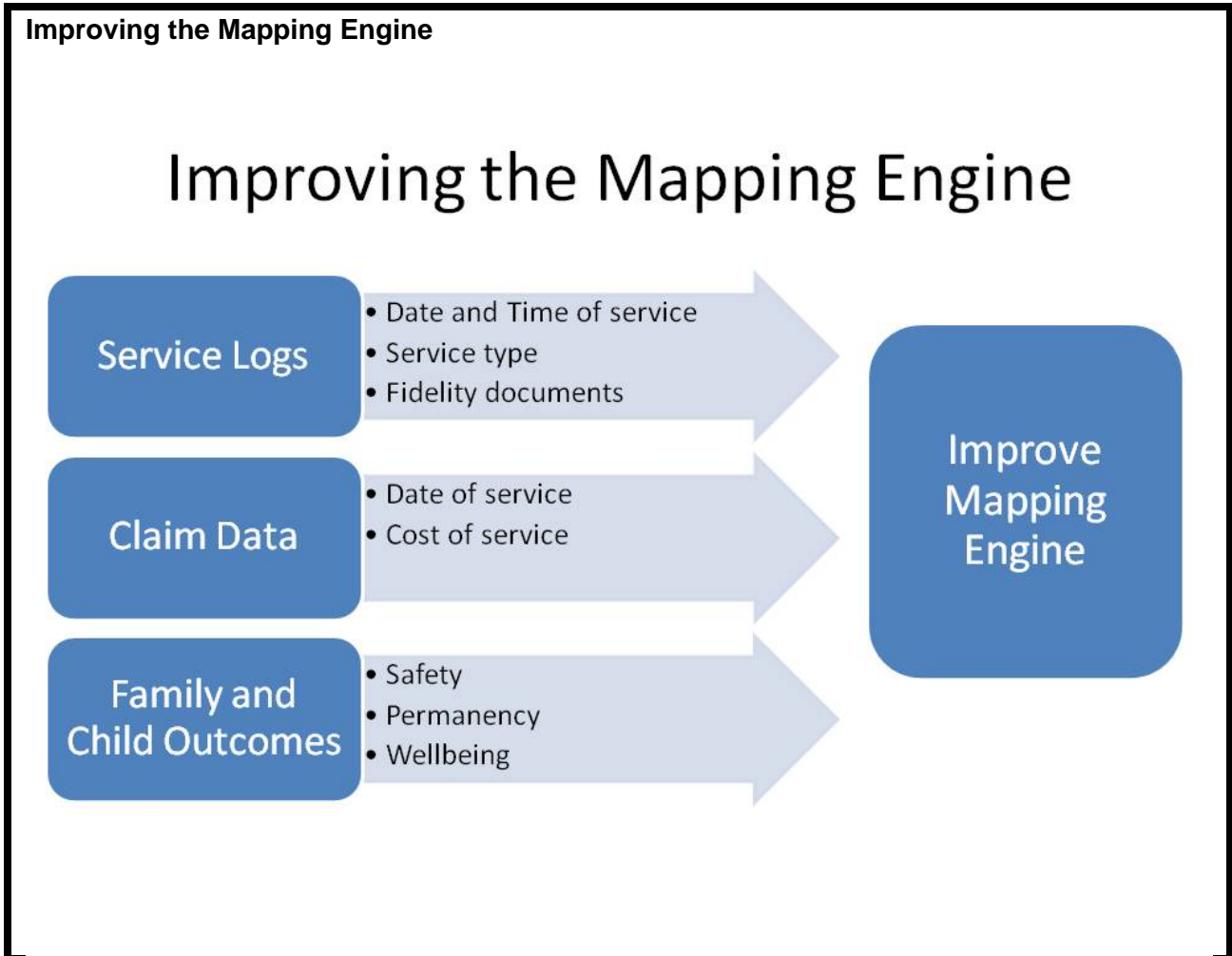


The service mapping system utilizes information from the CANS as well as the Structured Decision Making Tool for Risk Assessment. In addition, the FCM is asked seven questions about each child and two questions about the family. This information is then paired with the case information (demographics, case type, and other information) and contract information to produce service recommendations for the family. The Mapping Engine utilizes more than 100 data points in order to determine individualized services for families. There are more than 12,000 different ways for a family to map to a service. In addition to service recommendations, the Mapping Engine provides information about service gaps by essentially summarizing what services would have been mapped had they been available in the community.

Basic Functionality...



The basic functionality of the service mapping includes gathering information and providing a recommendation. Also, to ensure service duplication is minimized, the system checks to see what other services are being provided at the time a new referral is initiated. These duplicative referrals are canceled in the system if the provider accepts the referral in the system within 48 hours. Providers, FCMs, and supervisors are notified via email of the referral progress as it moves through the system (e.g., when the referral is sent to the provider via email, when the provider accepts or rejects the referral, and when the duplicative referrals are canceled).



Several other systems work in conjunction with the Mapping Engine. Service logs were developed to provide detailed data on the actual service provision, including the date and time of service, the type or category of service being provided as well as any fidelity documents or milestones that pertain to the model. Claim data will also be utilized to show the cost of the service provision. Family and child outcomes in the areas of safety, permanency, and wellbeing will be utilized as well to improve the Mapping Engine and ensure the families are matched to the most appropriate services.

CQI and Service Mapping

Continuous Quality Improvement



Service Mapping is a critical part of the continuous quality improvement of services. As DCS looks to make improvements, the focus will be on the outcomes of children, youth, and families. The Mapping Engine will be altered as more information becomes available as to the success of the families involved in the various services. The mapping may also be altered to provide alternative recommendations for families who are not successful in the recommended services. Additional questions may be added to determine more information about families to improve service recommendations.

Programs will be evaluated to determine their effectiveness with specific target populations. The Family Centered Treatment Sub-study is one example of how program evaluation is tied to Service Mapping. Results from this study may expand or eliminate programs or alter the target population served by specific EBPs. In addition to evaluating at the program level, DCS will evaluate at the provider level. This information will allow for comparison between providers which could lead to further refinement of the target population by service provider, further support and training of the provider, or elimination or expansion of some service provider services.

Lastly, service gaps will be identified and closely monitored. This information will assist DCS as regional needs assessments are completed to develop the Biennial Regional Services

Strategic Plans. The plan could lead to an expansion or elimination of services in a particular county or region.

Service Coordinators

In 2009, DCS established state positions to serve in the role of Regional Child Welfare Service Coordinators; prior to that time, this role was an external contracted service. The shift to internal positions was an important move when child welfare service funding changed from county funds to state funds. This change necessitated state contracts for services that were previously paid through local contracts or memoranda of understanding. There are currently 8 positions located throughout the state. Service Coordinators are the service experts for the region and provide case level support to assist the Family Case Manager (FCM) in the selection of appropriate services. In addition, the Service Coordinators facilitate the Biennial Regional Services Strategic Plans and assist with the resulting Action Plans. They also work to address any existing service gaps in the region by working collaboratively with service providers to expand existing services or by initiating requests for proposals. Lastly, Service Coordinators monitor service quality and liaison between the local office and the provider when issues arise with service delivery.

Education Liaisons

The Education Liaison team serves as subject matter experts and resources to DCS staff and external stakeholders, including school districts, biological parents, relatives, foster parents and service providers. Because of their extensive knowledge and skills related to navigating the complex network of education and special education related services, they are able to provide guidance and recommendations to FCMs on how to work with parents, families, and schools to navigate education issues (both positive and negative) and develop a sustainable plan for how to address such issues in the future. They work to emphasize the significance of community collaboration by communicating and advocating to DCS staff and school districts about the importance of working together to identify and address the educational needs, including determining if the need for special education services of youth in DCS care is present. The team also works to:

- develop and present trainings for parents, relatives, DCS staff, school districts, local agencies and foster parents, with the intent to help build their capacity to support the educational success of children in DCS care and provide strategies to assist them;
- implement systems and processes to ensure timely transfer of information between DCS, school districts and the Department of Education, including timely transfer of education records, notice of medical needs, prompt schedule of move in and/or 504 conference, etc.;
- partner with and serve as liaisons between the Indiana Department of Education, school districts, and DCS to develop and implement strategies for addressing the educational needs of youth in care, improving educational outcomes for this population and ensuring a seamless transition for students transferring from residential placement and/or to a new school;

- work closely with Collaborative Care and Independent Living staff to ensure that older DCS youth are aware of and how to apply for opportunities of post-secondary education, financial aid, scholarships and other funding supporting their transition to post-secondary education.
- assist FCMs with how to develop plans to identify, address and resolve a child's unmet educational needs and strengths including participating in child and family team meetings, case staffing or planning sessions, and/or school conferences (IEP, discipline, etc.) as appropriate.

Clinical Resource Team

To better serve youth and families with complex mental health needs, DCS implemented the Clinical Resource Team (CRT) in 2011. The CRT consists of 12 licensed mental health clinicians based regionally throughout the state and supervised by a licensed psychologist. Clinicians provide a range of services to FCMs and local offices, including:

- consultation regarding safety/risk concerns, need for additional assessment, placement decisions, complex behavioral health issues, and service planning;
- liaison between DCS and other human service systems, including mental health, juvenile justice, education and mental health providers;
- assist with linkage and referral for services (e.g., Psychiatric Residential Treatment Facility admission, state hospital referral, etc.);
- assessment of the child and/or family (e.g., complex multi-system involvement, unusual circumstances, etc.); and
- educate regarding complex mental health issues and best practice models.

Clinicians receive referrals directly from the local offices and provide clinical recommendations based on the following priorities:

- ensuring the safety of all children and family members involved in the case;
- seeking the best **possible** permanency outcome;
- securing evidence-based treatments whenever possible; and
- planning for the child's future beyond DCS involvement by identifying developmental assets and resources.

Nurse Consultants

The DCS Nurse Consultants are one of the specialized services available throughout the state to provide support to FCMs. The DCS Nurse Consultants are registered nurses with various levels of expertise and training. They have unique educational backgrounds and a knowledge base with their experience and practice areas focused around children and families. The DCS Nurse Consultants' mission is to provide consultation, assist with health and medical issues, and to support FCMs in their decisions to impact positive health, well-being, and safety for children and families working with DCS. The DCS Nurse Consultants work in conjunction/

collaboration with Field staff as well as with the other Permanency and Practice Support Division teams.

The DCS Nurse Consultant may serve as a support for the following areas, but are not limited to:

- providing consultation for assessments and ongoing cases with complex or multiple medical and health needs including fatalities;
- answering medical or health related questions (e.g. symptoms, diagnosis, procedures/treatment, cultural beliefs, Drug Endangered Children (DEC), medications etc.);
- identifying medical or health related resources available for children and families;
- accessing the Child and Hoosier Immunization Registry Program (CHIRP) to provide and interpret immunization records;
- reviewing, interpreting and summarizing medical records;
- accompanying FCMs on visits (home, provider, school, etc.) for both assessments or ongoing cases;
- performing training for DCS staff and contracted service providers and community;
- providing training/education for parents, guardians, and/or custodians;
- attending Child and Family Team Meetings, Case Conferences, Staffings, Permanency Roundtables (PRTs); and assisting with Child and Adolescent Needs and Strengths Assessment (CANS) questions;
- providing skilled or expert witness testimony (when determined appropriate) during court proceedings; and/or
- providing written recommendations based on facts, provided or supportive documentation, observation, and medical knowledge.

Contracted & External Resources

Assessment for Medicaid Rehabilitation Option (MRO)/Children's Mental Health Wraparound (CMHW)

DCS recommends referring children and youth with a CANS behavioral health recommendation of 3 or more to the Community Mental Health Center for an assessment. The purpose of this initial assessment is to determine eligibility for MRO/CMHW and to have the following completed and summarized in a report:

- CANS assessment;
- Bio-psychosocial assessment;
- Diagnosis (if applicable); and
- Recommendation for services for the child and family.

Clinical Interview and Assessment

The purpose of the Clinical Interview and Assessment is to provide a clinical snapshot of the referred client and to generate recommendations to address identified needs. The Clinical Interview and Assessment will have the following completed and summarized in a report:

- bio-psychosocial assessment (including initial impression of parent functioning);
- diagnosis (if applicable) for the referred client per 405 IAC 5-20-8 (3), a physician, psychiatrist or HSPP must certify the diagnosis. Record of certification by qualified individual must be provided if a diagnosis is included; and
- summary of Recommended Services and Service Approach

The completed report will utilize the DCS standardized “Clinical Interview and Assessment” report format. The report should be completed with a summary to DCS within 14 calendar days of referral. The service provider may recommend attachment and bonding assessment, trauma assessment, psychological testing, psycho-sexual assessment, neuro-psychological testing and/or psychiatric consultation/medication evaluation as a result of the bio-psychological assessment. If attachment and bonding assessment, trauma assessment, psychological testing or neuropsychological testing is recommended, the service provider should include in the report the specific issues/questions the testing should address.

Attachment and Bonding Assessment

An attachment and bonding assessment is used to determine the quality and nature of a child’s bond or attachment to a particular person or persons. This might include biological parents, foster parents, guardians, prospective adoptive parents, relatives or siblings. The assessment may be used as one piece of information when making decisions about a child’s placement options. Information obtained from the attachment and bonding assessment is focused on the needs of the child, as well as ways to foster relationships and improve attachment quality. This assessment is used specifically to:

- identify secure vs. insecure attachment patterns;
- predict the impact on a child continuing to be in the current situation as opposed to other placement alternatives;
- assist a parent or caregiver in learning about their own strengths and weaknesses, as well as ways to improve their parenting style based on the needs of the child;
- assess the future potential and needs of the caregiver-child relationship; and
- determine the most appropriate parenting style/skills/qualities for substitute caregivers.

The clinician will respond with a written report and recommendation of services within 14 days from the date of assessment. At a minimum, the attachment and bonding assessment should include the following components:

- social history of the child and caregiver(s)/sibling(s);
- developmental history of the child; and
- direct observation of the child with his/her caregiver/sibling using the following 9 episode standardized format.

Trauma Assessment

Many people involved with DCS have experienced trauma and meet the clinical criteria for Post-Traumatic Stress Disorder (PTSD). However, many who do not meet the full criteria for

PTSD still suffer significant post-traumatic symptoms that can have an adverse impact on their behavior, judgment, educational performance and ability to connect with caregivers. A comprehensive trauma assessment helps determine which intervention will be most beneficial. At a minimum, the trauma assessment should include the following components:

- social history of the client;
- developmental history of the client;
- trauma history, including all forms of traumatic events experience directly or witnessed by the client;
- use of at least one standardized clinical measure to identify types and severity of symptoms the client has experienced. Examples include the UCLA PTSD Index for DSM-IV, Trauma Assessment for Adults- Self Report (TAA), the Trauma Symptoms Checklist for Children (TSCC), the Trauma Symptoms Checklist for Young Children (TSCYC), the Child Sexual Behavior Inventory (CSBI), and the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
- integration of DCS CANS scores; and
- recommendations for evidence-based, trauma-informed treatment, as appropriate.

The clinician will respond with a written report with recommendation of services within 14 days from the date assessment.

Psychological Testing and Neuropsychological Testing

The psychologist will conduct applicable psychological testing and/or neuropsychological testing as recommended during the Clinical Interview and Assessment and approved by DCS. The psychologist will respond with a written report that clearly outlines the findings of the psychological test within 30 days from the completion of the testing. The detailed written report should include, but not be limited to, defining any applicable diagnosis with appropriate treatment recommendations and considerations, present functioning of the referred individual, and description of the referred individual's history.

Casey Life Skills Assessment

The Successful Adulthood (SA) Learning Plan is developed between the youth and the contracted Older Youth Services provider. This plan should be based off of results from the Casey Life Skills Assessment and strongly driven by the youth's input. This plan may be developed during the Transitional Plan for Successful Adulthood Child and Family Team Meeting, but it is not required to be done at that time. The plan must be completed within 30 days of the youth's referral to an Older Youth Services service agency. The Learning Plan must include information on specific steps that will be taken to ensure that the youth's individual learning needs are met, including: identifying the youth's need/goal, what activities will be done to help complete that goal, who is responsible for completing specific activities and expected dates of completion for each activity and goal. The Learning Plan should be used as a tool to help teach older youth the planning and goal making process as well as a tool to document casework completed for the youth's individual case record. The youth should receive a copy of this plan.

Substance Use Disorder Assessment

The following standardized assessment tools for drug/alcohol use may be administered to accurately determine if further substance use assessment is indicated: Substance Use Subtle Screening Inventory (SASSI), Addiction Severity Index (ASI) Teen Addiction Severity Index (T-ASI), ASI Lite, Addiction Society of Medicine Placement Patient Criteria Revised Version II (ASAM PPII), Drug Use Screening Test (DAST), Substance Use Relapse Assessment (SARA). Other standardized tools may be used to best assess the specific needs of the client.

A multi-axial system must be used to develop a comprehensive bio-psychosocial assessment to include a mental status examination at the time of the initial appointment.

All sample collections drug screens will be observed sample collections screens. The vendor shall also ensure that all screens are observed by an individual of the same gender as the client.

Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Tramadol, Buprenorphine, Synthetic Marijuana, Bath Salts, Methamphetamine and other drugs indicated by client's history. Other substances not listed that the client may report a history of using may also be tested. The agency will be expected to provide reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation. Assurance must be given for accurate results even if the confirmation process is the only means to ensure accurate results due to the screening process providing inaccurate results.

Bio-Psychosocial Assessment must include:

- description of the presenting problem;
- clinical Syndromes and/or other conditions that may be a focus of clinical attention
- an in-depth drug and alcohol use history with information regarding onset, duration, frequency, and amount of use; substance(s) of use and primary drug of choice;
- any associated medical, psychological and social history of the client, associated health, work, family, person, and interpersonal problems; driving record related to drinking or drug use; past participation in treatment programs; and
- client's attitude toward treatment.

Assessing for Child Safety:

Parental substance use can negatively impact a child's safety. It is important to assess the risk of parental substance use to the child and immediately report the concerns to the DCS Intake Hotline or the Family Case Manager. During the assessment the provider shall inquire about who lives in the client's home, if the client has children and if so, then inquire about child safety. Clients who meet at least 1 of the following criteria shall be screened for child safety concerns:

- Client is a parent, male or female;
- Client has caretaking responsibilities for a child; or
- Client has full or part-time care of their children.

The following questions, based on The Screening and Assessment for Family Engagement Retention and Recovery (SAFEER) principles, are utilized in assessing child safety:

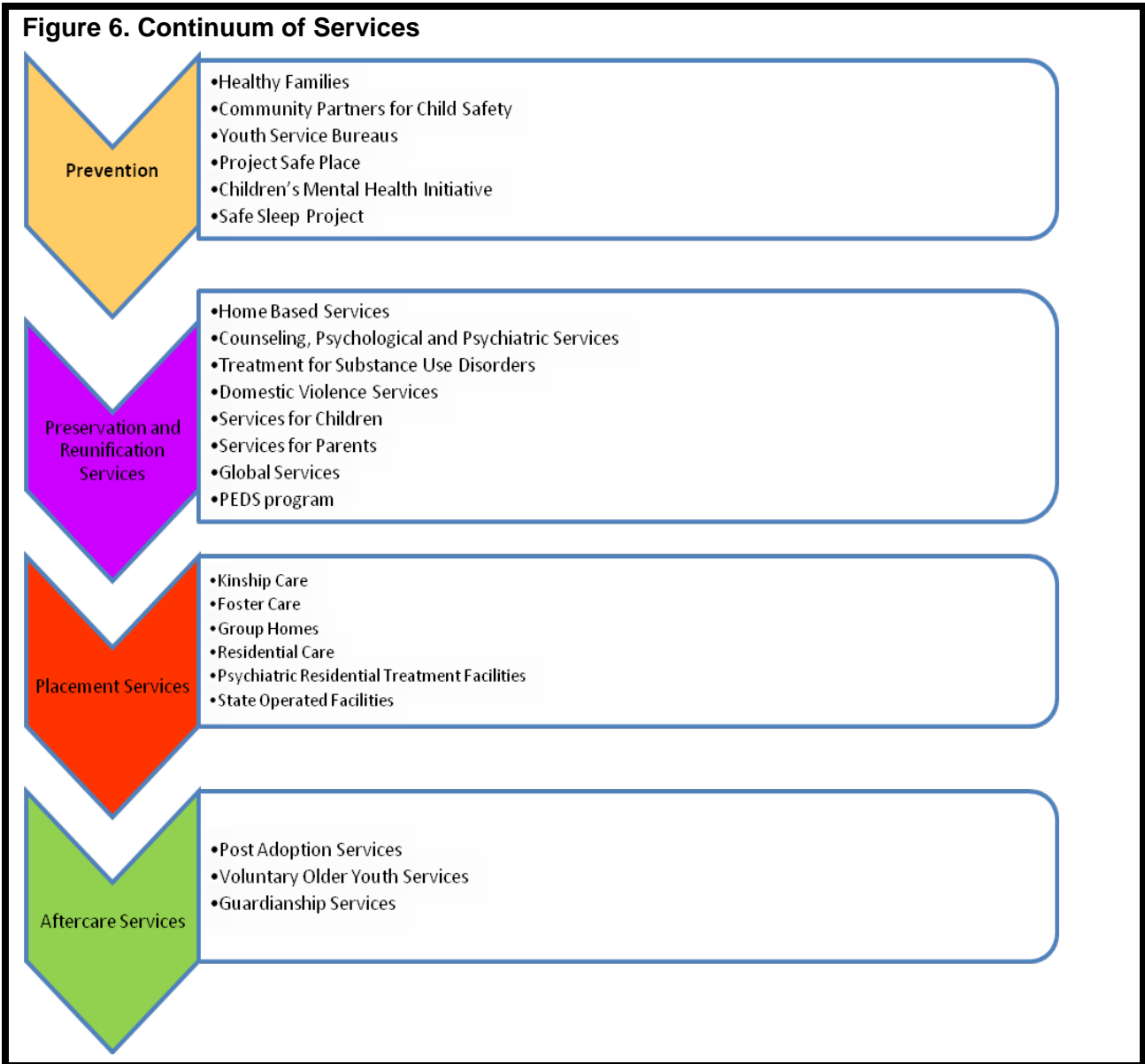
- Where are your children at the time you use alcohol and/or drugs?
- Have you ever worried that you would not be able to take care of your children while you were using drugs and/or alcohol?
- Has anyone ever told you they were worried about how you could take care of your children because of your drug and/or alcohol use?
- Have you ever had trouble getting your children food, clothing or a place to live, or had a hard time getting your kids to school because you were using? When do your children eat their meals and what are examples of food they often eat?
- Has anyone ever reported you to the child welfare system in the past?
- Are any other agencies involved with your family because of concerns about your children?

Follow-up questions regarding safety protective factors could be helpful in assessing the risk to child safety. Examples on assessing protective factors are as follows:

- Is the child in someone else's care when the client uses drugs and/or alcohol?
- Does the client have sober relatives/friends they can utilize when they are not sober and cannot care for the children?
- How does the client keep the child safe when they are using drugs and/or alcohol?
- Determine what the willingness of the parent is to accept and participate in treatment and if the parent acknowledges they have a substance use disorder.

Services that address the needs of families in addition to individual children in order to create a safe home environment; Services that enable children to remain safely with their parents when reasonable; and Services that help children in foster and adoptive placements achieve permanency.

As set out below, DCS provides a full continuum of services statewide that address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency. Those services can be categorized in the following manner:



Prevention Services

Kids First Trust Fund

As a member of the National Alliance of Children’s Trusts, Indiana raises funds through license plate sales, filing fee surcharges, and contributions. This fund was created by Indiana statute, is overseen by a Board, and staffed by DCS. Funds from Kids First go toward primary prevention efforts through the Prevent Child Abuse Indiana (PCAI), Healthy Families Indiana and the Community Partners for Child Safety program.

Youth Service Bureau

Youth Service Bureaus are created by Indiana statute for the purpose of funding delinquency prevention programs through a state-wide network. This fund supports 31 Youth Service

Bureaus to provide a range of programs including: Teen Court, Mentoring, Recreation Activities, Skills Training, Counselling, Shelter, School Intervention, and Parent Education.

Project Safe Place

The Project Safe Place fund, created by Indiana statute, provides a state-wide network of safe places for children to go to report abuse, neglect, and runaway status. These safe places are public places like convenience stores, police departments, fire departments and other places where children gather. Some emergency shelter is also funded through licensed emergency shelter agencies.

