



DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D.C. 20201

October 24, 2017

Mary Beth Bonaventura
Director
Indiana Department of Child Services
302 W. Washington Street
Room E306-MS47
Indianapolis, Indiana 46204-2739

Dear Director Bonaventura:

Thank you for submitting Indiana's Annual Progress and Services Report (APSR), including the annual report on the use of funds under the Child Abuse Prevention and Treatment Act, and the CFS-101 forms requesting funding for fiscal year (FY) 2018 to address the following programs:

- Title IV-B, subpart 1 (Stephanie Tubbs Jones Child Welfare Services) of the Social Security Act (the Act);
- Title IV-B, subpart 2 (Promoting Safe and Stable Families Program and Monthly Caseworker Visit Grant) of the Act;
- Child Abuse Prevention and Treatment Act (CAPTA) State Grant;
- Chafee Foster Care Independence Program (CFCIP); and
- Education and Training Vouchers (ETV) Program.

These programs provide important funding to help state child welfare agencies ensure safety, permanency, and well-being for children, youth and their families. The APSR facilitates continued assessment, development, and implementation of a comprehensive continuum of services for children and families. It provides an opportunity to integrate more fully each state's strategic planning around use of federal funds with its work relating to the Child and Family Services Reviews and continuous program improvement activities.

Approval

The Children's Bureau (CB) has reviewed your APSR for FY 2018 and the annual report on the use of CAPTA funds and finds them to be in compliance with applicable federal statutory and regulatory requirements. Therefore, we approve FY 2018 funding under the title IV-B, subpart 1; title IV-B, subpart 2; CAPTA; CFCIP; and ETV programs.

Counter-signed copies of the CFS-101 forms are enclosed for your records. The Children's Bureau may ask for a revised CFS-101, Part I, should the final allotment for any of the approved programs be more than that requested in the Annual Budget Request.

The Administration for Children and Families' Office of Grants Management (OGM) will issue a grant notification award letter with pertinent grant information. Please note that OGM requires grantees to submit additional financial reports, using the form SF-425, at the close of the expenditure period according to the terms and conditions of the award.

Training Plan

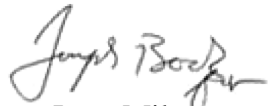
This approval for the FY 2018 funding for title IV-B, subpart 1; title IV-B, subpart 2; CAPTA; CFCIP; and ETV programs does not release the state from ensuring that training costs included in the training plan and charged to title IV-E of the Act comply with the requirements at 45 CFR 1356.60(b) and (c) and 45 CFR 235.63 through 235.66(a), including properly allocating costs to all benefiting programs in accordance with the state's approved cost allocation plan.

Additional Information Required

Pursuant to Section 424(f) of the Act, states are required to collect and report on caseworker visits with children in foster care. The FY 2017 caseworker visit data must be submitted to the Regional Office by December 15, 2017. States that wish to use a sampling methodology to obtain the required data must obtain prior approval from the Regional Office.

The CB looks forward to working with you and your staff. Should you have any questions or concerns, please contact Kendall Darling, Child Welfare Regional Program Manager in Region 5, at (312) 353-9672 or by e-mail at kendall.darling@acf.hhs.gov. You also may contact Charlene Blackmore, Child and Family Program Specialist, at (312) 886-4938 or by e-mail at Charlene.blackmore@acf.hhs.gov

Sincerely,



Jerry Milner
Associate Commissioner
Children's Bureau

Enclosure(s)

cc: Gail Collins, Director; CB, Division of Program Implementation; Washington, DC
Deborah M. Bell, Financial Management Specialist; ACF, OA, OGM; Washington, DC
Kendall Darling, Child Welfare Regional Program Manager; CB, Region 5; Chicago, IL
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Eric J. Holcomb, Governor

Mary Beth Bonaventura, Director

Indiana Department of Child Services

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INDIANA
CHILD AND FAMILY SERVICES PLAN
2015 - 2019

ANNUAL PROGRESS AND SERVICES REPORT
JULY 1, 2017-JUNE 30, 2018

Submitted to Children's Bureau
Administration for Child and Families
U.S. Department of Health and Human Services
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I. GENERAL INFORMATION

AGENCY INFORMATION

The Department of Child Services was established in January 2005 by an executive order of Governor Mitch Daniels. DCS protects children who are victims of abuse or neglect and strengthens families through services that focus on family support and preservation. The Department also administers child support, child protection, adoption, and foster care throughout the state of Indiana.