Community-Based Child Abuse Prevention

Federal funds available through the Child Abuse Prevention and Treatment Act (CAPTA) support building a community-based child abuse prevention network through which prevention services can be delivered.

Healthy Families Indiana (HFI)

A combination of federal, state, and local funding provides prevention home visiting services through contract to parents of children zero to three years old. The purpose is to teach parents to bond with and nurture their children. The program also advocates for positive, nurturing, non-violent discipline of children.

Community Partners for Child Safety (CPCS)

The purpose of CPCS is to develop a child abuse prevention service array that can be delivered in every region of the state. This service builds community resources that promote support to families identified through self-referral or other community agency referral to a service that will connect families to the resources needed to strengthen the family and prevent child abuse and neglect. It is intended, through the delivery of these prevention services, that the need for referral to Child Protective Services will not be necessary. Community resources include, but are not limited to: schools, social services agencies, local DCS offices, Healthy Families Indiana, Prevent Child Abuse Indiana Chapters, Youth Services Bureaus, Child Advocacy Centers, the faith-based community, local school systems and Twelve Step Programs.

Maternal Infant Early Childhood Home Visiting (MIECHV)

Maternal Infant Early Childhood Home Visiting (MIECHV) grants are designed to: (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The Indiana State Department of Health (ISDH) and the Department of Child Services (DCS) are co-leads of this federal grant and collaborate with Indiana University, Goodwill Industries of Central Indiana, Riley Child Development Center, Women, Infants, and Children (WIC), and the Sunny Start Healthy Bodies, Healthy Minds Initiative at the state agency level to achieve MIECHV goals.

The Indiana MIECHV funding supports direct client service through the expansion of two evidenced-based home visiting programs, Healthy Families Indiana (HFI) and Nurse Family Partnerships (NFP), to pair families—particularly low-income, single-parent families—with

trained professionals who can provide parenting information, resources and support during a woman's pregnancy and throughout a child's first few years of life. These models have been shown to make a real difference in a child's health, development, and ability to learn and include supports such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance.

Children's Mental Health Initiative

The Children's Mental Health Initiative (CMHI) provides service access for children with significant mental health issues who have historically been unable to access high level services. CMHI specifically focuses on those children and youth who do not qualify for Medicaid services and whose families are struggling to access services due to their inability to pay for the services. CMHI helps to ensure that children are served in the most appropriate system and that they do not enter the child welfare system or probation system for the sole purpose of accessing mental health services.

CMHI is collaboration between DCS and the local Access Sites, Community Mental Health Centers and the Indiana Family and Social Services Administration - Division of Mental Health and Addiction. Available services include:

- Rehabilitation Option Services,
- Clinic Based Therapeutic and Diagnostic Services,
- Children's Mental Health Wraparound Services,
- Wraparound Facilitation,
- Habilitation,
- Family Support and Training,
- Respite (overnight respite must be provided by a DCS licensed provider), and
- Placement Services.

Eligibility for the CMHI mirrors that of Medicaid paid services under the Children's Mental Health Wraparound and includes:

- DSM-IV-TR Diagnosis- Youth meets criteria for two (2) or more diagnoses.
- CANS 4, 5, or 6 and DMHA/DCS Project Algorithm must be a 1
- Child or adolescent age 6 through the age of 17
- Youth who are experiencing significant emotional and/or functional impairments that impact their level of functioning at home or in the community (e.g., Seriously Emotionally Disturbed classification)
- Not Medicaid Eligible/Lack funding for service array
- Other children who have been approved by DCS to receive services under the Children's Mental Health Initiative because they are a danger to themselves or others

Note: CMHI is a voluntary service and the caregiver must be engaged in order to access services.

The CMHI started as a pilot project in 2012 and spread throughout Indiana in 2013 and early 2014. The CMHI and the Family Evaluation process were implemented jointly to improve service access to families without requiring entry into the probation system or the child welfare

system in order to access services. As the CMHI service availability expands, the need for Family Evaluations for this target population diminishes.

Preservation and Reunification Services

Indiana DCS will continue to provide a full service array throughout the state. Services provided to families will include a variety of services outlined below.

Home Based Services

- Comprehensive Home Based Services
- Homebuilders
- Home-Based Family Centered Casework Services
- Home-Based Family Centered Therapy Services
- Homemaker/Parent Aid
- Child Parent Psychotherapy

Counseling, Psychological and Psychiatric Services

- Counseling
- Clinical Interview and Assessment
- Bonding and Attachment Assessment
- Trauma Assessment
- Psychological Testing
- Neuropsychological Testing
- Functional Family Therapy
- Medication Evaluation and Medication Monitoring
- Parent and Family Functioning Assessment

Treatment for Substance Use Disorder

- Drug Screens
- Substance Use Disorder Assessment
- Detoxification Services-Inpatient
- Detoxification Services-Outpatient
- Outpatient Services
- Intensive Outpatient Treatment
- Residential Services
- Housing with Supportive Services for Addictions
- Sobriety Treatment and Recovery Teams (START)

Domestic Violence Services

- Batterers Intervention Program
- Victim and Child Services

Services for Children

- Child Advocacy Center Interview
- Services for Sexually Maladaptive Youth
- Day Treatment
- Day Reporting
- Tutoring
- Transition from Restrictive Placements
- Cross Systems Care Coordination
- Children's Mental Health Wraparound Services
- Services for Truancy
- Older Youth Services
- Therapeutic Services for Autism
- LGBTQ Services

Services for Parents

- Support Services for Parents of CHINS
- Parent Education
- Father Engagement Services
- Groups for Non-offending Parents
- Apartment Based Family Preservation
- Visitation Supervision

Global (Concrete) Services

- Special Services and Products
- Travel
- Rent & Utilities
- Special Occasions
- Extracurricular Activities

These services are provided according to service standards found at:

<http://www.in.gov/dcs/3159.htm>

Home Based Services Overview

Services currently available under the home based service array include:

Home Based Services

Service Standard	Duration	Intensity	Conditions/Service Summary
<p>Homebuilders ® (Must call provider referral line first to determine appropriateness of services) (Master's Level or Bachelors with 2 yr experience)</p>	<p>4 – 6 Weeks</p>	<p>Minimum of 40 hours of face to face and additional collateral contacts</p>	<p>Placement Prevention: Provision of intensive services to prevent the child's removal from the home, other less intensive services have been utilized or are not appropriate or Reunification: it is an unusually complex situation and less intensive services are not sufficient for reunification to occur. Services are available 24/7 Maximum case load of 2-3</p>
<p>Home-Based Therapy (HBT) (Master's Level)</p>	<p>Up to 6 months</p>	<p>1-8 direct face-to face service hrs/week (intensity of service should decrease over the duration of the referral)</p>	<p>Structured, goal-oriented, time-limited therapy in the natural environment to assist in recovering from physical, sexual, emotional abuse, and neglect, mental illness, personality/behavior disorder, developmental disability, dysfunctional family of origin, and current family dysfunction. Service is available 24/7. Beginning 7/1/11, some providers will have a 1 hour response time for families in crisis. Maximum case load of 12.</p>
<p>Home-Based Casework (HBC) (Bachelor's Level)</p>	<p>Up to 6 months</p>	<p>direct face-to-face service hours/week (intensity of service should decrease over the duration of the referral)</p>	<p>Home-Based Casework services typically focus on assisting the family with complex needs, such as behavior modification techniques, managing crisis, navigating services systems and assistance with developing short and long term goals. Service is available 24/7. Beginning 7/1/11, some providers will have a 1 hour response time for families in crisis. Maximum case load of 12.</p>

Service Standard	Duration	Intensity	Conditions/Service Summary
Homemaker/ Parent Aid (HM/PA) (Para-professional)	Up to 6 months	1-8 direct face-to-face service hours/week	Assistance and support to parents who are unable to appropriately fulfill parenting and/or homemaking functions, by assisting the family through advocating, teaching, demonstrating, monitoring, and/or role modeling new, appropriate skills for coping. Some providers have a 1 hour response time for families in crisis. Maximum case load of 12.
Comprehensive Home Based Services	Up to 6 months	5-8 direct hours with or on behalf of the family	Utilizing an evidence based model to assist families with high need for multiple home based intensive services. Additionally, will provide: supervised visits, transportation, parent education, homemaker/parent aid, and case management. Some evidence based models require a therapist to provide home based clinical services and treatment. These services are provided by one agency. This is referable through service mapping or the Regional Services Coordinator Maximum case load of 5-8.

Comprehensive Home-Based Services

The most recent addition to the home-based service array includes Comprehensive Home-Based Services. Comprehensive Services include an array of home based services provided by a single provider agency. All providers offering services through this standard are required to utilize an EBP model in service implementation, which include but is not limited to, Motivational interviewing, Trauma Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy.

In addition, Family Centered Treatment is being supported by DCS as a model of Comprehensive Home-Based Services. This service provides intensive therapeutic services to families with children at risk of placement or to support the family in transitioning the child from residential placement back to the family. This model also is effective in working with families who have very complex needs. The service works to implement sustainable value change that will improve life functioning and prevent future system involvement.

Services Available Through Comprehensive Home Based Services

Service Standard	Target Population	Service Summary
FCT – Family Centered Therapy	<ul style="list-style-type: none"> ● Families that are resistant to services ● Families that have had multiple, unsuccessful attempts at home based services ● Traditional services that are unable to successfully meet the underlying need ● Families that have experienced family violence ● Families that have previous DCS involvement ● High risk juveniles who are not responding to typical community based services ● Juveniles who have been found to need residential placement or are returning from incarceration or residential placement 	<p>This program offers an average of 6 months of evidenced based practice that quickly engages the entire family (family as defined by the family members) through a four phase process. The therapist works intensively with the family to help them understand what their values are and helps motivate them to a sustainable value change that will improve the lives of the whole family.</p>
MI – Motivational Interviewing	<ul style="list-style-type: none"> ● effective in facilitating many types of behavior change ● addictions ● non-compliance and running away of teens ● discipline practices of parents. 	<p>This program offers direct, client-centered counseling approaches for therapists to help clients/families clarify and resolve their ambivalence about change. Motivational Interviewing identifies strategies for practitioners including related tasks for the clients within each stage of change to minimize and overcome resistance. This model has been shown to be effective in facilitating many types of behavior change including addictions, non-compliance, running away behaviors in teens, and inappropriate discipline practices of parents.</p>

Service Standard	Target Population	Service Summary
<p>TFCBT – Trauma Focused Cognitive Behavioral Therapy</p>	<ul style="list-style-type: none"> ● Children ages 3-18 who have experienced trauma ● Children who may be experiencing significant emotional problems ● Children with PTSD 	<p>This program offers treatment of youth ages 3-18 who have experienced trauma. The treatment includes child-parent sessions, uses psycho education, parenting skills, stress management, cognitive coping, etc. to enhance future safety. Treatment assists the family in working through trauma in order to prevent future behaviors related to trauma, and a non-offending adult caregiver must be available to participate in services.</p>
<p>AFCBT – Alternative Family Cognitive Behavioral Therapy</p>	<ul style="list-style-type: none"> ● Children diagnosed with behavior problems ● Children with Conduct Disorder ● Children with Oppositional Defiant Disorder ● Families with a history of physical force and conflict 	<p>This program offers treatment to improve relationships between children and parents/caregivers by strengthening healthy parenting practices. In addition, services enhance child coping and social skills, maintains family safety, reduces coercive practices by caregivers and other family members, reduces the use of physical force by caregivers and the child and/ or improves child safety/welfare and family functioning.</p>
<p>ABA – Applied Behavioral Analysis</p>	<ul style="list-style-type: none"> ● Children with a diagnosis on the Autism Spectrum 	<p>This program offers treatment for youth with autism diagnosis to improve functional capacity in speech and language, activities of daily living, repetitive behaviors and intensive intervention for development of social and academic skills.</p>

Service Standard	Target Population	Service Summary
<p>CPP – Child Parent Psychotherapy</p>	<ul style="list-style-type: none"> ● Children ages 0-5 who have experienced trauma ● Children who have been victims of maltreatment ● Children who have witnessed DV ● Children with attachment disorders ● Toddlers of depressed mothers 	<p>This program offers techniques to support and strengthen the caregiver and child relationship as an avenue for restoring and protecting the child’s mental health, improve child and parent domains, and increase the caregiver's ability to interact in positive ways with the child(ren). This model is based on attachment theory but integrates other behavioral therapies.</p>
<p>IN-AJSOP</p>	<p>Children with sexually maladaptive behaviors and their families</p>	<p>This program offers treatment to youth who have exhibited inappropriate sexually aggressive behavior. The youth may be reintegrating into the community following out-of-home placement for treatment of sexually maladaptive behaviors. Youth may have sexually maladaptive behaviors and co-occurring mental health, intellectual disabilities or autism spectrum diagnoses. CBT-IN-AJSOP focuses on skill development for youth, family members and members of the community to manage and reduce risk. Youth and families learn specific skills including the identification of distorted thinking, the modification of beliefs, the practice of pro social skills, and the changing of specific behaviors</p>
<p>Intercept</p>	<p>Children of any age with serious emotional and behavioral problems</p>	<p>Treatment is family-centered and includes strength-based interventions, including family therapy using multiple evidence based models (EBM), mental health treatment for caregivers, parenting skills education, educational interventions, and development of positive peer groups.</p>

Sobriety Treatment and Recovery Teams (START)

Indiana is currently piloting a promising practice program that has shown very positive outcomes with families in Kentucky. The program combines a specially trained FCM, Family Mentor, and Treatment Coordinator to serve families where there are children under the age of 5 and the parent struggles with a substance use disorder. The Family Mentor is someone who has had history with the child welfare system and is currently in recovery. The program is being piloted in Monroe County. Currently there are three active FCMs, one Family Mentor and one Treatment Coordinator with the ability to add 2 additional mentors. It is estimated that the full team will be serving approximately 30 families at any given time. Currently DCS is expanding this program to Vigo County, Indiana.

Adolescent Community Reinforcement Approach (ACRA)

The Department of Mental Health Addictions (DMHA) has trained therapists at two agencies in Indianapolis. This model will be expanded through this inter-department collaboration and ensures that the service is available to adolescents in need. This EBP uses community reinforcers in the form of social capital to support recovery of youth in an outpatient setting. ACRA is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery.

This outpatient program targets youth 12 to 18 years old with DSM-IV cannabis, alcohol, and/or other substance use disorders. Therapists choose from among 17 ACRA procedures that address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in pro-social activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. Role-playing/behavioral rehearsal is a critical component of the skills training used in ACRA, particularly for the acquisition of better communication and relapse prevention skills. Homework between sessions consists of practicing skills learned during sessions and participating in pro-social leisure activities. The ACRA is delivered in one-hour sessions with certified therapists.

Trauma Assessments, TF-CBT, CPP

DCS recently expanded the service array to include Trauma Assessments and Bonding and Attachment Assessments. Trauma Assessments will be provided to appropriate children, using at least one standardized clinical measure to identify types and severity of trauma symptoms. Bonding and Attachment Assessments will use the Boris direct observation protocol. These new assessments will provide recommendations for appropriate treatment.

Child Parent Psychotherapy (CPP) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) are two of the possible models that could be utilized. DCS has trained a cohort of 28 therapists to provide Child Parent Psychotherapy. This first cohort of trained therapists includes 9 teams of 3 therapists from within the CMHC network and one additional DCS clinician. These

therapists completed their training in May 2014, but will receive another year of consultation through the Child Trauma Training Institute as they begin to fully implement the model. DCS began offering training to a second cohort of clinicians to ensure service availability for children in need. DCS has trained approximately 300 clinicians throughout the state to provide TF-CBT. These agencies are both CMHC's and community-based providers and will ensure that TF-CBT is available for children and families in need.

Parent Child Interaction Therapy

DMHA has started training therapists at Community Mental Health Centers in Parent Child Interaction Therapy (PCIT), which DCS children and families will access through our collaboration and master contracts with the CMHC's. Additionally, with the DCS Comprehensive Service supporting the usage of evidenced-based models, PCIT will increase in its availability throughout the state.

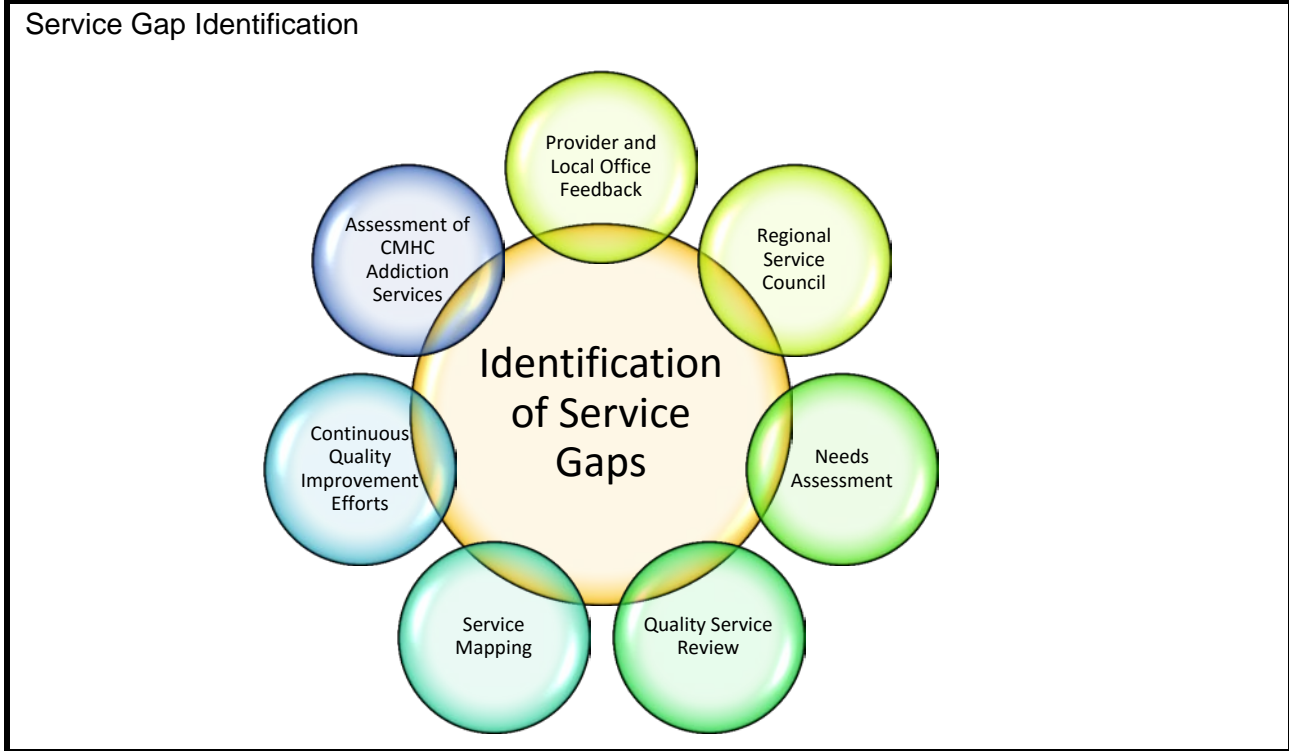
PCIT is an evidence-based treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Disruptive behavior is the most common reason for referral of young children for mental health services and can vary from relatively minor infractions such as talking back to significant acts of aggression. The most commonly treated Disruptive Behavior Disorders may be classified as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD), depending on the severity of the behavior and the nature of the presenting problems. The disorders often co-occur with Attention-Deficit Hyperactivity Disorder (ADHD). PCIT uses a unique combination of behavioral therapy, play therapy, and parent training to teach more effective discipline techniques and improve the parent-child relationship. PCIT draws on both attachment and social learning theories to achieve authoritative parenting. The authoritative parenting style has been associated with fewer child behavior problems than alternative parenting styles.

The state has all the above-referenced services in each political jurisdiction covered by the CFSP;

To demonstrate that the above-referenced services are available statewide, a list of the contracted services sorted by DCS Region and provider are listed in **Attachment 11**.

Any gaps in the above-referenced array of services in terms of accessibility of such services across all political jurisdictions covered by the CFSP.

Service gaps are continuously monitored and addressed at both a statewide and regional level. The sources of information that lead to the identification of a service gap are identified in graphic below.



Biennial Regional Services Strategic Plans (BRSP)

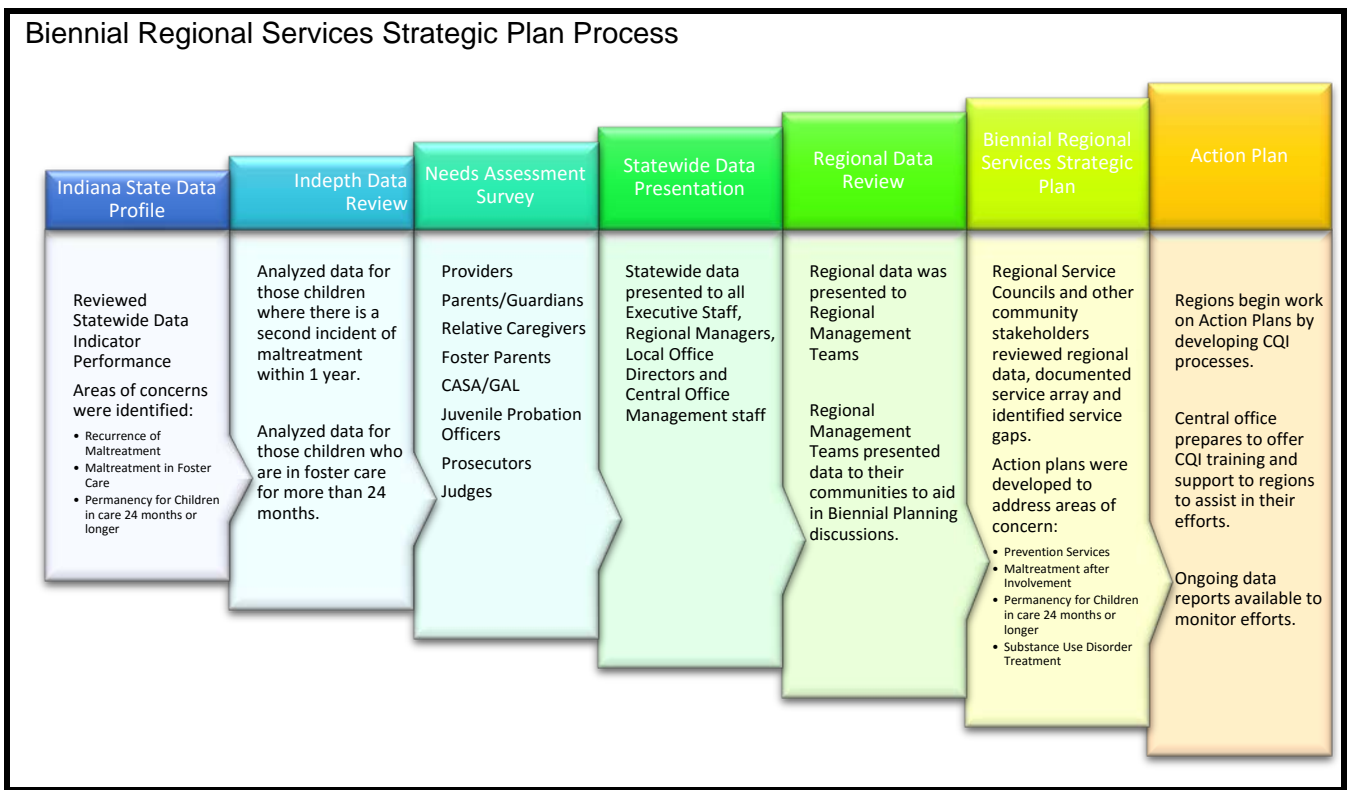
One of the most comprehensive tools in identifying and addressing service gaps is the BRSP. Over the course of the last 10 years, DCS has launched a number of initiatives to improve the manner in which child welfare is administered in Indiana, including the DCS practice model (Teaming, Engaging, Assessing, Planning and Intervening or "TEAPI") and the Safely Home Families First Initiative. In 2008, State legislation was passed that added the requirement for a BRSP that would be tailored toward the provision of services for children in need of services or delinquent children. The BRSP incorporates the "Early Intervention Plan" and the "Child Protection Plan" as well as new requirements under the Biennial Plan. The Early Intervention Plan was a focus on programs and service to prevent child abuse and neglect or to intervene early to prevent families from entering the child welfare or delinquency system. The Child Protection Plan described the implementation of the plan for the protective services of children. It included the following information: Organization; Staffing; Mode of operations; Financing of the child protection services; and the provisions made for the purchase of services and interagency relations.

The Regional Services Council is the structure responsible for development of the BRSP. The purpose of the Regional Services Council is to evaluate and address regional service needs (including the identification of service gaps and how to address them), regional expenditures, and to serve as a liaison to the community leaders, providers and residents of the region. The BRSP allows local service providers and community members to be represented in the evaluation of local child welfare service needs. Additional evaluation is conducted via a survey that is sent to local providers as well as interested community partners. The Regional Services Council also conduct a meeting to take public testimony regarding local service needs

and system changes. Among the items addressed in the final version of the BRSP is the service array, available services, and needs assessment survey. Information that is gathered from the BRSP is analyzed to see if any statewide trends are identified that can be acted on and implemented into the CFSP.

As an example of how the BRSP planning process identifies service gaps, information gathered from the BRSP process in 2014 identified significant service gaps in substance use assessment and treatment services as each region identified this service need in their BRSP. As a result of this information, Objective 1.4 in the CFSP – Improving Accessibility and Effectiveness of Substance Use Disorder Treatment - was developed. The goals and action steps listed in Objective 1.4 were developed as a result of collaborations with stakeholders that were involved in the BRSP.

For the most recent round of BRSP development, DCS began the process by analyzing service availability, delivery, and perceived effectiveness. The graphic below outlines the steps taken to develop the Biennial Regional Services Strategic Plans.



The following is an overview of the most recent BRSP process with relevant findings as it relates to Indiana’s service array:

1. Indiana State Data Profile: The first step in the process included a review of the Indiana State Data Profile. During the review, it was determined that the BRSP process would focus on the items for which Indiana was below the national standard. Those items included:
 - Recurrence of Maltreatment

- Maltreatment in Foster Care, and
 - Permanency for children in care 24 months or longer.
2. In-depth Data Review: DCS determined additional information was necessary in order to determine the best next steps to address the federal benchmarks. The DCS Research and Evaluation Team conducted an in-depth review of those children who had an incident of maltreatment within one (1) year of substantiated involvement with DCS. The review included children with substantiated abuse and/or neglect during the second quarter of 2014. The children were followed for one (1) year to see if there was a subsequent substantiation. It was expected that addressing the systemic issues that might exist with this population would improve both federal measures; recurrence of maltreatment and maltreatment in foster care. The review included a comparison of those children who had a second incident of maltreatment and those that did not.

In addition to maltreatment after involvement, an in-depth review was completed for those children who had been in care for 24 months or longer. Those youth that reached permanency within the following year were compared to those that did not. This information was analyzed at the state level and then also at the regional level.

3. Needs Assessment: The statewide Needs Assessment Survey was developed during the spring and summer of 2015 and focused on perceived service **availability, utilization, and effectiveness**. Additional information regarding the Needs Assessment Surveys is included in Item 25 – Quality Assurance System. The statewide results are summarized in the semi-annual 2015 Wavier Evaluation Reports which are attached hereto as **Attachment 12**. The information was analyzed at the statewide level and also on a regional level for use by the Regional Service Councils in development of their BRSP.

The needs assessment included the following surveys:

- FCMs – In April 2015, 1238 FCMs were asked questions about teaming and the need, utilization, and effectiveness of services.
- Court – In August 2015, six (6) groups: judges, prosecutors, attorneys, law enforcement, CASA/GAL, and probation received a survey. Director Bonaventura sent out the survey to judges via an email list. Probation, law enforcement, prosecutors, attorneys, and CASA/GAL surveys were sent out on a listserv put together by the DCS Executive Team. This population was asked about service effectiveness and teaming. Additionally, they were asked to rate DCS employees in regards to court processes. Similar to the Community Service Provider survey, the snowball sampling method resulted in the data collection period being extended to Saturday, August 22nd. The majority of respondents were GAL/CASA (n=478), followed by probation (n=87), prosecutor (n=39), and judge (n=31).

- Caregiver/youth – In August 2015, a survey was administered for the first two weeks of August 2015 where FCMs, on their monthly visit, had the birth-parent, foster parent, relative, or older youth fill out the survey. Parents/guardians were able to rate DCS and the services that they have used. In addition, questions were asked about the teaming process and concrete services. To complete the survey, FCMs informed the caregiver and youth (3CM/CHINS or Collaborative Care) that they were selected as a possible participant because they are an individual that receives services from DCS and then asked if he/she would be willing to fill out a survey. The FCM filled out the name of the focus child whose first name was first in alphabetical order. The reason for this was the questions focused on a particular child; and with the possibility of multiple children in the home, the CQI team wanted to randomize who was selected in the house. The caregiver/youth then filled out the survey. The Caregiver and Youth Survey stopped collection on Friday, August 14th, 2015 at 11:59pm. Respondents consisted of bio parents (n=121), foster parents (n=123), relatives (n=56), and youth (n=56).
 - Service Provider – Also in August 2015, a survey was directed at CEOs, therapists, and administration. The Community Service Provider survey mirrored the FCM survey, asking them to rate the need, availability, utilization and effectiveness of services as well as some questions on teaming and specific questions about their facility. This survey was distributed by DCS through an existing service provider list. Recipients were asked to forward the survey to other works for additional feedback. The majority of respondents were frontline workers (n=181), followed by program managers (n=161), agency CEO (n=114), and central/administrative operations (n=85).
4. Statewide Data Presentation: DCS formally kicked off the BRSP process by bringing together the Executive Staff, Central Office Management, and Local Field Management for a State of the Agency address. Statewide data was reviewed which included case trends, needs assessment data (see #3 above), the two in-depth reviews (maltreatment after involvement and permanency for those in care 24 months or longer), practice model implementation data, and service information. The Statewide Data Presentation is attached as **Attachment 13**.

Relevant information regarding service array begins on page 78 of the Statewide Data Presentation. For each service grouping (26 were listed), survey participants were asked to rate the need and then the availability when needed on a scale of 1 (minimum) to 5 (maximum). Next, survey participants were asked to rate services based on their utilization when needed and then asked to rate service effectiveness when utilized using the same scale.

- FCMs surveys indicated that health care services, home-based case management, substance use/abuse, and mental health services were

both the highest need and most available services statewide. Least available were employment/training services, legal assistance, child care, and housing.

- Service providers listed case management, home-based casework, home-based services, and mental health services as the highest need and most available. Father engagement services, housing services, child care, and respite were believed to be least available.

Overall, the above data indicates that statewide, when service needs are ranked high, so is service availability.

5. Regional Data Review: Following the Statewide Data Presentation, the regional management teams were given their regional data. Data experts facilitated a discussion about the data to prepare the local teams to take the data back to their communities for utilization in their BRSP process. For example, in Region 15, the FCM survey identified mental health, health care, home-based case management, father engagement, and basic services as the highest availability. Housing, legal services, employment, child care, and motivational interviewing.
6. Biennial Regional Services Strategic Plan and Action Plans: The planning process to develop the BRSP involved a series of regional activities led by a guided workgroup composed of representatives from the Regional Service Council and others in the community. The workgroups were topic specific and focused on items and goals that were identified in DCS' CFSP Goals:
 - Prevention Services
 - Maltreatment After Involvement
 - Permanency for Children in Care 24 months or longer
 - Substance Use Disorder Treatment
 - Region Identified Issue(s)

Regional Data was reviewed and considered for each topic area. The workgroup considered the Regional Data in conjunction with previous service utilization and public testimony to determine the appropriate utilization of available services and to identify gaps in service. As a result, the workgroup developed a regional action plan to address service needs and gaps that are specific to the region.

The BRSPs were approved by the Regional Service Council and subsequently submitted to the Director of the Department of Child Services on February 2, 2016 for final approval. A sample BRSP for Region 15 is attached as **Attachment 14**. All BRSPs are posted to the DCS website upon approval by the Director.

Quality Service Review

Quality Service Review data is also used to identify service needs and inform decisions on where improvements need to be made. The below graph demonstrates the continued high rate of resource availability (the degree at which formal supports, services, and resources necessary to implement planned change strategies are available as required) following Round 4 of the QSR.

INDICATORS	Baseline	Round 2	Round 3	Round 4	Score Change * Increase/Decrease	Percentage (%)** Improvement/Decline
Resource Availability	75	88	93	95	2	2.15%

Despite the high ranking in resource availability, other data collected in the QSR reinforces the need for improved access to substance abuse services, mental health services, and father engagement.

Substance Abuse: Parent stress factors that were identified from the end of QSR Round 4 included the following:

- 59% Drug Dependency
- 48% Lack of Parenting Skills
- 41% Mental Health
- 40% Domestic Violence
- 37% Insufficient Income

Father Engagement: Despite marginal improvement, data for role & voice of father continues to be low, as indicated in the table below. Staff development used Round 4 QSR data to enhance engagement training curriculum and require staff to receive the updating training.

INDICATORS	Baseline	Round 2	Round 3	Round 4	Score Change * Increase/Decrease	Percentage (%)** Improvement/Decline
Role & Voice Father	25	29	37	31	-6	-16.22%

QSR data also identified concerted action trends for DCS Regions statewide. Examples of service gaps identified by the QSR concerted action trends are listed below.

- DCS Regions 15 and 17 did not have services available for incarcerated parents. To address this ongoing issue, DCS reached out to partners at the DOC to begin a dialogue for establishing a documented process for engaging incarcerated parents. The collaboration between the two agencies resulted in a memorandum of understanding outlining the procedure for child visitation and service provider coordination. A copy of the memorandum of understanding is attached is **Attachment 4**.
- DCS Regions 3, 5, 6, 11, and 13 had a number of services that were available to meet the specific needs of families. However, due to demand and the low number of

providers, waitlists prevented timely access to services. In addition, providers were not able to see families with the intensity needed due to their limited availability.

- DCS Regions 14, 9, 18, 17, 14, 4, 12, 15, 6, 8, and 1 had limited services available locally to meet the specific needs of families (i.e. therapeutic needs, substance abuse treatment, transportation, housing, affordable childcare, residential placements, shelters, or resources for families impacted by domestic violence).

Governors Tasks Force on Drug Enforcement

In addition to the BRSP process, DCS is working with the Governor's office and other state agencies to address service gaps that exist in the treatment of Substance Use Disorders. Established by Executive Order, the Governor's Task Force on Drug Enforcement, Treatment, and Prevention is bringing together Indiana experts from a variety of specialties to evaluate the growing national drug problem in Indiana. Specifically, the Task Force is charged with:

- Statewide assessment: Evaluate the existing resources across all areas, identify gaps in enforcement, treatment and prevention and provide recommendations for improvement
- Enforcement: Identify effective strategies so federal, state, and local law enforcement can partner together to combat drug abuse
- Treatment: Analyze available resources for treatment and identify best practices for treating drug addiction.
- Prevention: Identify programs and/or policies which are effective in preventing drug abuse, including early youth intervention programs

Assessment of CMHC Addiction Services

In late 2015, DCS also requested the assistance of Jeff Jamar, a consultant through Child and Family Futures, to evaluate how the various systems work together to ensure services to treat Substance Use Disorder are available for families who are involved with the child welfare system. Mr. Jamar's research involved surveying and interviewing Indiana's Community Mental Health Centers regarding the services they provide to DCS clients who need assessment and treatment for Substance Use Disorder. DCS will be reviewing the recommendations in the report and determining how to best address the service gaps and issues identified.

Item 30: Individualizing Services

How well is the service array and resource development system functioning statewide to ensure that the services in item 29 can be individualized to meet the unique needs of children and families served by the agency?

Please provide relevant quantitative/qualitative data or information that show whether the services in item 29 are individualized to meet the unique needs of children and families served by the agency.

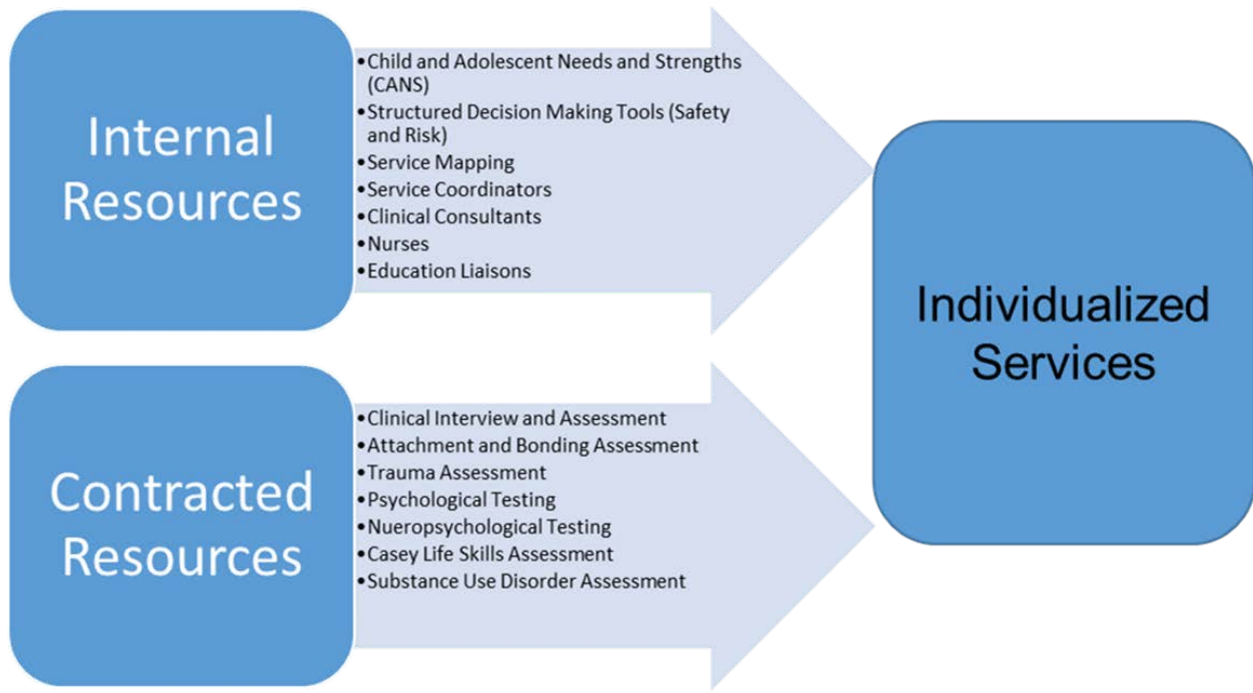
- Services that are developmentally and/or culturally appropriate (including linguistically competent), responsive to disability and special needs, or accessed through flexible funding are examples of how the unique needs of children and families are met by the agency.

State Response:

Insert state response to Item 30: Individualizing Services

The Department of Child Services (DCS) utilizes several methods to improve the individualization of services for children and families making this item a strength of the agency. These methods are outlined in the figure below and a complete description of each is included in Item 29 - Service Array.

Assessment Resources



Contractual Requirements

DCS has instituted contractual requirements to assist in ensuring service provision is appropriate and contract audit staff check for compliance during audit visits. The following language is included in all DCS Service Standards (which are incorporated into the contract by reference):

“Cultural and Religious Competence.

Provider must respect the culture of the children and families with which it provides services. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth. The guidebook can be found at:

<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>

Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.”

As of round 4 of the QSR (June 2014-July 2015), respondents agreed that DCS respected their culture (90%), continuing the trend of DCS’ improvement with this indicator.

INDICATORS	Baseline	Round 2	Round 3	Round 4
Cultural Recognition	78%	83%	89%	90%

For those populations that do not speak English, DCS provides interpreter services that are available statewide for both in person (in home visits, interviews, etc.) and over the phone services, further demonstrating DCS’ commitment to meeting the language needs of the children and families it serves. A list of the language services that were provided in calendar year 2015 is below:

Language	Jobs	%
Spanish	1522	72.5%
ASL	313	14.9%
Burmese	100	4.8%
Chin	54	2.6%
Arabic	19	0.9%
Chinese Man	15	0.7%
Nepali	10	0.5%
Hindi	9	0.4%
Vietnamese	9	0.4%
Tibetan	9	0.4%
Other	40	1.9%

Furthermore, the chart below identifies locations of in person interpreter services that were provided in calendar year 2015.

Location	# of Jobs	%
Home Visit	214	10%
DCS-Marion County, Juvenile Court, 2451 North Keystone Ave Indianapolis, IN.	106	5%
DCS-Boone County, DCS Lebanon Office, 953 Monument Drive Lebanon, IN. 46052	63	3%
DCS-Marion County, Child Advocacy Center, 5419 White Horse Road Indianapolis, IN 46224	62	3%
DCS-Shelby County, Home Visit, 1203 E. State Rd. 44#16 Shelbyville, IN 46176	27	1%
DCS-Healthy Families, 2005 Arrowhead Drive #3a, Merrillville, IN 46410, USA	25	1%
DCS-Allen County, 201 E Rudisill BLVD STE 200 Fort Wayne, IN 46806	24	1%
DCS-Marion County, Indiana School for the Deaf, 1200 East 42nd St Indianapolis, IN 46205	16	1%
DCS-Bartholomew County, Home Visit, 605 McClure Rd Columbus, IN 47201	13	1%
DCS-Madison County, Home Visit, 222 E 10th St. Anderson, IN 46016	12	1%
Other locations throughout Indiana	1538	73%

DCS also offers interpreter phone services when requested. Below is a chart with the number of completed calls for calendar year 2015 in each county. More detailed reports that contain the language used for each call in the county are also available.

DCS Allen County (Location-02)	159
DCS Bartholomew County (Location-03)	23
DCS Benton County (Location-04)	8
DCS Boone County (Location-06)	36
DCS Carroll County (Location-08)	1
DCS Cass County (Location-09)	4
DCS Clark County (Location-10)	10
DCS Clinton County (Location-12)	51
DCS Daviess County (Location-14)	44
DCS Delaware County (Location-18)	1
DCS Dubois County (Location-19)	76
DCS Elkhart County (Location-20)	12
DCS Floyd County (Location-22)	5
DCS Franklin County (Location-24)	2
DCS Fulton County (Location-25)	4
DCS Gibson County (Location-26)	13
DCS Hamilton County (Location-29)	33
DCS Hancock County (Location-30)	1
DCS Hendricks County (Location-32)	41
DCS Howard County (Location-34)	48
DCS Jackson County (Location-36)	21
DCS Jasper County (Location-37)	3
DCS Jefferson County (Location-39)	1
DCS Johnson County (Location-41)	28
DCS Knox County (Location-42)	1
DCS Kosciusko County (Location-43)	7
DCS Lake County (Location-45)	6
DCS Madison County (Location-48)	25
DCS Marion County (Location-49)	896

DCS Marshall County (Location-50)	11
DCS Monroe County (Location-53)	5
DCS Morgan County (Location-55)	4
DCS Newton County (Location-56)	2
DCS Noble County (Location-57)	12
DCS Orange County (Location-59)	2
DCS Porter County (Location-64)	2
DCS Randolph County (Location-68)	1
DCS Ripley County (Location-69)	8
DCS Shelby County (Location-72)	6
DCS Spencer County (Location-73)	8
DCS Tippecanoe County (Location-79)	10
DCS Vanderburgh County (Location-82)	11
DCS Vigo County (Location-84)	15
DCS Warrick County (Location-87)	1
DCS White County (Location-91)	14
DCS Hotline Call Center (Location-93)	284
DCS St Joe Hotline Call Center (Location-94)	29
DCS KidsLine (Location-95)	930
DCS Parenting Time Hotline (Location-96)	7
DCS Lawrence Hotline Call Center (Location-97)	25
DCS Blackford Hotline Call Center (Location-98)	41
DCS DCS Central Office (Location-99)	26
DCS Vanderburgh Hotline Call Ctr (Location-100)	14

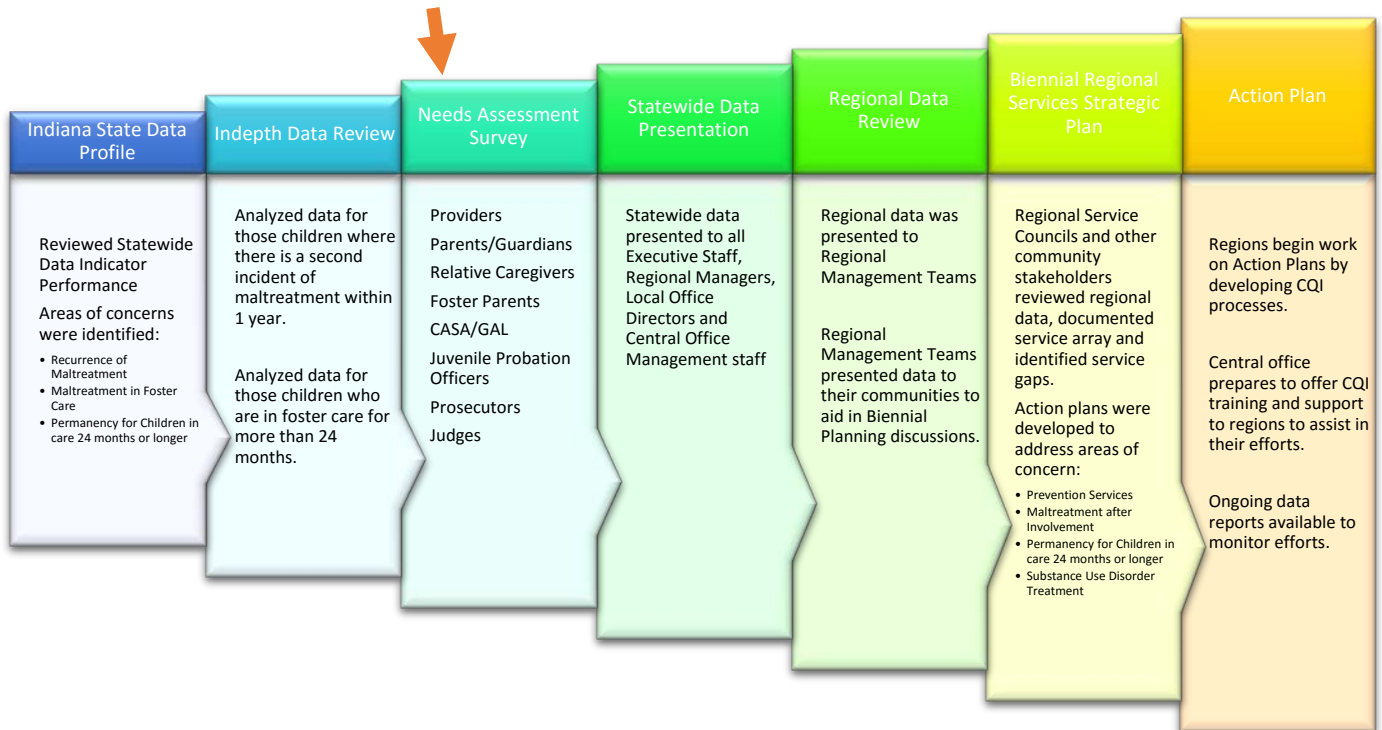
In addition, DCS requires providers to comply with the Assurances (also incorporated into the contract by reference). The following is language from the Assurances:

1. The provider agrees to conform to Title VI of the Federal Civil Rights Act of 1964, as amended, and to Indiana Code 22-9-1-10, as amended, and thus assures non-discrimination in practices concerned with staff recruitment as well as in the provision of services without distinction as to color, race, religion, sex, handicap, ancestry.
2. The provider agrees to upgrade and maintain cultural knowledge base of staff regarding issues of diversity and cultural competence, particularly with primary populations being served.