Judge Mary Beth Bonaventura was appointed by Governor Michael R. Pence to lead the Department in 2013. Director Bonaventura brings a wealth of knowledge and experience to DCS, having served as Senior Judge of the Lake County Superior Court, Juvenile Division—one of the toughest juvenile divisions in the state. Judge Bonaventura was appointed Senior Judge in 1993, by then Governor Evan Bayh, after having served more than a decade as a Magistrate in the Juvenile Court.

DCS' infrastructure includes local offices in all ninety two (92) Indiana counties, organized into eighteen (18) geographical regions. In SFY 2013, DCS created an additional region to encompass central office Family Case Managers (FCMs) from the Institutional Assessment Unit and the Collaborative Care Unit, for a total of 19 regions. In 2010, DCS added a centralized hotline, located in Indianapolis, and in 2013, added three regional hotline sites located in Blackford, Lawrence and St. Joseph counties. A fourth regional hotline site opened in Vanderburgh County in June 2014. In the spring of 2017, DCS began the process of dividing its Marion County local office – DCS' largest office in the state's most populous city, Indianapolis – into three smaller local offices. This localization plan was initiated to create a more community focused structure that will improve access and quality of interactions with families by fostering a community approach to child welfare as well as improve employee retention. The first new office was opened on the west side of Indianapolis in March 2017 with the next office opening later in the year.

Prior to 2005, child welfare services were provided by the Division of Family and Children (DFC), a division within an umbrella agency, the Family and Social Services Administration (FSSA). As a new cabinet-level Department, DCS was charged with providing more direct attention and oversight of two critical areas: protection of children and child support enforcement. The former mission statement, "helping families help themselves," was changed to "The Indiana Department of Child Services (DCS) protects children from abuse and neglect. DCS does this by partnering with families and communities to provide safe, nurturing, and stable homes." In December 2005, DCS initiated a major shift in how Indiana provided services to children and families called the "New Practice Model."

The DCS practice model was founded on five core competency areas: Teaming, Engaging, Assessing, Planning and Intervening (TEAPI). The practice model incorporates an approach which includes engaging families, teaming and planning with families, and supporting families when possible, while still holding parents accountable for their children. This model operates through Child and Family Team Meetings, in which a DCS Family Case Manager facilitates an individualized team including the family members, informal supports, and relevant service providers that reviews strengths, risks, and needs, and develops and monitors the implementation of a collaborative service plan.

MISSION AND VISION STATEMENTS

1. Mission

The Indiana Department of Child Services (DCS) protects children from abuse and neglect, and works to ensure their financial support.

2. Vision

Children thrive in safe, caring, and supportive families and communities.

UPDATE ON COLLABORATION

Collaboration and communication with stakeholders is vital to obtaining improved outcomes for children and families in Indiana. Feedback was used to identify system strengths and challenges when setting goals and objectives for the 2014 Child and Family Services Plan (CFSP). For example, Objective 1.7 – Improve Communications with Service Providers to Better Ensure Child Safety - was developed as 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 is working to leverage the recent Round 3 CFSR to renew and enhance its efforts for meaningful collaboration with the state's child welfare stakeholders to make improvements to Indiana's child welfare system. As part of the program improvement plan development process, stakeholders were included on teams focused on either safety, permanency, well-being, or probation initiatives. These teams were tasked with reviewing the CFSR findings and brainstorming ideas for inclusion in the program improvement plan. These teams met weekly for over a month and were made up of DCS staff, probation officers, judicial/court employees (judges, administrators, and staff), and service providers. Furthermore, CFSR findings are being used to inform changes and improvements during ongoing communications with state child welfare stakeholders. DCS also continued the practice of exchanging and discussing the APSR with the Pokagon tribe during semi-annual collaboration meetings, as described in more detail in Section VI of this document.

1. Regional Service Councils & Biennial Regional Services Strategic Plan

DCS collaborates with community stakeholders involved in child welfare through multi-disciplinary teams in each of DCS' 18 regions, known as Regional Service Councils (RSC). The RSC's complete biennial plans, which include service arrays for the regions. All DCS regions conduct the Biennial Regional Strategic Services Plan (BRSSP) process.