3. In order to improve outcomes for LGBTQ youth, service providers will provide a culturally competent, safe, and supportive environment for all youth regardless of sexual orientation. All staff must be sensitive to the sexual and/or gender orientation of the family members, including lesbian, gay, bisexual, transgender or questioning (LGBTQ) children/youth. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
 - a. The LGBTQ Practice Guidebook and LGBTQ Computer Assisted Training (CAT) are both available online.
 - b. All DCS child welfare service agencies are required to have all of their new staff understand the information in the LGBTQ Practice Guidebook within 30 days of start date. New The Guidebook is located at: <http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>
 - c. All DCS child welfare service agencies are required to have all of their new staff complete the LGBTQ Computer Assisted Training (CAT) within 30 days of start date. The training is located at: <http://childwelfare.iu.edu/cat/DCS09030/>

Needs Assessment Survey

Biennial Regional Services Strategic Plan Process



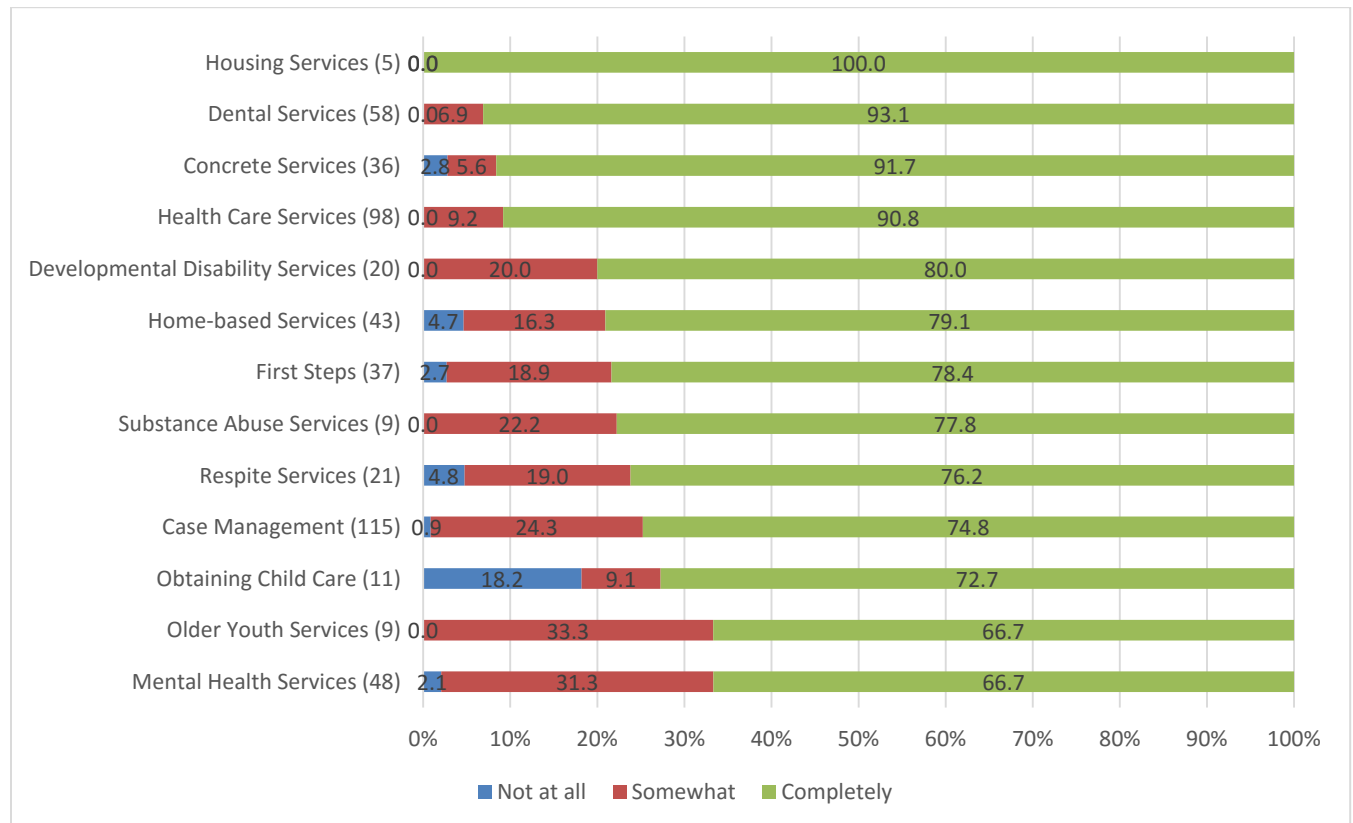
As detailed in Item 25 – Quality Assurance, as part of the IV-E Waiver Evaluation and the BRSP process, during August 2015, the Needs Assessment Surveys were administered to providers, parents/guardians, relative caregivers, foster parents, CASA/GAL, juvenile probation

officers, prosecutors, and judges. The results are summarized in the attached semi-annual Waiver Evaluation Reports from calendar year 2015 (**Attachment 12**). It should be noted that the parent survey had a very low response rate (DCS has since started including the survey as part of the Quality Service Review (QSR) process to try to increase participation and also tie the responses to the actual outcomes of the case. Service need, availability, utilization, and satisfaction were each rated on a five-point scale with high scores indicating greater need, availability, utilization, and satisfaction. Below is data from the Needs Assessment Survey that speaks to services being individualized.

Effectiveness of Services to Meet Family’s Needs Rated by Foster Parents/Relatives

Foster parents and relatives were asked to rate the extent to which services that they used met their needs. In the chart below, many respondents indicated that the services used for families “completely” met their needs, ranging from 66.7% to 100% across the services. More specifically, the highest rated were housing services (100%), dental services (93.1%), concrete services (91.7%), and health care services (90.8%). However, over eighteen percent of the respondents, who used the services to obtain child care (n =11), reported that the services did not meet their needs at all. This percentage was relatively higher than those of other services.

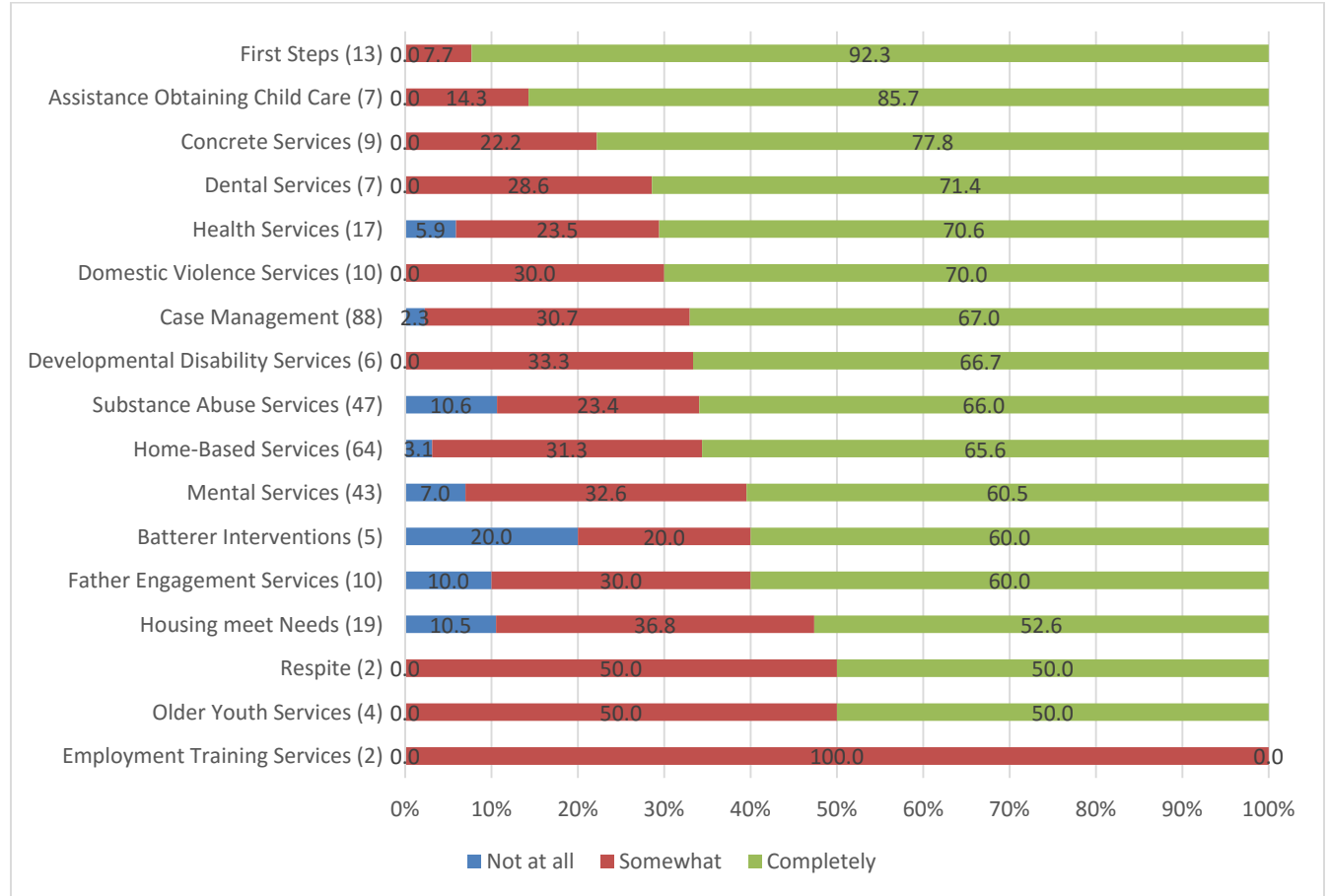
Effectiveness of Services to Meet Family’s Needs Rated by Foster Parents/Relative Caregivers (number of respondents is listed after service)



Effectiveness of Services to Meet Family’s Needs Rated by Bio Parents

Bio parents were also asked to rate the extent to which services that they used met their needs (see chart below). Many respondents indicated that the services used for families “completely” met their needs, ranging from 50% to 92.3% across the services. More specifically, the highest rated were first steps (92.3%), assistance obtaining child care (85.7%), concrete services (77.8%), and dental services (71.4%).

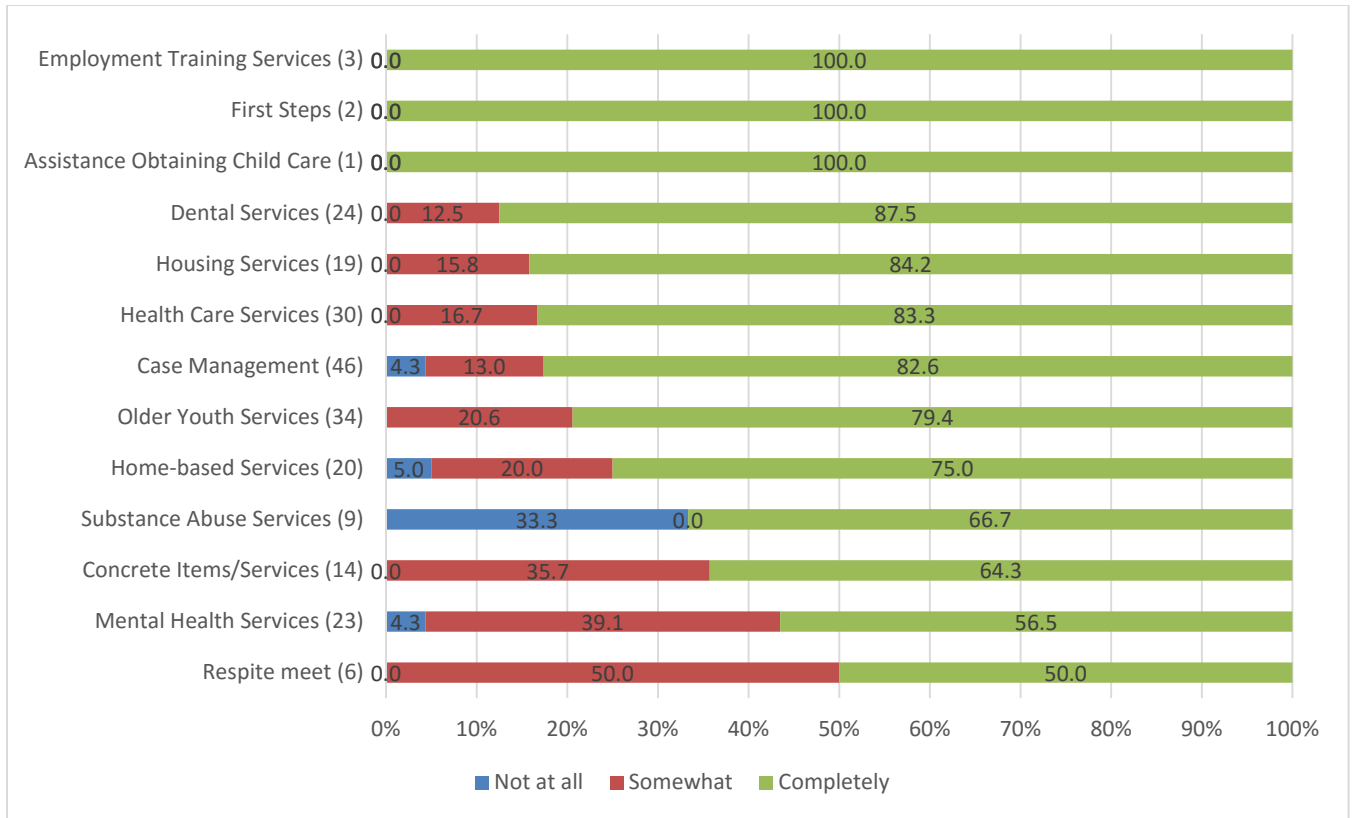
Effectiveness of Services to Meet Family’s Needs Rated by Bio Parents



Effectiveness of Services to Meet Family’s Needs Rated by Youth

Similar to other adult respondents, at least 50% of youth reported that all the services used “completely” met their needs (see chart below). Youth rated highest on employment training services, first steps, and child care; but it should be noted that only a small number of youth (≤3) rated these services.

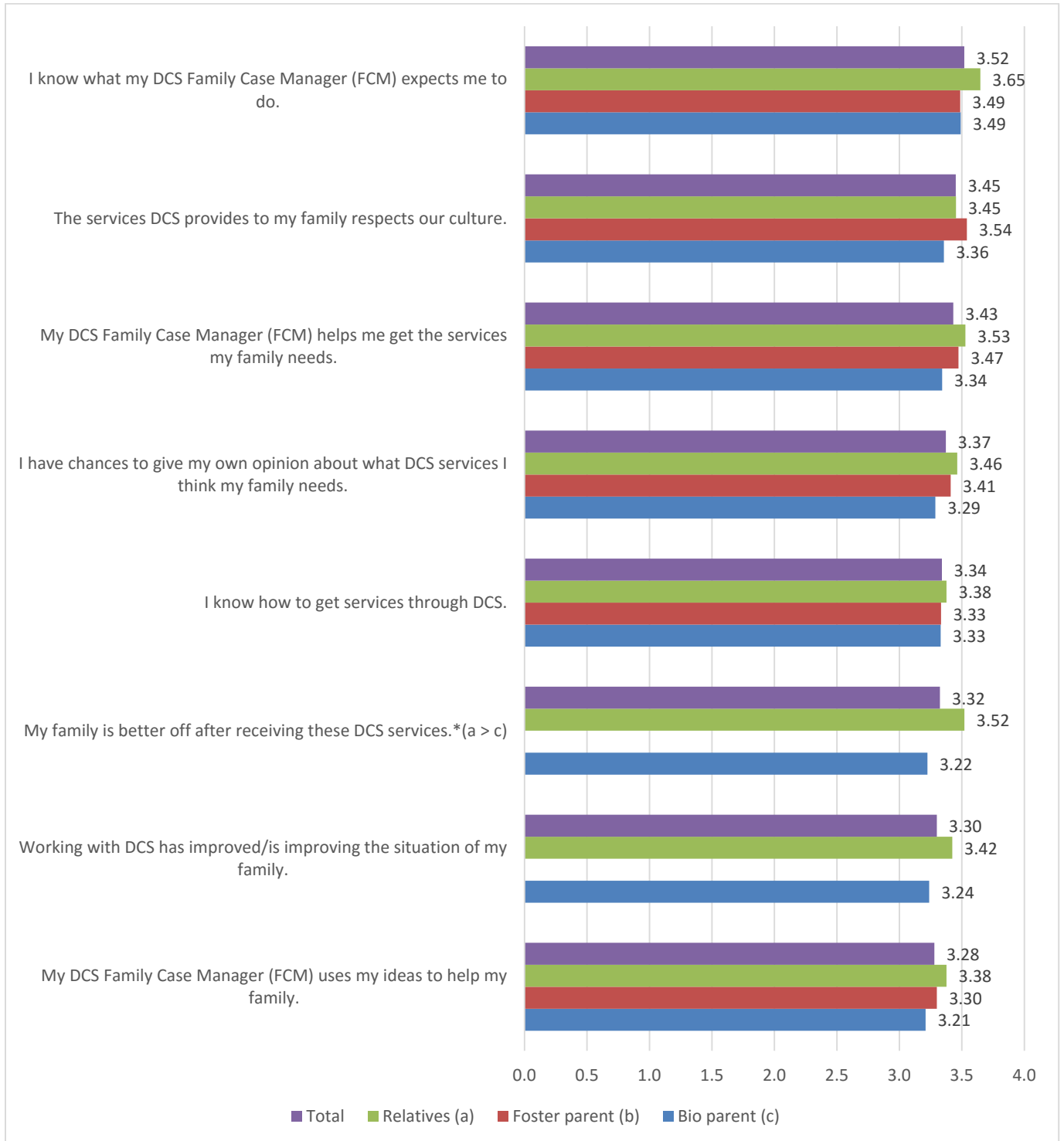
Effectiveness of Services to Meet Family’s Needs Rated by Youth



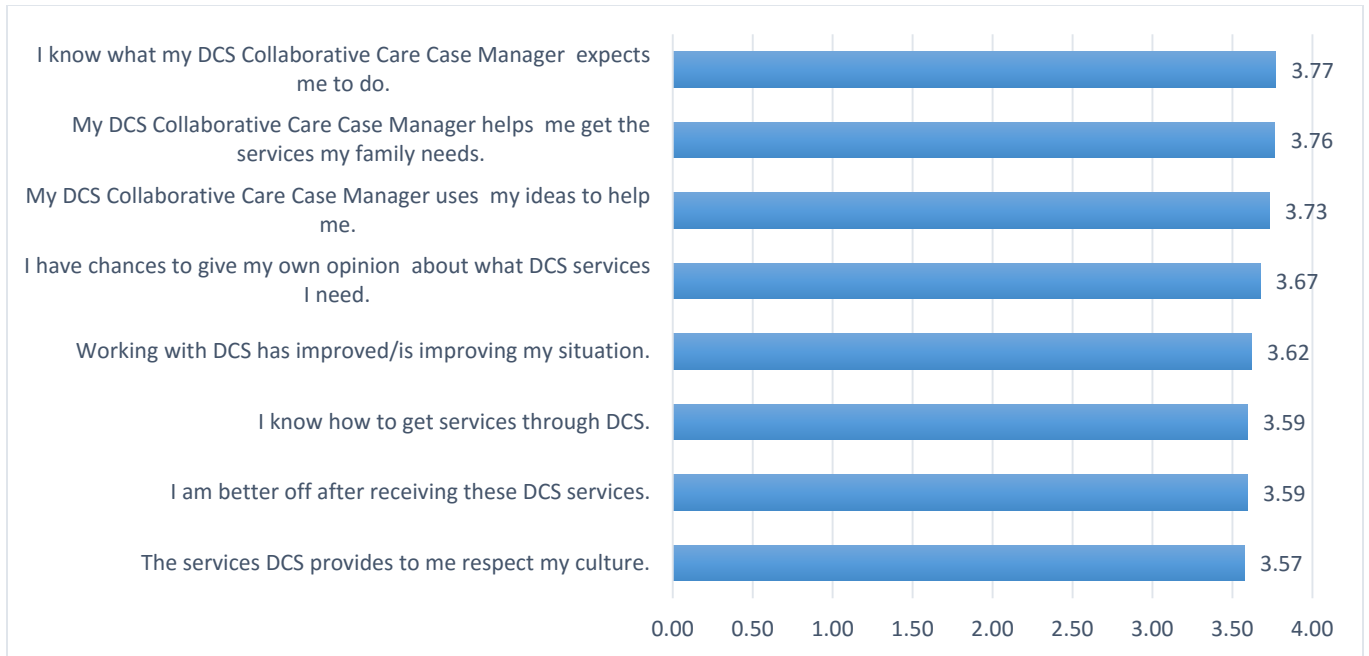
Satisfaction of Adult Caregivers and Youth in DCS Services and Case Managers

Mean responses of questions relating to satisfaction of adult caregivers and youth in DCS services and case managers are presented in the three charts below. In general, both adult caregivers and youth agreed or strongly agreed with most questions of satisfaction about DCS services and case managers. For adult caregivers, the questions with relatively higher average scores include: “I know what my DCS Family Case Manager (FCM) expects me to do” (M = 3.52), “the services DCS provides to my family respects our culture” (M = 3.45), and “my DCS FCM helps me get the services my family needs” (M = 3.45). There was one question that showed a significant difference between types of adult caregivers. Relatives were more likely than bio parents to perceive that “my family is better off after receiving DCS services (3.52 vs. 3.22, p < .05). Similarly, youth rated relatively higher average scores on some questions: “I know what my DCS Collaborative Care Case Manager expects me to do” (M = 3.77), “my DCS Collaborative Care Case Managers helps me get the services my family needs” (M = 3.76), and “my DCS Collaborative Care Managers uses my ideas to help me” (3.73). The final chart below depicts the results of comparing the levels of satisfaction in three questions that were commonly answered by three groups. Youths perceived significantly higher satisfaction in the statement, “working with DCS has improved/is improving the situation of my family” than did bio parent (3.62 vs. 3.24, p < .01). They also had a significantly higher average score on the statement, “I know how to get services through DCS” as compared to both foster parent/relative and bio parent groups” (3.59 vs. 3.35 and 3.33, p < .05).

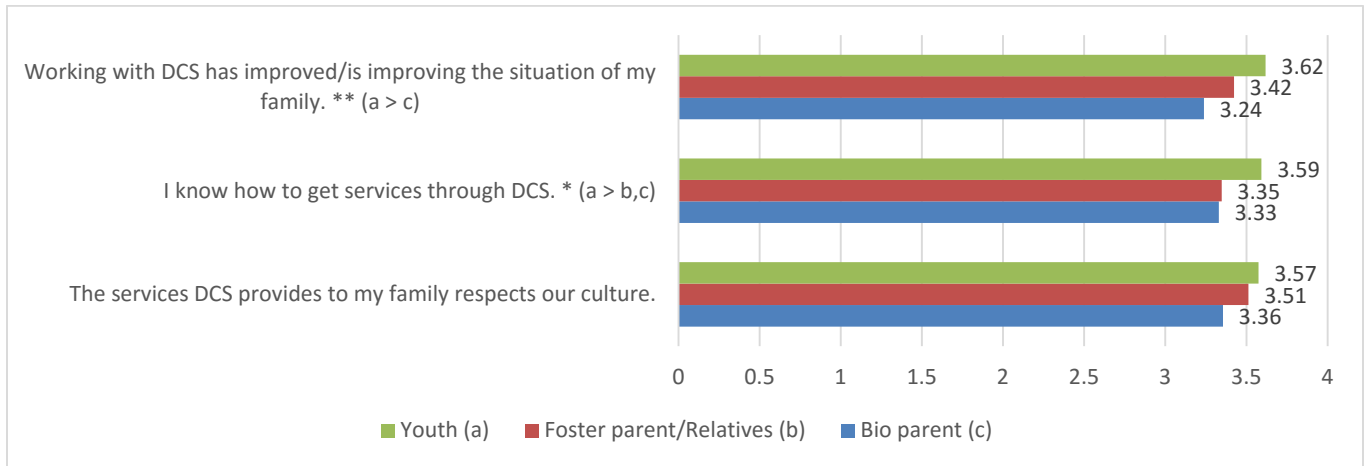
Adult Caregivers' Average Rating of Satisfaction in DCS Services and Case Managers



Youth's Average Rating of Satisfaction in DCS Services and Case Managers



Comparing Average Rating of the Satisfaction between the Types of Respondent

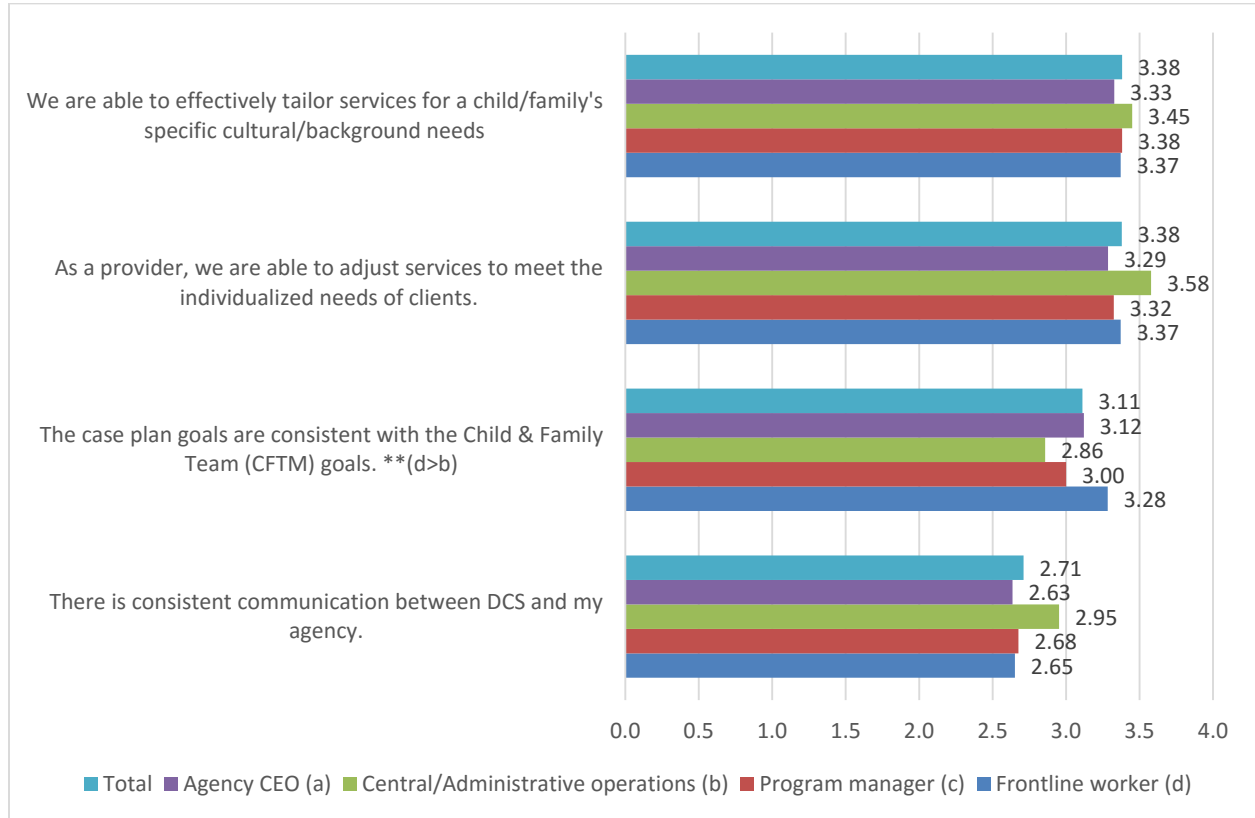


Service Provider Average Rating of the Experience in a Child and Family Team Meeting (CFTM)

Service provider respondents were asked to answer some questions to investigate their experiences in attending a CFTM. Overall, respondents agreed or strongly agreed with all statements (see chart below). More specifically, the highest average rating statements were “we are able to effectively tailor services for a child/family’s specific cultural/background needs” (M = 3.38) and “as a provider, we are able to adjust services to meet the individualized needs of clients” (M=3.38), whereas the lowest average rating statement was “there is consistent communication between DCS and my agency” (M = 2.71). There were not significant differences in the perceptions of the CFTM experience between the respondent types, with the

exception of one statement, “the case plan goals are consistent with the Child & Family Team (CFTM) goals” (frontline workers 3.28 > central/administrative operations 2.86, $p < .01$).

Average Rating of the Experience in a CFTM



In circumstances where services may not be available due to the unique needs of a child/family or, in the alternative, new services and or resources need to be identified, DCS utilizes a Multidisciplinary Team (MDT) to assist in identifying solutions. The MDT is made up of representatives from state agencies to provide a team approach in order to move youth and children through appropriate systems with a collaborative approach. The team consists of representation from the Indiana Department of Child Services (which includes Collaborative Care, Field Operations, Clinical Consultants, and Children’s Mental Health Initiative), Indiana Bureau of Developmental Disabilities Services, Indiana Division of Mental Health and Addiction, Probation, Indiana Department of Corrections and Indiana Department of Education. Children and youth involved in any of these systems are staffed through agency collaboration to coordinate where the best fit would be for the family and what additional services may assist in supporting the case. The MDT reviews specific cases, often referred through a local/regional office, that need additional problem-solving; guidance and navigation through the system array, to ensure families are being served within the most appropriate service delivery system; assistance to the local communities so families do have to navigate multiple systems; and

review any gaps in services throughout the State that arise through a multiagency approach. Many of these children and youth brought to the MDT have dual diagnoses which include mental health needs as well as developmental and intellectual disabilities, which put these youth at a higher need for creative/individualized solutions.

For those children with unique or specialized mental health needs, DCS developed the Children's Mental Health Initiative (CMHI). The CMHI is a collaboration between DCS and Indiana Family and Social Services Administration – Division of Mental Health and Addictions and local Community Mental Health Centers who serve as access sites to ensure children are served in the most appropriate system to meet their needs. The CMHI focuses on children and youth who do not qualify for Medicaid services and whose families are struggling to access services due to their inability to pay for the services. The service array includes wraparound services, community based skill building and therapeutic services, clinic based services, and residential services.

The Indiana Judicial Center (IJC) hosted the Cross System Youth Symposium in July, 2015 as a joint effort between IJC, DCS and the work of the Cross System Task Force of the Commission on Improving the Status of Children in Indiana to address the individualized needs of youth who have unique needs that potentially impact multiple agencies. Forty-two (42) counties were represented at the Symposium and each county team was to be represented by their juvenile court judicial officer (Judge/Magistrate/Referee), a Chief of Police in their county or their Chief/Supervisor of juvenile probation, the local office Director for the Department of Child Services, a representative from mental health from the county, and a representative from the local schools. The Symposium was broken down in to several presentations that were followed by a group activity.

1. Who are these youth who cross between multiple systems and how do you define them?
2. What agencies are best suited to serving the multi-system youth?
3. What are the barriers we face in identifying and working with this population?
4. Next Steps: Action Plans- the work begins when you get home?

Each group completed documents with responses to each of the above questions individualized to each county. For example, the groups defined the multi-systems youth in the county and documented what agencies would best able to serve the multi-system youth population. Their next group activity documented the barriers that the county has in implementing a program for the multi-system youth and the final document was their action plan for multi-system youth. The documentation was then coded by a doctoral student at IUPUI and recently presented as issues to be addressed.

Lastly, DCS has a number of internal specialists that are available to FCMs to address the individualized needs of youth, such as a clinical services manager, nursing team, and education consultants.

F. Agency Responsiveness to the Community

Item 31: State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR

How well is the agency responsiveness to the community system functioning statewide to ensure that in implementing the provisions of the CFSP and developing related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP?

Please provide relevant quantitative/qualitative data or information that show that in implementing the provisions of the CFSP and related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP.

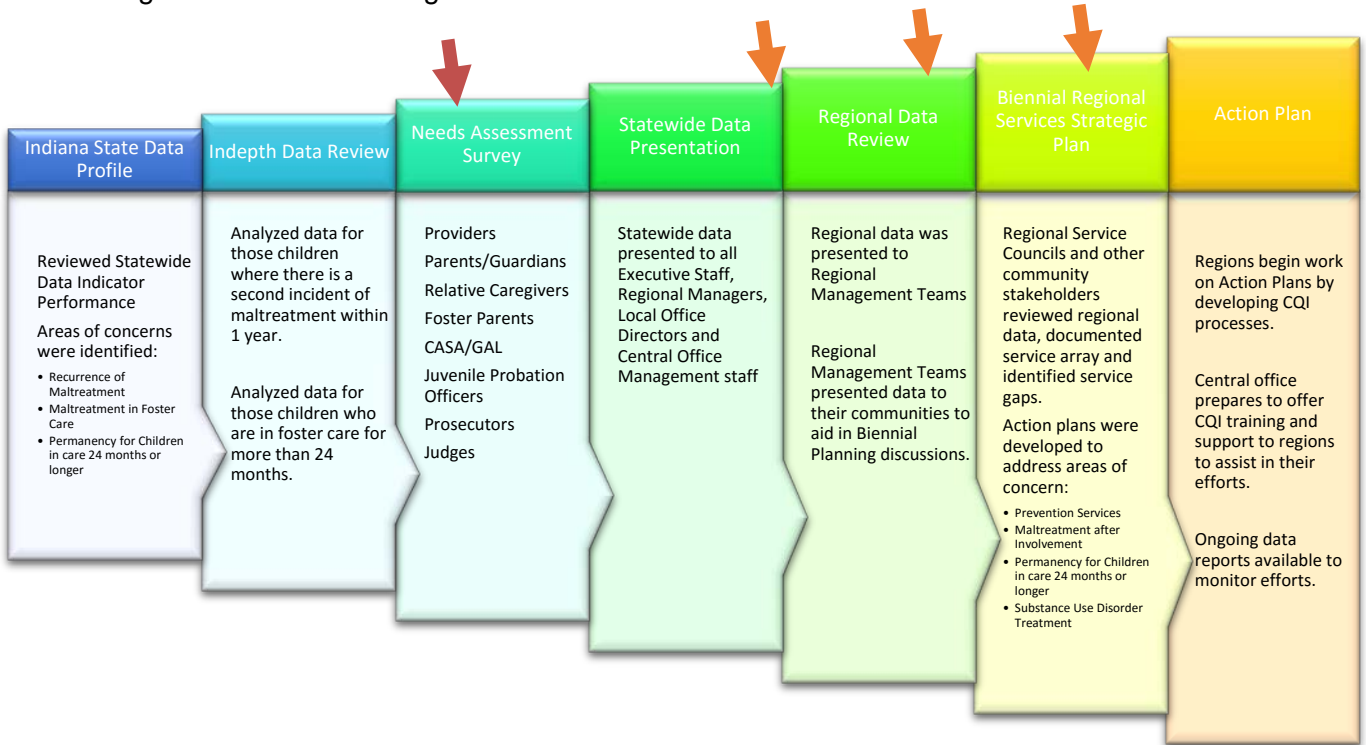
State Response:

Insert state response to Item 31: State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR

The Indiana Department of Child Services routinely collaborates with other stakeholders as outlined below. Additional details regarding the collaborations DCS are currently involved with are included on page 8 of the 2016 APSR. As a result of the systemic collaborations which are a part of the BRSP process, as well as those mentioned below, DCS believes this item is a strength.

DCS has routinely included stakeholders in the Biennial Regional Services Strategic Plan Process (BRSP) in planning for services throughout the state. As shown in the figure below, stakeholders, including consumers, were a part of the BRSP committees and examples of the data and information developed as part of the BRSP used to develop the objectives outlined in the CFSP included the Needs Assessment, the Regional Data Review, Biennial Regional Services Strategic Plans, and Action Plans (as set out in more detail in Items 29 and 30).

Biennial Regional Services Strategic Plan Process



For example, information gathered from the BRSP process in 2014 identified significant service gaps in substance use assessment and treatment services. In fact, each region identified this service need in their BRSP. As a result, Objective 1.4 in the CFSP – Improving Accessibility and Effectiveness of Substance Use Disorder Treatment - was developed. The goals and action steps are listed in Objective 1.4 with many of them coming as a result of collaborations with stakeholders that were involved in the BRSP. One such action step was the identification of promising programs to implement to address this service gap across the state, such as the establishment of Sobriety Treatment and Recovery Teams (START) programs in appropriate communities across the State and a comprehensive review of the CMHCs and substance use services by Jeff Jamar (See Item 29- Service Array).

Pokagon Band

The Pokagon Band of Potawatomi Indians (hereinafter Pokagon Band) officially moved its tribal organization and its tribal court to Dowagiac, Michigan. However, members of this Pokagon Band have lived in the lower Great Lakes area for hundreds of years and the Pokagon Band’s homeland covers six northern Indiana counties including LaPorte, St. Joseph, Elkhart, Starke, Marshall, and Kosciusko. In the past, various state staff have met with Social Services Director Mark Pompey, and in moving forward Indiana DCS has established partnership/collaboration meetings with representatives from the Pokagon Band twice a year.

On September 25, 2014, DCS staff (Wade Hornbacher, General Counsel; Reba James, Deputy Director of Permanency and Practice Support; Lisa Rich, Deputy Director of Services and Outcomes; and Sheryl Alyea, ICWA Coordinator for the International and Cultural Affairs Program) met with Pokagon’s Social Services Director, Mark Pompey, in Dowagiac, Michigan, and toured Pokagon’s grounds, properties, Executive offices, and the court system. DCS staff

learned about the Band's traditions, growth, housing, and both the court and child welfare systems. Director Pompey expressed Pokagon's desire to be involved and interact with DCS when Pokagon Band members come to our agency's attention. Other discussion included ongoing issues with joint cases, as well as where processes are running smoothly. Director Pompey noted some concern/interest in the fact that Saint Joseph County in Indiana has a large Pokagon Band population, yet there are very few DCS cases identified from that area. Discussion ensued about the ongoing steps that DCS has put into place to improve 'identification' of the Indian child, including improved forms, education, training, and support for DCS field staff. Director Pompey was provided with a draft of the CFSP, noting the specific areas addressing Pokagon Band interaction with our agency. Director Pompey also provided feedback which prompted changes to the CFSP, including strategies for ongoing compliance with ICWA and improved procedures for identifying and collaborating with the Pokagon Band.

On March 9, 2015, DCS staff hosted another meeting with Pokagon staff, Social Services Director Mark Pompey, and Pokagon Presenting Officer/Prosecutor Annette Nickel, in Indianapolis, IN. As before, parties openly discussed any concerns or persistent issues with mutual cases. In addition, the topics of legacy, confidentiality, parties to a CHINS case, Termination of Parental Rights, IV-E income (per capita/stipends), the updated ICWA Guidelines from February 25th, and ideas for better identifications including checks and balances were discussed. The Pokagon guests were also introduced and given the opportunity to talk with DCS Director Bonaventura and DCS General Counsel accompanied them on a tour of the Marion County Juvenile Court system during the afternoon.

DCS staff and the Pokagon Band staff met again in November of 2015 in Michigan at the Band's headquarters. DCS staff (Wade Hornbacher, General Counsel; Jane Bisbee, Deputy Director of Field Operations; Lisa Rich, Deputy Director of Services and Outcomes; and Sheryl Alyea, ICWA Coordinator for the International and Cultural Affairs Program) met with Social Services Director Mark Pompey and Presenting Officer/Prosecutor Annette Nickel. Discussion of the ICWA, child welfare programs, providers, and suggestions were shared by all. Counsel Hornbacher addressed questions about the percentage of county judges that are asking the parents, guardians, custodians and represented children the ICWA eligibility questions in court, and from the onset of a CHINS case. He shared having knowledge that the majority of judges in the larger cities are now responsibly asking. It was reported by Pokagon staff that they have around 360 households in Indiana. This brought up a follow-up discussion regarding how statistically unlikely it is that our Indiana 'Pokagon' counties have no involvement/cases with Indiana DCS.

Presenting Officer/Prosecutor Annette Nickel shared the importance that ICWA Notifications go to Director Mark Pompey for all Pokagon involved members. She stressed the importance of making sure the FCMs have the correct information, correct spelling of names, and correct dates of birth for all Notifications, and explained how this plays a very important part in correct identification. As a result of this feedback, as part of the annual updates to the CFSP, DCS has noted its continued efforts in identifying ICWA cases and utilizing Permanency Roundtables for identifying and reviewing ICWA cases as a means of checks and balances for

identification, compliance, and services. Furthermore, notification responsibility was given to attorneys and changes to ICWA Policy were implemented to improve notification efforts.

DCS has continued to provide approved copies of the CFSP and APSR's to Pokagon Band officials at DCS' semi-annual meetings with the tribe. Improved collaboration efforts will focus on preserving the children's connections to their families and tribes and also preserving the Indian culture so it continues to thrive.

Indiana Native American Indian Affairs Commission

Executive Director Kerry Steiner made contact with the DCS ICWA Coordinator in April 2015 and invited DCS to present at the Commission's May meeting which is open to the public. DCS ICWA Coordinator accepted the invitation and provided a brief power-point presentation to the Commission's board and members of the public in attendance regarding DCS and ICWA.

Mexican Consulate

DCS has continued to have monthly meetings with the Mexican Consulate in Indianapolis and quarterly meetings with the Mexican Consulate in Chicago. Meetings involve discussions around cases, ways to improve collaboration, and development and/or changes to the memorandum of understanding between the agencies.

Systems of Care

Systems of care meet within local communities and are composed of community agencies, schools, law enforcement, and prosecutors and their focus is on ensuring that services are available in the community to meet the needs of families. One such service is high fidelity wraparound that is funded through Medicaid or the Children's Mental Health Initiative and prevents youth residential placement by providing targeted individual services and family support services for children with high behavioral health needs. Other services include residential services as well as state operated facilities for those children who cannot be safely served in the community.

Regional Service Councils & Coordinators

The Regional Service Councils and Regional Service Coordinators both work to enhance the coordination of services. The purpose of the Regional Services Council is to: evaluate and address regional service needs; manage regional expenditures; and to serve as a liaison to the community leaders, providers and residents of the region. The Regional Service Coordinators and Probation Consultants then work with local agencies through the contracting process to help fill regional service gaps. Additionally, Indiana continues to work with its partner agencies to evaluate progress and identify areas for continued improvement. The Regional Service Councils also play an important role in the development of the Biennial Regional Service Plans, as further detailed in Items 29 and 30 and the attached Biennial Regional Service Plan for Region 15 (**Attachment 14**). The meeting schedules for each DCS Region can be found at <http://in.gov/dcs/2349.htm>.

Children's Justice Act Task Force

Indiana maintains a multidisciplinary Task Force (CJA Task Force) on children's justice that is composed of professionals with knowledge of and experience with the criminal justice

system and the system handling child physical abuse, child neglect, child sexual abuse and exploitation, and child maltreatment related fatalities. A copy of the 2016 Indiana CJA Task Force Membership List is attached as **Attachment 15**. The CJA Task Force reviews and evaluates Indiana's handling of investigative, administrative, and civil and criminal judicial handling of cases of child abuse and neglect and makes policy and training recommendations. The CJA Task Force meets monthly on the second Friday of each month to discuss, review, and make recommendations regarding projects funded by the CJA grants and to discuss and evaluate current events related to child physical abuse and neglect. Indiana must then respond to each recommendation by demonstrating how progress is being made to achieve improved outcomes. In the most recent Three Year Assessment, the CJA Task Force, after reviewing a series of BRSPPs, made recommendations for improving the front-end investigative and intake piece of child welfare. These recommendations included encouraging DCS to continue to build collaborative community and industry relationships to address gaps in services and develop strategies for effectively addressing identified needs.

Indiana's current CFSP was provided to the CJA Task Force and the goal and objectives were discussed in task force meetings. As was the case with the previous CFSP, moving forward, any Program Improvement Plans that result from the CFSP will be utilized by the task force as one of the tools in assessing and developing future recommendations.

Youth Advisory Board

The Indiana Youth Advisory Board (YAB) consists of youth that are currently or have been a part of the Indiana foster care system. The YAB is comprised of current and former foster youth from the 18 regions within the state. The YAB meets at least four times per year to develop and implement their mission to positively impact the foster care system in Indiana. In an effort to increase YAB participation and meet the needs of youth, YAB meetings are held in different locations throughout the state. A calendar year 2015 program overview of the YAB, including meeting and event locations, dates, and outcomes/summaries is attached as **Attachment 16**.

2015 YAB Calendar Year Numbers include:

- 14 YAB Meetings
- 75 Youth Participants
- 25 Community Engaging Events
- 39 Total YAB Events
- 7 Trainings Facilitated

Provider Workgroups

DCS has worked to engage service provider partners through continued meetings and workgroups. Objective 1.7 of the CFSP – Improve Communications with Service Providers to Better Ensure Child Safety – was a result of feedback from service providers to ensure DCS is providing relevant information at the time of referral and appropriate ongoing communication takes place to ensure consistency and improved outcomes. DCS will continue its annual CMHC/DCS Collaboration Conference, ongoing meetings with the Community Mental Health Centers (as described on page 8 of the 2016 APSR), and Regional Collaboration Meetings

between DCS and the CMHC's. Feedback from meetings reviewing the CFSP with CMHCs and Community-Based Providers resulted in changes being implemented into the goals.

For example, DCS collaborated with the Community Mental Health Centers to develop local initiatives to address service gaps and improve outcomes for families. This collaboration included DCS adding an intervention to Objective 1.4 of the CFSP, to include a collaborative effort with CMHCs to educate staff on the effects of substance use disorders on children and best practices in substance abuse disorder treatment. Furthermore, via Casey Family Programs, DCS was able to connect with Jeff Jamar to assist substance use disorder providers to develop their services to meet the needs of child welfare involved families. The first step of the evaluation process was a comprehensive study and report (see Item 29-Service Array).

Regional Service Coordinators will continue facilitating the ongoing support groups for specific services such as Family Centered Treatment, Father Engagement, Homebuilders, and START. This facilitation includes monthly calls, yearly conferences, and break out workgroups.

In 2015, DCS held two (2) provider forums; one with residential providers and another with licensed child placing agencies. The first provider forum was held with residential providers to discuss older youth with conduct disorders. The second provider forum was held with licensed child placing agencies (LCPA) and focused on younger children with high mental health and behavioral needs. Discussions from these forums resulted in a Request for Information (RFI) being created and later, DCS working with Casey Family Programs and providers to issue a request for proposal for therapeutic foster care services.

Service Support Groups

The success of the service support groups has led to the planned expansion into additional groups including services such as Cross System Care Coordination, Child Parent Psychotherapy, and Diagnostic and Evaluation Services. DCS will continue collaborating with existing state-wide associations, such as Indiana Council Community Mental Health Centers Child and Adolescent Committee, Coalition of Family Based Services, and the Indiana Chapter of National Children's Alliance.

Community-Based Providers and Indiana Association of Resources and Child Advocacy (IARCA)

DCS has continued to elicit feedback from a Community Based Provider workgroup regarding referrals, billing, training, staff qualifications and service standard updates. DCS Executive Management will also continue regular meetings with IARCA leadership to work on systemic provider issues. Currently, DCS is working with IARCA on residential and LCPA rate setting, on capacity building and on access to psychiatric residential treatment centers, among other things. DCS also works with IARCA on any necessary modifications to the LCPA and residential contracts. DCS Placement Support and Compliance will continue monthly conference calls with residential providers and monthly calls with LCPAs to collaborate on residential and foster care issues, such as improving quality of services provided to children and the relationship between DCS and the providers. Additionally, the Executive Director of IARCA, Cathy Graham, is participating in the upcoming CFSP Onsite Review.

Indiana Judicial Center

DCS and the Indiana Judicial Center (IJC) have continued to collaborate on a number of juvenile justice initiatives; below is a sample of those initiatives.

- Juvenile Detention Alternatives Initiative (JDAI): JDAI is a national model that focuses on the reduction of juveniles placed in detention. It was first brought to Marion County, Indiana due to the Marion County detention center being continually over-populated. On a daily basis they had over 200 youth in a facility designed for 144 youth. Due to the success in Marion County which currently has a “hard cap” of 96 youth being in detention, JDAI has now been established in an additional 18 counties and is beginning in another 32 counties; representing nearly 65% of the juveniles in the State of Indiana. DCS partners with JDAI as one of the lead state agencies which also includes the Indiana Criminal Justice Institute (ICJI), the Indiana Supreme Court represented by the IJC, the Indiana Department of Correction (DOC), and the Family and Social Services Administration (FSSA) represented by the Department of Mental Health and Addiction (DMHA). As a lead agent, DCS collaborates with the ongoing efforts in determining county expansion, cost sharing (e.g. IJC is responsible for administration, DOC offers grants to participating counties, DCS funds a contracted position for data in addition to funding detention and disposition alternatives, ICJI funds grants to IJC for technical assistance). On a local front, DCS participates in the local JDAI initiatives by helping determine services to address the needs of children in those communities. Additional information regarding Indiana’s JDAI can be found at <https://secure.in.gov/judiciary/center/2823.htm>.
- The Dual System Youth (DSY): DSY began as concept that recognized that a certain percentage of youth (depending upon the jurisdiction and the type of “dual” that is being counted) between 9% to nearly 42% of youth can be identified in both the juvenile CHINS system and the juvenile delinquency system. During the 2015 Legislative Session, Indiana Representative McNamara initially proposed a statute related to the establishment of a “lead agency,” however upon review by judicial officers, the dual system youth statute was created allowing a court to review a dual status youth as early as a detention hearing to determine how a case and which agency can manage the risk, needs and strengths of the family most effectively. The statute helped define dually identified, dually involved and dually adjudicated youth. During the legislative session, DCS, through its legislative liaison, worked with Representative McNamara in addition to judicial officers to craft the legislation that would work effectively for both DCS and the delinquency courts. Upon the legislation being signed, DCS along with the judicial officers and IJC have continued their work on an implementation process that includes five (5) pilot sites in Tippecanoe, Elkhart, Allen, Clark and Henry (TEACH) counties. These pilot sites are implementing program components to help develop policies, procedures and best practices for full implementation in the State. A listing of the meetings, minutes, and reports can be found at <http://in.gov/children/2345.htm>.
- Collaborative Communication Committee: During the 2008 legislative session, property tax reform changed the fundamental manner in which child services were funded from

the local level to the State. As a result, a collaborative effort was started to include DCS administration, IJC, judicial officers and probation officers for implementation of what now is referred to HEA 1001-08. Upon implementation, collaborative efforts subsided in favor of communication efforts in and among agencies that also began to flounder. In 2014, as a leadership project, the DCS liaison with probation rejuvenated the effort to meet with probation and re-open a dialogue with probation with regard to DCS paid services. The Collaborative Communication Committee continues to meet approximately every 60 days and currently serves as a sounding board for DCS to collaborate with probation on programs and or practices, allowing an opportunity for probation to have a voice with regard to DCS and any changes that may be proposed in programming or practice that directly impact probation. This committee has assisted DCS in implementation of issues relating to Federal legislation (HR 4980, Bill of Rights for probation youth), changes in case plan, development of a resource manual for probation, a step down/disruption policy as it relates to youth placed out-of-home, defining temporary home visits, and reviewing service standards.

- Juvenile Justice Improvement Committee (JJIC): The JJIC is a long standing committee of the IJC with membership for juvenile judicial officers (judges and magistrates). JJIC works in the area of juvenile justice by serving as a liaison with state and private agencies that work with juveniles, discuss policy matters that affect juveniles, and review recent legislation concerning juveniles and juvenile courts. JJIC meets approximately 7 times per year. DCS meets with the JJIC when requested by the chair no less than annually; however, DCS has been in attendance at most meetings over the last two (2) years. Meeting with the committee formalizes a relationship between the juvenile court judges in the State of Indiana and DCS. This relationship allows DCS to work directly with juvenile court judges on the practices of DCS. DCS also presents its legislative agenda to the JJIC for feedback from a judicial perspective.
- Judicial Decision Collaborations: DCS is also part of a committee that meets prior to JJIC meetings to address recent Indiana Supreme Court decisions. For example, the committee has been meeting to id regarding a recent decision of the Indiana Supreme Court that expressed an overriding concern in any “delay in achieving permanency resulting from attempts to comply with the decision handed down”. Members have been working collaboratively to identify methods to address the concerns

Item 32: Coordination of CFSP Services With Other Federal Programs

How well is the agency responsiveness to the community system functioning statewide to ensure that the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population?

Please provide relevant quantitative/qualitative data or information that show the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population.

State Response:

Insert state response to Item 32: Coordination of CFSP Services With Other Federal Programs

DCS has built an extensive network of federal, state, local and private partnerships and collaborations to support child maltreatment and prevention programs and activities. The DCS Prevention Team and the Community Partners for Child Safety contracted providers build on these efforts to promote and support families by connecting families with a continuum of services and resources needed to strengthen the family and prevent child abuse and neglect.

More specifically, federal funds awarded to Indiana and the extensive collaboration and coordination between state agencies, both directly and in-directly, result in the below mentioned partnerships, ultimately supporting communities and families at the local level and supporting DCS's belief that this item is a strength of the agency.

Indiana State Department of Health (ISDH):

ISDH houses a number of divisions that receive federal funding to administer several programs that are vital to families and children in Indiana. At the state level, multiple partnerships have been formed between DCS and ISDH in an effort to better coordinate federal and state resources.

- Maternal and Child Health (MCH): At the state level, MCH is funded in large part by the federal Maternal and Child Health Bureau (MCHB) Title V Block Grants. MCH also houses a number of projects, programs and services that are vital to the families and children served by DCS, as outlined in more detail below.
- Early Childhood Comprehensive System (ECCS) and Project for Linking Actions for Unmet Needs in Children's Health (Project LAUNCH): Indiana's ECCS grant provided the impetus for a much needed collaboration of statewide early childhood organizations to come together with the goal to develop coordinated services and policies so that children arrive at school healthy, safe, ready to learn, and able to succeed. Indiana has utilized the ECCS model very successfully to help build a state infrastructure that better meets the needs of infants and toddlers with social-emotional challenges. With the incorporation of Project LAUNCH in 2012, along with a shift in federal focus at Health Resources & Service Administration to funding project focused initiatives as opposed to

infrastructure-building, the ECCS partnership has reengaged its purpose and is now actively involved in quality improvement initiatives that target a broad range of needs in early childhood, including social-emotional health, behavioral health, and integrating physical health. Home visiting programs from across the state continue to play a pivotal role in identifying at-risk children at the earliest opportunity so that improvements in behavioral health outcomes are optimized.

Some other efforts supported by ECCS (which includes Project LAUNCH co-lead, Indiana Family and Social Services Administration (FSSA) -Division of Mental Health and Addiction (DMHA), the state's single state agency for substance abuse services) served to move the infant mental health agenda forward in Indiana:

- Development and dissemination of a module clarifying reimbursement for infant mental health (IMH) services in Community Mental Health Center (CMHC) systems
- Coordination with Indiana University School of Social Work for the following graduate level classes: Early Childhood Diagnosis, a one credit course on Diagnostic Criteria Zero to Three-Revised (DC0-3R) and a 3-credit course titled Advanced Issues in Early Childhood Mental Health which provides overview of important foundational areas of early childhood mental health.
- Adoption of Michigan Association for Infant Mental Health Endorsement (IMH-E®), a widely used set of competencies and a credentialing process for culturally sensitive, relationship-focused practice promoting infant mental health. ISDH, Indiana Head Start State Collaborative, and DCS supported the Endorsement. DMHA provided additional funding for the training of a cadre of providers who received intensive IMH-E® training and supervision.
- Awareness and training activities such as white papers on Infant Mental Health (IMH) assessment and intervention through Indiana's Early Intervention System, a discussion paper on early intervention and autism, a Crosswalk between the DC 0-3R, DSM, and ICD systems, and presentations to Early Intervention Service Coordinators and foster care parents on ECMH/IMH
- A white paper was published, Providing Services to Infants, Toddlers and Preschoolers within a Recovery-Oriented Behavioral Health Care System which reviews the Medicaid Rehabilitation Option that supports the acquisition of skills that lead to recovery and optimum functioning of individuals with mental health challenges.
- Development of resources including Family Resource Fact Sheets, a developmental calendar, and a Child's Wellness Passport with a special health care needs addendum
- The Bureau of Child Development and the Indiana Association for Child Care Resource and Referral supported the creation and presentation of the Infant Mental Health Modules

Collaborative work of the ECCS is championed by recent legislation that established the Indiana Commission on Improving the Status of Children (CISC) under a new law signed by Governor Pence on April 30, 2013. This 18-member Commission consists of leadership from all three branches of government; an organizational chart of the CISC is attached hereto as **Attachment 17**. CISC is charged with studying and evaluating services for vulnerable youth, promoting information sharing and best practices, and reviewing and making recommendations concerning pending legislation. This broad-based state commission studies and evaluates state agency policy and practice as well as proposes legislation that affects the well-being and best interests of children in Indiana. Enhancement and expansion of our statewide home visiting programs aligns well with this multi-tiered, action-oriented, outcome-expected approach. Committees and Task Forces that report to the CISC include:

- Child Services Oversight Committee
- Cross-System Youth
- Data Sharing & Mapping
- Educational Outcomes Task Force
- Infant Mortality & Child Health
- Substance Abuse & Child Safety

Additional information on CISC can be found online at <http://in.gov/children>.

In addition to CISC, the Early Learning Advisory Committee (ELAC) was established in 2013 by the Indiana General Assembly. Committee membership is appointed by the Governor and includes representation from Bureau of Child Care, Department of Education, Head Start, Cummins, Eli Lilly, and Wellborn Baptist Foundation. The State Young Child Wellness Council has an ELAC representative from the Bureau of Child Care and the Head Start State Collaboration Office who participate on Project LAUNCH. The ELAC's responsibilities include:

1. Conducting periodic statewide needs assessments concerning quality and availability of early education programs for children from birth to the age of school entry, including the availability of high quality prekindergarten education for low income children in Indiana.
2. Identifying opportunities for and barriers to collaboration and coordination among federally and state funded child development, child care, and early childhood education programs and services, including governmental agencies that administer programs and services.
3. Assessing capacity and effectiveness of two and four year public and private higher education institutions in Indiana for support and development of early educators including professional development and career advancement plans and practice or internships with or prekindergarten programs.
4. Recommending to the Division procedures, policies, and eligibility criteria for the Early Education Matching Grant program.

The DCS Prevention Manager (Community Based Child Abuse Prevention (CBCAP) Lead) and ISDH MIECHV Coordinator are active members of Project LAUNCH including, the Home Visiting Sub-committee and the ECCS Social Emotional Sub-committee which is also chaired by the Director from the Riley Child Development Center (RCDC, described in more detail below).

The work of the Social Emotional Sub-committee centers around increasing the number of direct service providers with knowledge, practical skills and specialization in the effects and treatment of mitigating toxic stress and trauma as well as enhancing linkages and cooperation across systems serving infants and children. The Social Emotional Sub-committee is focused on outreach and supportive efforts to increase the number of professionals and paraprofessionals in the state that are endorsed by the Indiana Association for Infant and Toddler Mental Health (IAITMH). The Endorsement process will increase the mental health workforce capacity and create an integrated infrastructure that will ensure that all Indiana families with very young children have access to well-trained providers in their home communities.

Beginning in 2010, support to implement the Endorsement® process in Indiana has been provided by the Indiana Head Start Collaboration and the Department of Child Services. Benefits of the Endorsement® program are numerous for children and families, providers, agencies, and systems of care. Individuals who have earned the Endorsement® cite the program as leading to an increase in professional development, including the completion of a degree or adding a graduate degree. In addition to the positive provider experiences, families have benefitted from greater access to well-trained providers whether their family is in need of high quality child care or the services of a mental health professional. Agencies have found the Endorsement® helpful in structuring training and ensuring a well-prepared early child care and intervention workforce. Finally, systems have realized improvements in agreement about best practices, increased workforce capacity, and even cost savings because prevention and promotion of behavioural health by workers at Levels I and II reduces the need for services at more costly levels.

In addition, the DCS Services Division is also in discussions to explore how the agency can support efforts of contracted providers for Prevention, Preservation and Intervention services to achieve and maintain the Endorsement. In recent years, IAITMH® has also received expanded support through various state initiatives to stream-line the endorsement process and enhance the training available. In FY2014, the number of Healthy Family Indiana staff in Indiana that had achieved the endorsement more than doubled, largely in-part by efforts to coordinate stakeholders and leverage multiple funding opportunities including a grant from the Indiana State Department of Health. By coordinating efforts between state and community stakeholders, the DCS Prevention Unit significantly contributed to existing efforts to expand the availability of competent individuals by supporting efforts of DCS Healthy Family Indiana (HFI) providers to complete the endorsement.

Another Project LAUNCH committee that the DCS Prevention Manager and MIECHV Coordinator are actively engaged in involves Enhanced Home Visitation to

a local community in the state through a grant awarded by Project LAUNCH in 2014 to One Community One Family, Inc., a private non-profit serving families and children in the South Eastern corner of the state. There are plans to enhance upon the providers current scope of work by including Incredible Years services to families who are eligible. Home visiting staff in the region will also receive enhanced trainings in Motivational Interviewing, Trauma-Informed Approaches, and Mental Health First Aid in order to improve outcomes for families and children. Additionally, selected programs serving young children in the region, including at least one HFI site, will receive mental health consultation that will serve to bolster their knowledge and continually serve families in the most effective manner. Such partnerships and collaborations between the DCS Prevention Teams and ISDH further demonstrate the strength and positive impacts for Indiana families and children.

- Maternal Infant Early Childhood Home Visiting (MIECHV): As stated previously, MIECHV grants are designed to: (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. ISDH and DCS are co-leads of the federal grant and collaborate with Indiana University (IU), Goodwill Industries of Central Indiana, Riley Child Development Center (RCDC), Women, Infants, and Children (WIC), and the Sunny Start Healthy Bodies, Healthy Minds Council at the state agency level to achieve MIECHV goals. A copy of the memorandum of understanding between the agencies is attached hereto as **Attachment 18**.

As part of the MIECHV partnership between DCS and ISDH, Indiana created the MIECHV Evaluation Advisory Board (EAB), IN MIECHV Team and the Indiana Home Visiting Advisory Board (INHVAB). The EAB is led by the MIECHV external evaluation team from Indiana University and includes stakeholders from DCS, HFI, ISDH, and Nurse Family Partnership (NFP) to review and advise on the MIECHV evaluation studies being completed in Indiana. The IN MIECHV Team includes stakeholders from DCS, HFI, ISDH, and NFP for the purpose of identifying aspects of the MIECHV project that should inform policy for home visiting within Indiana. The IN MIECHV Team also serves as the oversight committee for MIECHV Continuous Quality Improvement (CQI) development and activities. The Indiana Home Visiting Advisory Board (INHVAB), consists of the various state agencies who have a connection to home visiting services in Indiana through funding, utilization, or administration. The INHVAB oversees the Home Visiting Needs Assessment as well as efforts to ensure there are adequate home visiting services available throughout the state. Indiana believes that these advisory boards not only provide additional benefits to both HFI and NFP, these boards have and will continue to serve as catalysts for increasing collaboration and relationship building between DCS and ISDH, which will ultimately result in improved coordination and quality of home visiting services in Indiana.

- Safe Sleep- At the local level, ISDH is also reaching out to many HFI and Community Partners for Child Safety (CPCS) providers to coordinate safe sleep education and outreach efforts as well as implement a formal memorandum of

understanding through which the provider will become a crib distribution site for the Safe Sleep program in their local communities. In addition to development and collaboration around the safe sleep program, DCS currently provides funds to ISDH to assist in the purchase of the safe sleep kits. A copy of the memorandum of understanding between the agencies is attached hereto as **Attachment 19**.

Family and Social Services Administration (FSSA):

FSSA houses a number of divisions that receive federal funding to administer several programs that are vital to families and children in Indiana. At the state level, a number of partnerships have been formed between DCS and FSSA in an effort to better coordinate federal and state resources. Many of the partnerships with FSSA are integral to the achievement of the goals listed in the CFSP/APSR, including Objective 1.2 on page 79 of the 2016 APSR – Expanding DCS Service Capacity to Meet the Needs of DCS Involved Children with Developmental and Intellectual Disabilities.

- Department of Mental Health and Addiction (DMHA)-As stated previously, the Children's Mental Health Initiative (CMHI) is a collaboration between DCS and DMHA and local Community Mental Health Centers who serve as access sites to ensure children are served in the most appropriate system to meet their needs. The CMHI focuses on children and youth who do not qualify for Medicaid services and whose families are struggling to access services due to their inability to pay for the services. The CMHI helps to ensure that children are served in the most appropriate system and that they do not enter the child welfare system or probation system for the sole purpose of accessing mental health services. Due to the specific nature of child welfare services and all applicable statutory time frames under which DCS operates, DCS referred clients receive priority screenings/assessments and prompt initiation of services within the limits of a CMHC's capacity. At the local level, partnerships between CPCS providers and local access sites are beginning to develop as the CMHI project spreads throughout the state and the benefits of collaboration efforts are realized.
- DCS' Clinical Resource Team has been collaborating with FSSA – DMHA and Office of Medicaid Policy and Planning (OMPP) and the Indiana University School of Medicine to provide oversight, monitoring, education and consultation for youth in DCS care who are prescribed psychotropic medications. This initiative aligns with the *Fostering Connection to Success and Increasing Adoption Act*. The Indiana Psychotropic Medication Advisory Committee (PMAC) is an oversight committee that meets quarterly to review the psychiatric treatment of DCs-involved youth and includes members from Indiana University Department of Psychiatry, DCS, OMPP, DMHA, pediatricians, social workers, psychologists, pharmacists, child advocates and other identified stakeholders. More information regarding this initiative can be found on page 37 of the 2016 APSR.

DCS also has a memorandum of understanding with FSSA-OMPP to share Medicaid claims data, including psychotropic medication data. As part of the memorandum of understanding (attached hereto as **Attachment 20**), OMPP produces monthly utilization reports for DCS wards on psychotropic medications.

- Department of Family Resources (DFR)-FSSA's DFR houses a number of programs and services which are valuable resources for families and children; therefore it is vital for

DCS, the Prevention Team, and local CPCS providers to develop and maintain strong partnerships as outlined below. DFR is the designated agency to receive Temporary Assistance to Needy Families (TANF) funds on behalf of the state of Indiana and DCS and DFR have a memorandum of understanding in which they collaborate on the award of those funds. A copy of the memorandum of understanding is attached here to as **Attachment 21**. In 2015, DCS and DFR recently collaborated to come to an arrangement in which DCS could leverage increased TANF funds to put towards its Emergency Assistance Program.

- Below are specific examples of the programs and services DCS and DFR collaborate together on.
 - Housed in DFR, the Indiana Bureau of Child Care is funded by the Child Care and Development Fund (CCDF) and TANF to provide a number of services to low income families. Indiana Code (IC) 12-17.2 establishes the authority for DFR to regulate child care in the State. It also authorizes the division to adopt rules to implement the federal CCDF voucher program. Access to affordable, quality childcare is often a need for many families receiving CPCS services therefore it is vital at the local level for CPCS providers to have well established referral and outreach relationships with their local CCDF providers.
 - Also housed in DFR, the Indiana Head Start Collaboration Office (IHSCO) and the DCS Prevention Manager (CBCAP Lead) have a long time partnership which includes annual financial support from the IHSCO for the Institute for Strengthening Families conferences which allows for significant attendance from Head Start and Early Head Start Program staff. In addition, the DCS Prevention Manager is an active member of the IHSCO Bi-Annual Multi-Agency Advisory Council which brings partners and potential partners together to discuss the plans of the Collaboration office and discover how members might collaborate for the benefit of Indiana's youngest Hoosiers and their families. IHSCO members include: the Bureau of Child Development, Head Start and Early Head Start, Maternal and Child Health (MCH), Sunny Start and DCS Prevention Services. The Collaboration Office completed a statewide needs assessment in preparation for the 2009-2013 State Plan. The needs assessment reported data in the following areas: early childhood education and transition, professional development, child care, services to children with disabilities, services to children experiencing hopelessness, and community based services. DCS is an active partner with the Head Start Collaboration Office and works to develop intermediate and advanced training seminars at the Institute for Strengthening Families scheduled in April and September of each year.

At the local level, Federal grants are provided directly to local public and private non-profit and for-profit agencies to provide Head Start and Early Head Start programs which are comprehensive child development services to economically disadvantaged children and families, with a special focus on helping preschoolers develop the early reading and math skills they need to be successful in school. In FY 1995, the Early Head Start program was established to serve children from birth to three years of age in recognition of the mounting evidence that the earliest years matter a great

deal to children's growth and development. Head Start programs promote school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families. They engage parents in their children's learning and help them in making progress toward their educational, literacy and employment goals. Significant emphasis is placed on the involvement of parents in the administration of local Head Start programs. Many of the CPCS providers in the state are active members of their local Head Start and Early Head Start Advisory Boards and use the Head Start model of engaging parents in leadership activities as models for their own current and future plans for such within CPCS programs. Such sharing of effective practices further demonstrates the strength and extensive nature of such relationships.

- Bureau of Child Developmental Services-At the state level, FSSA's Bureau of Child Developmental Services administers the First Steps System which is Indiana's Early Intervention Program, Part C of the Individuals with Disabilities Education Act (IDEA). First Steps is a family-centered, locally-based, coordinated system that provides early intervention services to infants and young children with disabilities or who are developmentally vulnerable. First Steps brings together families and professionals from education, health and social service agencies. By coordinating locally available services, First Steps is working to give Indiana's children and their families the widest possible array of early intervention resources. Families who are eligible to participate in Indiana's First Steps System include children ages birth to three years, who are experiencing developmental delays and/or have a diagnosed condition that has a high probability of resulting in developmental delay.

At the state level, First Steps is advised by the Interagency Coordinating Council (ICC). The ICC is a federally mandated group that assists and advises the state's program of early intervention services for infants and toddlers with disabilities and their families. It is a Governor-appointed council that includes membership of all pertinent state agencies/departments, service providers, and family consumers. In 2014, the Prevention Program Manager (CBCAP Lead) has been invited to and will participate in ICC quarterly meetings. In addition, many First Steps providers regularly participate in the training opportunities available through the Institute for Strengthening Families.

Referral coordination occurs at the state level through a data exchange between DCS and First Steps. The Child Abuse Prevention and Treatment Act (CAPTA) provision at section 106(b)(2)(B)(xxi) requires that States have provisions and procedures for the referral of children under the age of three who are involved in substantiated cases of child abuse or neglect to early intervention services funded by Part C of the Individual with Disabilities Act (IDEA). Pursuant to the requirements of CAPTA, DCS screens all children referenced in section 106(b)(2)(B)(xxi) and, if appropriate, refers them to FSSA-Division of Disability and Rehabilitative Services (DDRS) for early intervention services. On a monthly basis, via secure file protocol, DCS sends a file with the referrals to DDRS.

At the local level, many of the CPCS providers have developed reciprocal referral relationships with their local First Steps offices as part of the outreach efforts to support families of children with disabilities.

- Bureau of Developmental Disabilities Services (BDDS) – DCS and FSSA-BDDS have entered into a memorandum of understanding (attached hereto as **Attachment 21**) for the purpose of facilitating the appropriate placement of DCS children who would benefit from placement in BDDS, Medicaid-approved Group Homes. DCS Children would be referred to Group Homes after their eligibility has been determined by DDRS. DCS provides the State Medical Assistance Percentage payment to FSSA for up to 80 DCS children and BDDS gives priority placement to up to 80 eligible DCS Children.
- DCS has a dedicated IV-E Central Eligibility Unit (CEU) that coordinates services funded by Title IV-E for eligible children. CEU verifies information necessary to determine IV-E eligibility and collaborates with DFR to utilize their Indiana Client Eligibility System (ICES) when additional research regarding eligibility is necessary.
- DCS' Medicaid Enrollment Unit (MEU) was created in July 2009 when DFR began their Eligibility Modernization Project which privatized certain functions in the Public Assistance Eligibility Process and created Enrollment Centers. Following the Eligibility Modernization Project, DCS worked for over a year with DFR and FSSA-Office of Medicaid Policy and Planning (OMPP) to create the MEU to serve as an Enrollment Center for DCS wards to ensure continuity of care. Similar to CEU, the MEU utilizes ICES for enrollment assistance and continues to collaborate with DFR and FSSA – OMPP regarding health coverage for DCS youth.
- Indiana's IV-D Child Support Program is administered by DCS. As a result of both DCS Child Support and Child Welfare both being under the umbrella of DCS, the two divisions work closely with one another to carry out their tasks, including information sharing and utilization of resources, when appropriate. DCS' Child Support Program was ranked 9th in FFY 2015, which is up from 34th in 2005.

Additional Programs:

- Governor's Domestic Violence Prevention and Treatment Council-The Governor's Domestic Violence Prevention and Treatment Council is administered by the Indiana Criminal Justice Institute (ICJI) under I.C. 5-2-6.6. The Governor's Domestic Violence Prevention and Treatment Council (DVPT) is responsible for developing a state -wide domestic violence and sexual assault strategic plan that includes analysis of: existing programs and services, gaps in services, funding, staffing and other resource needs and gaps and emerging issues and challenges for the delivery of services.
- Indiana Coalition against Domestic Violence (ICADV): The Indiana Coalition against Domestic Violence is a statewide alliance of domestic violence programs, support agencies and concerned individuals. ICADV provides technical assistance, resources, information and training to those who serve victims of domestic violence; and promote social and systems change through public policy, public awareness and education.

ICADV also developed Indiana's Batterers' Intervention Program (BIP) Standards and certification process to ensure overall quality and consistency for service providers who work with men who batter. An ICADV certified BIP is a community program that makes victim safety its first priority, establishes accountability for batterers and promotes a coordinated community response. These standards were developed by a committee of the Indiana Coalition against Domestic Violence and were first adopted in November 2001 and is currently in the process of reviewing and updating the standards. The ICADV BIP Standards are the result of extensive work among members of this committee and a review of the standards in other states. Many individuals from all areas of the state of Indiana participated in the process of developing these standards including judges, defense attorneys, prosecutors, law enforcement, probation officers, substance abuse counselors, mental health counselors, marriage and family therapists, social workers, clergy, academics, community activists, politicians, victim advocates, BIP providers, survivors, and many other concerned citizens. In 2014, the DCS Prevention Manager (CBCAP Lead) was identified as the DCS staff person assigned to participate as a member of the committee which currently meets monthly to update the standards. Participation of the DCS Prevention Manager in this workgroup is vital to building relationships with ICADV and the larger Domestic Violence infrastructure in the state and for creating the opportunity for future collaboration and partnerships which will result in more coordinated prevention and intervention efforts across the state.

- Riley Child Development Center (RCDC)-RCDS is housed in Riley Hospital for Children and their mission is to provide leadership education excellence in neurodevelopment and related disabilities to professionals who are preparing for careers in health care and other fields which enhance the quality of life for children with developmental disabilities and their families. The mission is achieved primarily through interdisciplinary training of long term trainees at the graduate and postgraduate levels who develop the clinical expertise, competence and leadership attributes that extend basic knowledge and acumen which prepares graduate trainees for leadership roles within local, regional, state and national communities.

Activities of the RCDC reflect a commitment to persons with disabilities and their families through the pursuit of new knowledge by way of critical inquiry and research, the provision of professional consultation and technical assistance to state and local health authorities and the provision of continuing education activities for all issues that involve children and families at the local, state, regional and national levels. In addition, the RCDC promotes the inclusion of content regarding children, families and neurodevelopmental disabilities in all curricula within Indiana University. RCDC activities are culturally sensitive and demonstrate respect for individual differences in behaviors, attitudes, beliefs, interpersonal styles and socioeconomic status. Members of the RCDS work closely with DCS and the Prevention team as part of the planning committee for the Institute for Strengthening Families which helps to ensure there are always affordable training opportunities for individuals seeking to achieve and maintain the IAITMH® Endorsement described above. The strong relationship between the DCS Prevention Team and RCDS has also been critical to establishing future plans for a pathway to supporting DCS field staff.

- DCS partners with the Indiana Department of Workforce Development (DWD) to ensure youth are referred for employment related coaching, TASC (Test Assessing Secondary Completion) classes, and testing. Specifically, DCS partners with DWD JAG (Jobs for American Graduates) program to identify foster youth in their junior and senior year in high school. Foster youth continue to be prioritized for local WorkOne (local DWD access sites for services) initiatives. More specifically, foster youth have been prioritized to participate in the Indiana Lt. Governor's State Fair Summary Employment Opportunity program.
- The Indiana Housing and Community Development Authority (IHCDA) and DCS entered into a partnership in 2009, starting with sharing information and education on how the two state systems can work together to focus on the housing needs of youth aging out of foster care. There have been three projects supported by IHCDA and the Corporation for Supporting Housing that have focused on making available supportive affordable housing for current and former foster youth. DCS has partnered with community stakeholders to ensure youth have an opportunity to reside at the Courtyard, a local affordable housing initiative for youth with identified disabilities.

G. Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 33: Standards Applied Equally

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that state standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds?

Please provide relevant quantitative/qualitative data or information that show the state's standards are applied equally to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds.

State Response:

Insert state response to Item 33: Standards Applied Equally

A broad overview of DCS' foster home and residential structure is provided beginning on page 67 of the 2016 APSR. As of December 2015, approximately 5,500 foster family homes were licensed through DCS local offices and licensed child placing agencies (LCPAs). LCPAs are private agencies that are licensed by DCS and in turn license foster homes on behalf of DCS.

DCS has 98 Regional Foster Care Specialists (RFCS) who are dedicated to recruiting, licensing, and supporting/retaining foster homes. An RFCS receives a two day training that is delivered annually and covers the topics of: (1) Roles and Responsibilities of a Foster Care Specialist, (2) Identification and Recruitment of Foster Parents, (3) The Licensing Process, (4) Foster Parent Engagement and Support and (5) Facilitating the Perfect Placement. DCS has monthly in-service meetings with foster care supervisors, managers and regional managers in order to provide information on current available resources. Furthermore, LCPA staff and RFCS staff are provided consistent training, guidance, and information through collaboration between the LCPA Licensing Unit and the DCS Central Office Foster Care Unit. Such collaborations include monthly calls between LCPAs and DCS Central Office Foster Care Unit Staff as well as monthly meetings with RFCS Supervisors.

Standards Applied Equally

Foster Homes

All DCS foster home applications after November 10, 2014 have been implemented utilizing the Structured Analysis Family Evaluation (SAFE) home study protocols and procedures. Since that time, feedback from DCS Foster Care Supervisors has indicated that the SAFE home study process is more thorough and leaves them with fewer unanswered questions or concerns upon approval. Other feedback suggests that the tools and procedures promote discussion around issues that likely would not have been revealed without the enhanced structure of the SAFE home study. As a result of the positive feedback from staff, DCS communicated to LCPAs the expectation that they become certified to implement the SAFE home study process. While some LCPAs have already begun transitioning, DCS is requiring all LCPAs utilize SAFE exclusively by January 1, 2017. Relative homes are expected to complete the same SAFE home study process, although waivers of certain requirements of licensure may be considered on a case by case basis.

Furthermore, DCS and LCPA licensed foster parents are all required to meet the same annual training requirements. However, DCS does require each licensee with a therapeutic certification to successfully complete an additional five (5) hours of training. In addition to ensuring all state statutes and regulations are followed, DCS Central Office Foster Care Unit Consultants are tasked with enforcement of all applicable foster care licensing policy and procedures and providing consistent guidance and training statewide.

Residential Placement Facilities

All standards for residential placement facilities are applied equally. As discussed on page 71 of the 2016 APSR, the DCS Residential Licensing and Contract Compliance Unit (RLCCU) licenses residential facilities which include private secure facilities, child caring institutions and group homes. There are currently 132 residential facilities licensed by DCS. Residential facilities are licensed for a four year period and must submit a new application for license renewal at the end of the four year period. To assess the compliance of residential facilities with Indiana Administrative Code (IAC), the DCS RLCCU conducts annual licensing reviews of each licensed facility. DCS is able to take action against a license for non-compliance, including requiring licensed agencies to submit plans of correction, limiting the licensed facilities ability to admit children and placing the agency on probationary status. Licensed residential facilities that serve children referred by DCS must enter into a contract with DCS and the State of Indiana. DCS began to audit residential facilities as to their compliance with the residential contract in 2013. Therefore, DCS is in year three of completion of these audits. Residential contract audits consist of program, clinical and fiscal components. DCS RLCCU staff conducts the programmatic audit, DCS residential clinical services specialists conduct the clinical audit and DCS fiscal staff conducts the fiscal audit. The residential contract contains requirements related to quality of services provided, which are reflective of voluntary accreditation organizations such as the Council on Accreditation. Examples include:

- All programs must utilize trauma focused CBT as a base competency;
- Other evidence-based practices should be utilized that are specific to the population being served; and
- Independent living skills must be provided to all children 16 years and older for a minimum of 3 hours per week.
- Specialized service standards have been developed for the following programs: developmental and/or intellectual disabilities, sexually maladaptive, short term diagnostic and evaluation, and substance abuse treatment.

In order to clarify findings and to make results more meaningful, significant changes were made in the method of rating facilities' compliance with contract compliance points effective January of 2015. The following rating scale is being used to document compliance with each item:

0 Noncompliance - Required practice standards are not implemented, or are implemented in a cursory or haphazard manner such that program processes and/or outcomes are compromised. Significant omissions or exceptions to required practices are observed. Exceptions occur routinely, involvement of required individuals is not valued and/or policies and procedures are not developed. Health, safety and/or wellbeing of residents may be compromised.

1 Partial Compliance - Significant aspects of the program's observed service delivery practices deviate from written policies or protocols. Omissions or exceptions to recommended practices occur regularly, involvement of required individuals is limited or lacking, procedures are superficial or personnel are poorly informed about procedures. Required practices are implemented in an inconsistent, cursory or haphazard manner, to an extent that the program processes and outcomes may be compromised. Health, safety and/or wellbeing of residents may be compromised.

2 Acceptable Level of Compliance - The program meets a majority of the standard's requirements; service delivery is purposeful and goal oriented. Appropriate policies and procedures are in place. Minor inconsistencies and not yet fully developed practices may be noted; however, these do not prevent demonstration of how services make a difference/achieve their intended purpose, and do not hamper service delivery or significantly diminish program quality.

3 Outstanding Performance - All elements or requirements of the standard are evident with rare or no exceptions. The program's service delivery practices and policies fully meet the standard and reflect "best practice" in the identified area.

In addition to being rated via the rating scale, each item on the contract audit tool is also categorized based on each item's potential impact on the health, safety and well-being of children in placement. Impact categories are defined as follows:

Immediate Threat: While not linked to any specific Clinical Compliance item, immediate threats are identified during Clinical Compliance Audits and represent an immediate threat to the health or safety of residents.

Potential Risk: This category is used to designate those items that directly impact the health, safety or wellbeing of residents (noncompliance presents a potential risk to residents).

Direct Impact: This category is used to designate those items that directly impact the quality of care, treatment and services, but not necessarily health, safety or wellbeing.

Indirect Impact: This category is used to designate those items that indirectly impact the quality of care, treatment and services.

The impact ratings are intended to identify critical issues and focus on child safety and outcomes. As the use of these impact ratings was implemented in early 2015, the RLCCU continues to develop required follow up protocols based on these ratings. In addition to the changes to the scale, the RLCCU has added a mechanism to record whether the noncompliance was cited in a previous year.

DCS also has an established waiver approval process for licensees that must meet certain requirements (must be an undue hardship and *not compromise health, safety, and welfare of children*).

- Foster Home Licenses: Data regarding the number of waivers granted and the most common types for foster homes is detailed on page 72 of the 2016 APSR.
- LCPA Licenses: out of 57 licenses (an LCPA may have more than one license) in calendar year 2015, three (3) were granted staff-specific waivers (for example, qualifications or education level) and two (2) were granted child specific waivers (for example, age or capacity).
- Residential Licenses: Out of 117 licenses in calendar year 2015, twenty-one (21) were granted ongoing-related waivers (for example, delayed lock on doors or physical space); three (3) were granted staff-specific waivers (for example, qualifications or education) and twenty-eight (28) were granted child-specific waivers (for example, age or capacity).

The Central Office (CO) Foster Care Unit has 3 consultants who provide oversight to DCS and LCPA staff regarding the licensure and monitoring of foster homes. Two of the consultants work with DCS licensing staff and one consultant works primarily with LCPA licensing staff; this arrangement helps ensure consistency in the standards that are applied statewide. The CO foster care consultants are staff of equal qualifications (meeting supervisor experience and requirements), who work closely under the supervision of the CO foster care program manager. The consultants are experts in licensing regulations and rules and how to interpret them. Any submission for a license that is requesting a waiver, variance or exception to a licensing requirement must be reviewed and approved by them. The consultants are centrally located and staff cases often with one another and with their program manager to make determinations on unique situations. The consultants also provide guidance and training to statewide licensing staff to ensure a shared understanding regarding how to interpret the regulations in varied situations. Licensing staff receive annual training as well as on-site or conference call consultation by CO foster care staff to address inconsistencies and misinterpretations of licensing regulations and rules. Furthermore, DCS collaborates with LCPAs in quarterly trainings for representative trainers; this lays the foundation for all foster parents in Indiana to have consistent, quality training. As mentioned in Item 28 – LCPA foster parents are also able to attend foster parent trainings put on by DCS.

DCS also continues LCPA and Residential Treatment Facility licensing reviews and contract and licensing audits as a means to establish consistent standards and results. These reviews and audits are detailed on page 72-76 of the 2016 APSR. Onsite licensing and contract audits provide an opportunity for licensees to give feedback to DCS. Additionally, as noted on page 76 of the 2016 APSR, many of the changes implemented in the LCPA and residential service contracts with DCS were a direct result of collaboration with licensees.

As part of its ongoing plan to develop quantitative reports that assist in measuring the impact on the qualitative outcomes, DCS staff utilizes the following reports to ensure standards are being met and applied equally:

- Timeliness of Licensure: As reported on page 69 of the 2016 APSR, this report provides information regarding the average time (in days) for FCMs to complete licensing. This report allows supervisors to assist FCMs in staffing barriers and issues related to licensing.
- Total licensed homes: This report provides statewide data on the number of DCS or LCPA; non-relative or relative homes (region specific data is also available). As of December 30, 2015, the report provides the following statewide data:

--	Relative Only	Non Relative	Total
DCS Licensed	1125	2433	3558
LCPA Licensed	31	1949	1980
DCS & LCPA Total	--	--	5538

As mentioned in the 2016 APSR, other reports are in development, including but not limited to the reason for foster parent withdrawal and foster home utilization and capacity. These reports along with licensing compliance reviews and Quality Service Review (QSR) data will allow a comprehensive data report to be provided for regional and program management to evaluate. Lastly, the Deputy Director of Placement Support and Compliance continues to host monthly conference calls with residential providers and LCPAs with significant participation to discuss ongoing issues and updates.

Item 34: Requirements for Criminal Background Checks

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that the state complies with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements, and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children?

Please provide relevant quantitative/qualitative data or information that show the state is complying with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children.

State Response:

Insert state response to Item 34: Requirements for Criminal Background Checks

Overview

DCS' Central Office Background Check Unit (COBCU) is responsible for implementing the extensive DCS policies and procedures regarding background checks, including the evaluation of all state and national FBI fingerprint based results. The background check policies/requirements can be found in Chapter 13 of the DCS Welfare Policies at <http://www.in.gov/dcs/2526.htm>. The policies are broken out to explain the categories of individuals (provider staff, licensed foster families, etc.) who require checks and the types of checks to be completed. DCS has statutory requirements for background checks for foster and adoptive families that exceed the federal standards. Additionally, effective July 1, 2015, Indiana's statutory scheme also requires that staff for LCPAs, residential providers, and service providers submit to national name based sex offender registry checks and local law enforcement criminal history checks.

This item is a strength of the agency as DCS continues to build on its strong practice in the areas of completing and documenting timely licensure and safety checks for foster parents and child caring institutions, as noted in the approval letter dated September 14, 2012 from The Children's Bureau – Administration for Children and Families to DCS, following DCS' Title IV-E foster care review.

In addition to the Child Protection Services, local law enforcement, and sex offender registry checks, Indiana also requires all licensed foster family applicants and household members 18 years and older to complete a state and national FBI fingerprint based criminal history check and be found either "qualified" or "waiver granted" before licensure of the foster home can occur. The COBCU uses an electronic system to receive state and national fingerprint based results. The system will automatically qualify a subject when the individual has not self-disclosed any arrest/conviction history and there is no information returned on the state and national reports. If the individual self-discloses arrests/convictions or any information is returned on either the state or national report, the criminal reports are evaluated by a member of the COBCU.

The requirements and evaluation standards for unlicensed relative/kinship homes are the same as licensed homes. One difference, however, is when a child must be placed in a relative/kinship home in exigent circumstances. When placement in an unlicensed relative/kinship home is considered before the department's ability to obtain a full fingerprint based National and State criminal history check, the department has the ability to request and receive criminal history information on all household members 18 years or older in the prospective relative/kinship home through the Interstate Identification Index (Triple I). Upon placement in this relative/kinship after the Triple I check, all household members 18 years and older are required to complete a follow-up national and state fingerprint based criminal history check in an established timeframe. Failure to comply with this requirement by the relative/kinship placement will result in the child(ren) being removed from that relative/kinship home. This requirement is further outlined in IC 10-13-3-27.5.

The specially trained staff of the COBCU are responsible for evaluating the criminal history records, including gathering further information when necessary. When there is any unknown information, such as the level of conviction, number counts, disposition that resulted after an arrest, or possible active warrants and/or arrests/convictions that could be related to the health and safety of a child and more information is required, the individual will be "conditionally disqualified". Furthermore, the COBCU will disqualify any subject that has been convicted of a felony, regardless of time passed since the conviction or the nature of the conviction. The subject will also receive a disqualified fingerprint based status if the subject has four or more counts that result in a misdemeanor conviction regardless of the nature or time passed since the conviction.

A fingerprint based disqualified result from any of the above convictions or combinations of convictions may be eligible to initiate the criminal history waiver process if the subject's conviction is not included in those prohibited by federal law. DCS' procedure for waiver approval or denial is one that provides for a thorough review at multiple levels of leadership within the agency. The criminal history waiver process includes the review of:

- the state and national fingerprint based report
- any dispositions and/or arrest reports gather by COBCU while finalizing the disqualified status
- the results of the National Sex Offender Registry for all states that the subject has resided in the past five years
- Child Protection Services History Checks for Indiana as well as all other states the subject has resided in the past five years
- Name based arrest report searches for all city policy/county sheriff offices that would have responded to an emergency at a past address listed for the subject

All of the above searches are completed using every name or combination of names ever used by the subject throughout their lifetime. This information is gathered, along with a letter from the foster care licensing worker with a recommendation regarding the waiver request as well as a letter from the subject requesting the waiver. These materials are reviewed by the COBCU consultant who also provides a recommendation. Thereafter, the materials are forwarded for a final recommendation to members of the waiver committee who include: DCS Local Office Director in the county of the foster home, Regional Manager, and the Foster Family Home Program Manager.

Evaluation

Licensed Foster Homes: The MaGIK Foster Family Background Check Report provides a snapshot of the fingerprint background check compliance status of DCS and LCPA foster homes which can be monitored and reviewed for compliance. A review of the currently licensed DCS and LCPA foster family homes licensed from December 1, 2014 – December 18, 2015 shows that 98% of the checks were compliant (timely completed). While the report performs well in demonstrating compliance, there are a few inherent discrepancies that could affect a small number of results. Below are examples of discrepancies with the report that DCS is working to correct:

- If an individual moves into a home after the license is effective and timely obtains the required background check, the report may incorrectly show noncompliance because it is after the effective date of the license.
- The report does not separate checks completed for initial verse re-licensure. Re-licensure can be retroactive to the expiration date of the initial licensure but show up as noncompliant.
- Human error when entering the report can result in incorrect results. For example, if the date of the fingerprint check is left blank, a result of noncompliance is shown. However, a manual check finds that if the date had been entered in the system, it would have resulted in a compliance finding.
- The report reflects only the license effective date, not the approval date. The effective date may be retroactive to before the approval date which may reflect a result of compliance. However, the fingerprint evaluation was issued after the effective date; but, before the approval date.

Residential and LCPA Providers: The DCS Residential Licensing and Contract Compliance Unit (RLCCU) audits residential programs, foster care homes and LCPAs for compliance with background check statutes, as Indiana requires 100% of employee background checks to be audited. Residential & LCPAs are required to obtain background checks for those individuals who have or will have direct contact on a regular and continuing basis with a child. Indiana also statutorily requires background checks of employees and volunteers of LCPAs and residential facilities. During the annual audits of residential facilities and LCPAs, the RLCCU check, via direct record review, that the appropriate background checks have been timely completed. These audits are reviewed by management to ensure consistent standards are applied and compliance is achieved. Unfortunately, the audits performed by the RLCCU are currently performed in such a way that the background checks cannot be tracked electronically and aggregated.

To gather data on the residential and LCPA background check compliance rate, a survey was completed by the RLCCU. There are currently over 170 LCPAs and residential providers licensed in Indiana and each of the licensees employ anywhere from 5 to 300 employees. An electronic survey completed by RLCCU staff identified 26 of the 117 Residential Licensees and 2 of the 57 LCPA Licensees being non-compliant with criminal background checks in calendar year 2015. For purposes of evaluating the percentage of compliant checks completed, however, the results are misleading as a licensee was considered non-compliant if one employee had a non-compliant check. Therefore, with LCPAs and residential providers licensed in Indiana employing anywhere from 5 to 300 employees, the number of persons for

whom background checks are performed is in the thousands. Non-compliance was determined as a result of the failure of the licensed facility to acquire, for at least one employee, at least one of the three required background checks (fingerprint based national criminal history; sex offender registry; and child protective services check). Non-compliance could have also been the result of timing of the acquisition of the background check (i.e. background check was clean but was acquired at a time in the employee's employment that was not consistent with the timing of the requirement for such check).

DCS continues to work with the residential facilities and LCPAs to ensure they are in 100% compliance and numbers are accurately reported. For example, when it is determined that an entity is not in compliance with licensing and or contract standards, the RLCCU requires that each facility develop a Plan of Correction (POC) in which the agency specifies what action will be taken to come into compliance. The POC must specify how the corrective action can be accomplished; who will be responsible for implementing each component; how will adherence be monitored, sustained, and evaluated to ensure new practices remain in place; the timeline for implementation; and how staff will be trained in any of the new processes/systems identified. If compliance is not achieved, DCS is able to take further action against a license (probation, limited ability to admit children, etc.).

For DCS foster family homes, a licensing compliance review process is in the final stages of development. The licensing compliance review will provide a second check for information that is documented within MaGIK for foster home licensure.

DCS continues to include provisions for addressing safety of foster care and adoptive placements for children in the Child and Family Team Meetings (CFTM) that occur during case planning. During the CFTM, a safety plan is created/updated, which includes the child's current level of safety in placement, visitation, school, etc.

Item 35: Diligent Recruitment of Foster and Adoptive Homes

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide?

Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide.

State Response:

Insert state response to Item 35: Diligent Recruitment of Foster and Adoptive Homes

Similar to other jurisdictions across the country, Indiana has seen an increase in children being placed into out of home care; resulting in DCS maximizing usage of available placement resources within Indiana. DCS continues to work to ensure that quality foster care and residential programs are available to children and families in Indiana. DCS is focused on actively recruiting foster and adoptive homes and improving the effectiveness of its targeted recruitment by utilizing reports and data. In an effort to recruit and retain foster and adoptive homes, Objective 2.2 of the CFSP – Expand Placement and Permanency Options, and Improve Placement Stability for Children in Foster Care Placements – was developed. More specifically, Objective 2.2(b) focuses on expanding the use of resources available to potential/current foster and adoptive parents.

The number of active licenses in Indiana continues to steadily grow, with approximately 5,500 resource (foster) family homes currently licensed through DCS local offices and through licensed child placing agencies (LCPAs). In order to assist in making improved and successful placement decisions, DCS has specialized staff in the field to assess for needs and support resource parents. First, 98 Regional Foster Care Specialists (RFCS) work with families and have enhanced knowledge of a families' strengths and needs. These RFCS are a strength of the agency as they are out in the field utilizing their unique knowledge of the regions ethnic and cultural characteristics which result in an increased likelihood of successful placements. Additionally, for relatives who will be serving as resource parents, 31 Relative Support Specialists provide similar assistance and information in the first 30 days of placement and regularly thereafter to support retention efforts. Additionally, Quality Service Review (QSR) data is currently being gathered on how well DCS assesses resource parents' needs and a report is currently in development for release.

DCS has a placement matching tool which is able to assist in targeting recruitment. Examples of factors foster parents that are tracked include age and gender preferences, special needs a home is able to accommodate, and location. While the report is useful to identify a

match and target recruitment, it continues to be refined in order to provide more reliable data. Additionally, a Foster Parent Recruitment Report for Non-Related Placements is utilized by DCS that shows demographic information and the Child and Adolescent Needs and Strengths Assessment (CANS) level of placements in licensed foster homes.

The table immediately below reflects data gathered from the Foster Parent Recruitment Report and provides a statewide snapshot of the race and ethnicity of licensed foster care providers and children statewide as of March 2016. The second table is from the same report and demonstrates how data can be drilled down to a region and county level to further identify needs and target recruitment. As the statewide data indicates, DCS is developing recruitment efforts that will target the Latino population statewide.

[Table 1]

Hispanic or Latino Origin

Who	#	%
Homes	114	3.05
Children	787	10.22

Race Uncertain

Who	#	%
Homes	3	0.08
Children	7	0.09

American Indian or Alaskan Native

Who	#	%
Homes	9	0.24
Children	8	0.10

Asian

Who	#	%
Homes	2	0.05
Children	17	0.22

Black or African American

Who	#	%
Homes	988	26.40
Children	1649	21.42

Native Hawaiian or other Pacific Islander

Who	#	%
Homes	2	0.05
Children	13	0.17

White

Who	#	%
Homes	2704	72.26
Children	5045	65.54

3

Who	#	%
Homes	34	0.91
Children	959	12.46

Total

Who	#
Homes	3742
Children	7698

[Table 2]

Region 3, Hispanic or Latino Origin

County	Who	# Hispanic or Latino Origin	% Hispanic or Latino Origin
Total	Homes	11	4.14
Total	Children	40	8.16
Elkhart	Homes	3	3.61
Elkhart	Children	11	6.88
Kosciusko	Homes	0	0.00
Kosciusko	Children	4	8.89
Marshall	Homes	0	0.00
Marshall	Children	2	4.88
Saint Joseph	Homes	8	6.06
Saint Joseph	Children	23	9.43

Region 3, Race Uncertain

County	Who	# Race Uncertain	% Race Uncertain
Total	Homes	0	0.00
Total	Children	0	0.00
Elkhart	Homes	0	0.00
Elkhart	Children	0	0.00
Kosciusko	Homes	0	0.00

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County	Who	# Race Uncertain	% Race Uncertain
Kosciusko	Children	0	0.00
Marshall	Homes	0	0.00
Marshall	Children	0	0.00
Saint Joseph	Homes	0	0.00
Saint Joseph	Children	0	0.00

Region 3, American Indian or Alaskan Native

County	Who	# American Indian or Alaskan Native	% American Indian or Alaskan Native
Total	Homes	1	0.38
Total	Children	2	0.41
Elkhart	Homes	1	1.20
Elkhart	Children	0	0.00
Kosciusko	Homes	0	0.00
Kosciusko	Children	0	0.00
Marshall	Homes	0	0.00
Marshall	Children	0	0.00
Saint Joseph	Homes	0	0.00
Saint Joseph	Children	2	0.82

Region 3, Asian

County	Who	# Asian	% Asian
Total	Homes	0	0.00
Total	Children	0	0.00
Elkhart	Homes	0	0.00
Elkhart	Children	0	0.00
Kosciusko	Homes	0	0.00
Kosciusko	Children	0	0.00
Marshall	Homes	0	0.00
Marshall	Children	0	0.00
Saint Joseph	Homes	0	0.00
Saint Joseph	Children	0	0.00

Region 3, Black or African American

County	Who	# Black or African American	% Black or African American
Total	Homes	62	23.31
Total	Children	100	20.41
Elkhart	Homes	16	19.28
Elkhart	Children	20	12.50
Kosciusko	Homes	0	0.00
Kosciusko	Children	1	2.22
Marshall	Homes	0	0.00
Marshall	Children	6	14.63
Saint Joseph	Homes	46	34.85
Saint Joseph	Children	73	29.92

Region 3, Native Hawaiian or other Pacific Islander

County	Who	# Native Hawaiian or other Pacific Islander	% Native Hawaiian or other Pacific Islander
Total	Homes	0	0.00
Total	Children	1	0.20
Elkhart	Homes	0	0.00
Elkhart	Children	0	0.00
Kosciusko	Homes	0	0.00
Kosciusko	Children	0	0.00
Marshall	Homes	0	0.00
Marshall	Children	0	0.00
Saint Joseph	Homes	0	0.00
Saint Joseph	Children	1	0.41

Region 3, White

County	Who	# White	% White
Total	Homes	202	75.94
Total	Children	303	61.84
Elkhart	Homes	66	79.52
Elkhart	Children	116	72.50
Kosciusko	Homes	27	100.00
Kosciusko	Children	40	88.89

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County	Who	# White	% White
Marshall	Homes	24	100.00
Marshall	Children	28	68.29
Saint Joseph	Homes	85	64.39
Saint Joseph	Children	119	48.77

Region 3, 3

County	Who	# 3	% 3
Total	Homes	1	0.38
Total	Children	84	17.14
Elkhart	Homes	0	0.00
Elkhart	Children	24	15.00
Kosciusko	Homes	0	0.00
Kosciusko	Children	4	8.89
Marshall	Homes	0	0.00
Marshall	Children	7	17.07
Saint Joseph	Homes	1	0.76
Saint Joseph	Children	49	20.08

Region 3, Totals

County	Who	Quantity
Total	Homes	266
Total	Children	490
Elkhart	Homes	83
Elkhart	Children	160
Kosciusko	Homes	27
Kosciusko	Children	45
Marshall	Homes	24
Marshall	Children	41
Saint Joseph	Homes	132
Saint Joseph	Children	244

DCS is continuing to work to increase the use of data in informing recruitment efforts. Focus on improvement revolves around: 1) more effectively identifying homes with availability

restrictions; 2) improving the Foster Parent Recruitment Report for Non-Related Placements; this report provides a good overview of where children are placed in each county, however, improvements are being implemented to more accurately capture data and simplify the report in order to increase its utility for staff in the field; and 3) conveying to FCMs the importance of accurate data entry for variables that inform recruitment.

Recruitment Data Distribution

In an effort to distribute data for targeted recruitment efforts, the DCS Deputy Director of Placement Support and Compliance sponsored an LCPA Forum in November 2015 to inform LCPAs on current statewide placement information regarding current placement and utilization of DCS and LCPA homes across the state. Regional data was also provided and distributed to groups so a more targeted approach for recruitment could be used. The regional data contained the following:

- Number of CHINS in licensed out of home placements (does not include unlicensed relative placements)
- Location breakdown (DCS home, LCPA home, Residential)
- Number of CHINS where case county differs from placement county
- Age Group Breakdown
- Race and Hispanic/Latino Origin (self-identified by clients)
- Sibling group information
- CANS Recommendations (Health and Placement)
- Developmental disability diagnosis

As an example of the regional data identified and distributed, data for DCS Region 5 is attached hereto as **Attachment 23**. To help inform and develop targeted recruitment efforts, the above regional data packets were also distributed to Regional DCS Field Management and RFCSSs. Trends from the regional data include the following:

- Lowest percentage of out of county placements were in major metropolitan areas (Regions 1 [18%], 10 [27%], 4 & 3 [32%])
- Highest percentage of out of county placements were in Regions 17 [74%], 6 [69%], 5 [63%], and 9 [63%])

LCPA Usage –

- High in Regions 1 [51%], 11 [46%], 10 [45%]
- Low in Regions 8 [7%], 16 [7%], 12 [12%]

Sibling Groups –

- Regions 12, 2, 1, 13, and 16 had 10% or more of their non-relative placements in sibling groups of 3 or more
- Region 2 [12%] and Region 9 [10%] had highest percentage of children with developmental disability diagnosis

As mentioned above, DCS is focusing on obtaining and refining information from licensed foster homes to identify their willingness to accept placements for youth with certain

characteristics. Data around willingness to foster plays a critical role in accurately reflecting the availability of homes and provides DCS the ability to further target recruitment. At the above mentioned forum, DCS presented data it had collected around the number of foster homes in each DCS Region for foster parents willing to foster youth with certain characteristics.

Examples of a few of the characteristics captured in the report include physically disabled, seriously emotionally disturbed, sexually maladaptive behaviors. DCS then renewed its request for submittal/verification of data around foster parent willingness to foster characteristics by asking LCPAs and DCS local offices to submit updated information to ensure accuracy of the Willingness to Foster report.

Contracted Recruitment Efforts

As described on page 68 of the 2016 APSR, DCS continues to contract with the Children's Bureau and the Transform Consulting Group (Heart Gallery) for adoption recruitment services that take place throughout the state.

Heart Gallery: In calendar year 2015, the Heart Gallery, a traveling exhibit that promotes youth that are eligible for adoption, featured 62 children, with 16 of those children matched with families. The Heart Gallery traveled to 75 events representing 45 cities and 17 DCS Regions. Additionally, the Heart Gallery hosted three major events in the north, south, and central regions of the state where families interested in learning more about foster adoption were able to come and meet with local DCS adoption specialists and view the Heart Gallery. Below is a schedule of the 2015 Heart Gallery Events.

Venue/Event	County	DCS Region	Start Date	End Date
Kennedy Public Library	Delaware	7	January 5, 2015	January 17, 2015
Randolph County YMCA	Randolph	7	January 5, 2015	January 17, 2015
Tipton County Public Library	Tipton	11	January 17, 2015	January 31, 2015
Trinity United Methodist Church, Hartford City	Blackford	7	January 18, 2015	February 1, 2015
Church of the Nazarene	Jay	7	February 1, 2015	February 14, 2015
Greenwood Public Library	Johnson	14	February 1, 2015	February 14, 2015
Ivy Tech Community College	Johnson	14	February 15, 2015	February 28, 2015
Strike Force Lanes	Shelby	11	February 15, 2015	February 28, 2015
Whale of a Sale Consignment	Hamilton	11	February 26, 2015	March 1, 2015
Foundation for Youth	Bartholomew	14	March 1, 2015	March 15, 2015
3 Pottery Studio	Hendricks	9	March 1, 2015	March 14, 2015

Section IV: Assessment of Systemic Factors

Venue/Event	County	DCS Region	Start Date	End Date
Indianapolis Children's Museum, Target Family Free Night	Marion	10	March 5, 2015	March 5, 2015
Indy Kids Consignment Sale	Hamilton	11	March 12, 2015	March 14, 2015
Central Indiana Autism Expo	Marion	10	March 21, 2015	March 21, 2015
Owen Co YMCA	Owen	13	March 21, 2015	April 4, 2015
H.J. Ricks Center for the Arts	Hamilton	11	March 27, 2015	April 11, 2015
Indiana Statehouse	Marion	10	April 1, 2015	April 8, 2015
Putnam County Public Library	Putnam	9	April 4, 2015	April 18, 2015
Franklin County Courthouse	Franklin	12	April 6, 2015	April 17, 2015
Toyota Motor Visitor Center	Gibson	16	April 10, 2015	April 27, 2015
Southern Indiana Autism Expo at French Lick	Orange	17	April 11, 2015	April 11, 2015
Fayette County Library	Fayette	12	April 18, 2015	May 2, 2015
Mooresville Public Library	Morgan	9	May 1, 2015	May 15, 2015
Indianapolis Children's Museum, Target Family Free Night	Marion	10	May 7, 2015	May 7, 2015
Fair Oaks Farms – Fly in the Air	Jasper	2	May 9, 2015	May 23, 2015
Family Fun Fair at Hamilton County Sports Complex	Hamilton	11	May 16, 2015	May 16, 2015
Annual Foster Care Conference	Lake	1	May 16, 2015	May 16, 2015
3 Play and Discovery Center	Lake	1	May 16, 2015	May 30, 2015
Recreation Unlimited	Hamilton	11	June 6, 2015	June 20, 2015
Indianapolis Children's Museum, Target Family Free Night	Marion	10	June 7, 2015	June 7, 2015
PBS Kids in the Park	Marion	10	June 13, 2015	June 13, 2015
Art Affair on the Square	Parke	9	June 20, 2015	June 20, 2015

Section IV: Assessment of Systemic Factors

Venue/Event	County	DCS Region	Start Date	End Date
Light the Night Festival	Boone	9	June 26, 2015	June 28, 2015
Tin Caps Baseball	Allen	4	June 29, 2015	June 29, 2015
Duneland YMCA	Porter	2	July 11, 2015	July 25, 2015
Scott County Fair	Scott	18	July 13, 2015	July 17, 2015
Indiana Black Expo Summer Celebration	Marion	10	July 17, 2015	July 19, 2015
The Commons	Bartholomew	14	July 17, 2015	July 30, 2015
LaGrange County Public Library	LaGrange	4	July 25, 2015	August 8, 2015
3333 Fest at Fair Oaks Farm	Jasper	2	August 1, 2015	August 1, 2015
American Family Day	3	2	August 2, 2015	August 2, 2015
Indianapolis Children's Museum, Target Family Free Night	Marion	10	August 6, 2015	August 6, 2015
Northern IN Heart Gallery Family Event at Deep River Water Park	Lake	1	August 7, 2015	August 7, 2015
Family Fun Fair at Hamilton County Sports Complex	Hamilton	11	August 8, 2015	August 8, 2015
3 Festival	DeKalb	4	August 28, 2015	September 11, 2015
Kokomo – Howard County Public Library	Howard	6	September 1, 2015	September 30, 2015
Indy Kids Consignment Sale	Hamilton	11	September 17, 2015	September 19, 2015
Southern IN Heart Gallery Family Event at Walthers Fun and Golf	Vanderburgh	16	September 17, 2015	September 17, 2015
Trinity United Methodist Church	Marion	10	September 25, 2015	October 5, 2015
Central IN Heart Gallery Family Event at RAPT Conference	Marion	10	October 8, 2015	October 10, 2015
Rockville Public Library	Parke	8	October 13, 2015	October 26, 2015
Institute for Strengthening Families Conference	Marion	10	October 13, 2015	October 15, 2015

Section IV: Assessment of Systemic Factors

Venue/Event	County	DCS Region	Start Date	End Date
Northern Indiana Autism Expo	St. Joseph	3	October 17, 2015	October 17, 2015
Boo at the Zoo	LaPorte	2	October 24, 2015	October 24, 2015
Brookside Church – Orphan Sunday, 11/8	Allen	4	November 2, 2015	November 16, 2015
Children's Museum of Indianapolis, NAM Event	Marion	10	November 5, 2015	November 5, 2015
La Porte County Public Library – Adoption Stories	LaPorte	2	November 5, 2015	November 11, 2015
New Hope Christian Church – Orphan Sunday, 11/8	Daviess	17	November 6, 2015	November 15, 2015
Spencer County Courthouse, NAM Event	Spencer	17	November 6, 2015	November 20, 2015
Terre Haute Children's Museum, NAM Event	Vigo	8	November 6, 2015	November 18, 2015
Vanderburgh County NAM Event, Barnes & Noble Booksellers	Vanderburgh	16	November 7, 2015	November 14, 2015
Church of the Harvest – Orphan Sunday Event	Vanderburgh	16	November 7, 2015	November 14, 2015
Star 88.3 Adoption Celebration, Wallen Baptist Church, Fort Wayne	Allen	4	November 7, 2015	November 7, 2015
Henry County Courthouse, NAM Event	Henry	12	November 9, 2015	November 23, 2015
St. Joseph County Probate Court, NAM Event	St. Joseph	3	November 12, 2015	November 13, 2015
Governor Pence's Adoption Fair at the Indiana Statehouse	Marion	10	November 16, 2015	November 16, 2015
Johnson County Courthouse, NAM Event	Johnson	14	November 16, 2015	November 23, 2015
Allen County Courthouse, NAM Event	Allen	4	November 19, 2015	November 19, 2015
Tippecanoe County Courthouse, NAM Event	Tippecanoe	5	November 19, 2015	November 19, 2015
Elkhart County Courthouse, NAM Event	Elkhart	3	November 20, 2015	November 20, 2015
Lake County Courthouse, NAM Event	Lake	1	November 20, 2015	November 20, 2015

Venue/Event	County	DCS Region	Start Date	End Date
Dubois County Courthouse	Dubois	17	November 20, 2015	December 4, 2015
The Journey Church	Hendricks	9	November 21, 2015	December 7, 2015
Indianapolis Children's Museum, Target Family Free Night	Marion	10	December 3, 2015	December 3, 2015
Fair Oaks Farms - Holiday Farm Frenzy	Jasper	2	December 19, 2015	December 19, 2015

Children's Bureau:

DCS contracts with the Children's Bureau to perform a number of adoption recruitment services, including meet and greets, production of videos and photo books, and general recruitment events statewide. The Children's Bureau collaborates with community resources in an effort to increase the effectiveness and appropriateness of services and works within the structure and needs of each DCS region. The intent is for events and ultimately recruited/licensed families to reflect the metropolitan and rural cultural norms of each DCS region.

The Children's Bureau submits quarterly reports to DCS detailing recruitment efforts from the previous quarter, including detailed regional information such as locations, attendance, and narratives around the events themselves. The following is a summary of the statewide activities Children's Bureau performed in calendar year 2015:

- 7 meet and greet events (brining families and adoption children together to allow them to interact in a non-threatening, fun atmosphere)
- 203 educational/informational events put on by Adoption Champions. Adoption Champions are 18 regionally based individuals who are knowledgeable of the Indiana adoption system and the needs of the specific region in which they are located in.
 - 24 of these educational/information events were focused on minority recruitment in the regions where appropriate
 - 515 new families signed in at the education/information events

Additional Recruitment Efforts

DCS' Special Needs Adoption Program (SNAP) Specialists continue their work to connect potential adoptive parents with children who are older (44% of youth in SNAP are 13 year of age or older), in sibling groups, minorities, or have special emotional or medical needs. For calendar year 2015, 221 homes were identified, processed, and approved by SNAP specialists and 319 (may include some duplicate referrals) children were referred to the SNAP Unit for recruitment. In State Fiscal Year 2015 (July 1, 2014-June 30, 2015), DCS finalized 1245 adoptions (average of last 7 years is 1382).

DCS Director Bonaventura often worked with the faith based community to educate members on the need for foster and adoptive parents during her time as a juvenile judge in Lake County, Indiana; under Director Bonaventura's leadership, DCS has renewed its focus on participating in similar outreach efforts. For example, in the spring of 2016, Director Bonaventura was a keynote speaker at an inaugural event called Every Child at Light of the World Christian Church in Indianapolis where she gave a presentation on the need for adoptive and foster parents in Indiana and how faith based organizations could help meet this need. The Heart Gallery Exhibit (described above) was also present at the event and provided prospective foster and adoptive parents an opportunity to get information on the children who were eligible for fostering or adoption. Additional Information can be found at <http://everychildin.org>.

DCS local offices continue to do outreach through various community events, faith based organizations, exhibitions, etc. Other outreach examples include a booth/information table at Indiana Black Expo Summer Celebration (one of the largest ethnic-cultural events in the United States), radio ads, website campaigns, and media interviews around the state. A targeted focus for DCS has been in the most populous counties with identified needs, including Marion, St. Joseph, Wayne, Allen, Delaware, Vanderburgh, Clark, and Vigo counties.

Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide?

Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide.

Please include quantitative data that specify what percentage of all home studies received from another state to facilitate a permanent foster or adoptive care placement is completed within 60 days.

State Response:

Insert state response to Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements

As DCS is a centralized agency, its use of cross-jurisdictional resources is a strength. Most, if not all, of the services offered to facilitate permanency transcend county lines as very few of the specialized staff are limited to just one county of service. As a result, limitations involving the availability and awareness of resources are minimized.

In order to assist with placements under the Interstate Compact for Placement of Children (ICPC), DCS has an ICPC Unit that is solely dedicated to implementing the policy and procedures in place for these types of placements. The ICPC Unit processed 1675 incoming and outgoing requests in 2015, an increase from previous years. These placements involved public and independent adoption, foster care, public and private residential, parent, relative, and relative foster care.

Any home studies that are not completed within 60 days appear on the overdue report which is distributed and reviewed monthly by field management staff. Of the 1675 requests in 2015, approximately 850 were incoming ICPC requests from other states, of which 49% were completed within the 60 day ICPC regulation timeframe. Common reasons DCS has identified for not completing a home study within 60 days include:

- the time necessary for fulfilling licensing requirements for foster care requests;
 - a second request meant to change the placement type (for example, from relative to adoption) may result in the resource parent delaying completion of the requirements because the child is already in the home;
- or

- lack of training on the ICPC requirements and/or turnover at the local office.

To combat the issue of home studies being delayed at the local offices, the DCS ICPC Unit is developing a statewide training plan to ensure that local office staff are informed about ICPC requirements.

The ICPC Unit also produces a report which monitors cases in which children under the care of DCS are placed outside of Indiana. FCMs follow these cases and the ICPC Unit keeps in contact with other states for reports and progress updates.

DCS continues to take steps to implement the National Electronic Interstate Compact Enterprise (NEICE) system, which will allow for the safe and secure transmission of data through a web-based program. DCS was one of six pilot states for NEICE which thus far has shown to save significant time when transmitting requests between states and between the ICPC Unit and the local offices.

As DCS is a centralized state agency with local county offices, FCMs are often called upon (and furthermore, required per policy) to work across county jurisdictions for matters related to investigations, services, permanency planning, and the transfer of a legal case from one county to another. DCS Executive Staff have access to the Locally Placed CHINS Report which tracks the placement of CHINS at a statewide, region, and county level. The report reflects the total number of children who are living in the same county as the court in which they were adjudicated as a CHINS. The percent of children locally placed is determined by dividing the number of children living in the same county by the total number of children with a CHINS case that are placed outside of their home. Below is a chart from that report as of December 2015 which reflects that 67% of children statewide are placed within their same county.

Location		Total Out Of Home Placements	Placed Out Of County	Placed In Same County	Percent Locally Placed
Statewide	Total	14333	4699	9634	67.2%

For those children placed out-of-county, the DCS Permanency and Practice Support Unit has staff located both centrally and across the state which focus on educating local staff on the resources that are available to them statewide to assist in achieving cross-jurisdictional permanency. FCMs are able to send a referral through the MaGIK -KidTraks portal (the same method used when requesting traditional services from providers) when services from the Permanency and Practice Unit are requested. Those resources include:

Investigators: DCS has a unit of 18 investigators that are dedicated to assisting local office staff with achieving permanency by locating relatives who may be a possible connection for the child at the onset, during, or after a case. Upon receiving a referral from an FCM, the investigator utilizes a variety of tools (public records, internet, etc.) to complete the referral. Any information the investigator is able to obtain is then returned to the FCM. Information returned often includes names, dates of birth, addresses, and phone numbers. For calendar year 2015 (as of November 30, 2015) DCS Investigators processed approximately 32,092 referrals from field staff and located approximately 30,543 individuals. Referrals may be for a father, mother, paternal relatives, or maternal relatives.

International and Cultural Affairs (ICA): DCS has worked to increase the resources available to FCMs in identifying and implementing services for multicultural populations, including children and families of immigrant and tribal origin. Trainings at supervisor and FCM workshops (developed in collaboration with Indiana University) continue to be utilized along with semiannual meetings with the Pokagon Band, Indiana's federally recognized tribe. DCS also works closely with the Indiana Native American Indian Affairs Commission to assist in related matters when necessary. Lastly, the QSR process may identify a family who is a member of a recognized tribe who has not been entered into MaGIK. These families are immediately referred to ICA for tribal referrals, follow-up and MaGIK entry. As a result of these improvements, the identification process has been improved and the referral process through MaGIK-KidTraks streamlined.

DCS also has multicultural teams at the regional level who act as resources for local staff and also monitor the CHINS Tribal Associations report. Although awareness of resources and the report have improved, issues with the format of the report and how the data is inputted by field staff necessitates improvements currently being discussed to more accurately measure and track performance. Furthermore, to verify information found in the CHINS Tribal Associations report, questions verifying a youth and/or family's tribal heritage are being included in the updated Reflective Practice Survey being deployed in 2016.

When a case involves immigrant children or children with immigrant parents, grandparents or extended family that live outside the United States, ICA works closely with FCMs to ensure those extended family members are contacted and part of the permanency planning process. To that end, DCS has entered into a memorandum of understanding with the Mexican Consulates in Chicago and Indianapolis to establish duties and procedures for working together when immigrant children and families come in to contact with DCS. A copy of the memorandum of understanding is attached as **Attachment 24**. In 2014, ICA received approximately 160 Consular Notifications and that number increased to over 200 in 2015. Increased use of these notifications assist DCS in identifying extended family members that can be included in the planning process and achieving timely permanency.

In addition to complying with consular notification and access, the ICA program also receives other referrals which involve inter-jurisdictional issues. Some issues involve, for example, verification of documents issued abroad and international family searches. DCS cooperates with consulates and federal agencies to ensure the best interest of a child in DCS is recognized in situations where a non-citizen parent is pending removal from the US.

Although working with other countries presents unique challenges, ICA has had a number of successes in calendar year 2015. For example, DCS placed seven (7) children in the United Kingdom, where three (3) were reunited with their father and four were placed under the guardianship of their grandparents. The cooperation between DCS, the Consulate of Great Britain, local social service agencies in the UK and the US were vital to achieving a successful outcome. Other successes occurred when ICA worked with the Consulate of Guatemala in the successful search of a Guatemalan child that was returned home. ICA also located parents of two unaccompanied Guatemalan children.