The Regional Management Team and Regional Service Council, in conjunction with regional service coordinators and performance quality improvement team staff, developed the BRSSP for July 1, 2017 – June 30, 2019 in the fall of 2015. Completed plans were submitted to Central Office for review and signature by Director Bonaventura. As in past years, the plans were developed using a collaborative approach, which included representation of stakeholders from the provider community, foster parents, youth, clients, probation, courts, CASA/GAL and

prosecutors. Providers from the community were invited to participate in focus groups which concentrated on four (4) areas of the BRSSP:

- Prevention Services
- Improving Access to and/or Retention in Substance Use Disorder Treatment Services
- Preventing Maltreatment After Involvement
- Obtaining Permanency for Children in Care 24+ months.

The focus groups were asked to identify gaps in services and strategies to improve the quality of services and availability of service array in a region. These plans incorporated CQI plans developed through the QSR and RPS processes, the child protection plan and the early intervention plan. The biennial plans also identified gaps in services and strategies to improve the quality of services and available service array in a region. State-wide quantitative and qualitative data, ad hoc reviews, and improvement planning outcomes were used to assess regional progress on their plans. Prevention data was also part of the data used to develop the BRSSP, as well as regional reports on contracted community-based services by county and their utilization in SFY 2015 (whether or not the service provider had a payment in SFY 2015). This data was used by the regions to develop both service strengths and gaps that could be addressed by DCS and the local communities. The Regional teams continue to utilize their plans to develop services within their regions and address service gaps that exist.

Biennial planning for the next two year cycle is currently underway with meetings being planned for the fall of 2017. A focus of the plans will be to provide updates on the progress of initiatives in their regions around the four (4) focus areas mentioned above. Regional Service Councils will again receive pertinent budget information and region specific service utilization information to aid in the development of their plans. To continue the focus on continuous quality improvement, regional councils will be receiving region specific data to make informed decisions on their plan. These data points are currently being developed and will provide information on outcomes in their regions as part of the agency's feedback loop to regional stakeholders. DCS Research and Outcomes staff will be developing a tutorial for the data to help regional councils understand the data provided and how it will help them in measuring performance of their region. Additionally, service utilization data will provide updates on the status of ongoing initiatives that are taking place in respective regions.

2. Community Mental Health Centers

Meetings with the CMHC Workgroup continue to occur monthly to discuss initiatives and current challenges. DCS partnered with Jeff Jamar, Behavioral Health Consultant for Children and Family Futures, who conducted in-person, face to face, visits with twenty of the twenty five CMHCs during the period of November and December, 2015. The purpose was to survey Indiana's Community Mental Health Centers regarding the services they were providing to DCS clients who needed assessment and treatment for Substance Use Disorder (SUD). These results were used to improve overall DCS/CMHC partnerships around this critical issue.

DSC also continued its work with the Indiana Council of Community Mental Health Centers and held a joint leadership meeting in August 2016 that focused on substance abuse treatment for children and families. Indiana CMHC's and DCS continued collaboration on its evidence-supported program called START (Sobriety Treatment and Recovery Teams) in 2 Indiana counties, aimed at addressing parental substance abuse and child abuse/neglect. DCS

is still working closely with Casey Family Programs in the monitoring of START and identifying resources and locations to launch the third (3rd) site.

During the development of the CFSP, DCS worked with the CMHCs to develop and monitor Objective 1.4 in Section IV below to identify the need to establish a collaborative effort to educate staff on the effects of substance use disorders on children and best practices in substance abuse disorder treatment.

DCS and the CMHC Workgroup continue to focus on the initiatives developed in the priorities document which included the following;

- Additional Members: Make sure the standing chair for the child and adolescent committee and the substance abuse committee attend the CMHC Workgroup meeting.
- Substance Use Disorder Treatment Services
- Creative approaches to services
- Workforce shortages
- Timeliness of access to services
- Engagement & Retention of Clients
- Medication Assisted Treatment Education
- Integration of physical health with behavioral health for substance using parents
- Insurance coverage for parents
- Children's Mental Health Initiative/Children's Mental Health Wraparound

3. Service Specific Workgroups

DCS facilitates ongoing collaborative meetings to improve the implementation of specific services such as:

- Family- Centered Treatment
 - A Regional Service Coordinator facilitates an individual meeting with FCT providers on a monthly basis to review performance data, share successes, and discuss challenges or barriers in cases or other service delivery issue.
- Community Partners for Child Safety
 - The DCS Prevention Team facilitates a monthly meeting to review current practice in the field, discuss programmatic issues, and troubleshoot any challenges/barriers to services and currently exploring curriculum to better meet programmatic needs. The group continuously discusses how to continue to meet the needs in the different regions.
- Healthy Families
 - Healthy Families Indiana has several committees that meet on a regular basis and focus on different areas of the program to ensure best practice and fidelity to the model. The committees provide feedback to the DCS Prevention Team on program improvement.
- Father Engagement

- A Regional Service Coordinator facilitates monthly meetings with Father Engagement providers to discuss what is going well with the program, review survey results, discuss any issues around fulfilling service components and how to resolve them and then provide time to have an open forum for the providers to network and get their questions answered.
- Findings from the Round 3 CFSR confirmed trends that have been identified and monitored in the Quality Service Reviews (QSR). This group will use the CFSR findings and ongoing QSR data to inform discussions and improvements as part of Objective 2.6 below.
- Home Based Coalition Workgroup
 - This group is the sub-group of the larger Indiana Coalition of Home Based Service Providers. The sub-group works on issues, assigned by the larger coalition group, that affect home based providers. The sub-group then makes recommendations to DCS to resolve the presenting issue and/or expand services for children in need.
- Cross Systems Care Coordination
 - Cross Systems of Care Coordination meets on a monthly basis to discuss referrals, programmatic issues and how to efficiently serve children and maximize available resources.
- Homebuilders
 - Monthly meetings are held with the providers to review referral information, capacity, discuss opportunities for training development and address any recommendations around programmatic needs. Consultants from the Institute for Family Development review CQI activities with participants.
- Sobriety Treatment And Recovery Teams (START)
 - Direct Line (comprised of field staff) and Steering Committee (comprised of management staff) meet on a monthly basis. Direct Line provides field staff the ability to discuss case issues and gain feedback on best practice. The Steering Committee drives field practice and ensures fidelity to the model. Programmatic changes/issues are addressed during this meeting. Quarterly calls are also held with substance use addiction providers.
 - Ongoing work is focused on program monitoring and the identification of a third pilot site.
- Children’s Mental Health Initiative Conference Calls
 - Monthly meetings are arranged to discuss state-wide access sites, the Children’s Mental Health Initiative, and the Children’s Mental Health Wraparound Services. The conference call provides updates on youth in Wraparound, the opportunity for access sites and key contacts to communicate, troubleshoot, and discuss the positive outcomes, and provide DCS with feedback. Collaboration with the Indiana Division of Mental Health and Addiction (DMHA) occurs as they assist to facilitate the meeting. Any changes or updates to both programs are also addressed at this meeting.

- Multi-Disciplinary Team (MDT) (DCS, Division of Mental Health and Addictions, Bureau of Developmental Disabilities Services, Division of Aging)
 - The MDT consists of a team of individuals from a variety of systems who meet bi-weekly to discuss high needs youth and how to navigate the service delivery systems to meet their individualized needs. This team joins forces to review specific cases that need guidance and manoeuvring through the system array, to ensure families are being served within the most appropriate service delivery system, to provide assistance to the local communities so families do not get bounced from one agency to another, to enhance supportive services within local communities, to assist local and community members find the appropriate services for families and children that prove best outcomes, and review any gaps in services throughout the state that arise through a multiagency approach.

- Enhanced Multi-Disciplinary Team (EMDT)
 - The EMDT consists of a variety of systems who also meet bi-weekly to study the gaps in services throughout the State. The EMDT discusses the available services and how, as state agencies, there can be increased services and funding to meet the needs of families and children. The EMDT focuses on community based efforts, residential services, as well as specialized assistance to address the needs. Then EMDT looks at the big picture within the state to solve issues and challenges through a multiagency approach.

- Family Evaluation Steering Committee
 - The Family Evaluation Steering Committee consists of field staff and management staff who collaborate to enhance Family Evaluations. Family Evaluations are reports that allow field staff to act as an advocate for children and families looking for services. Family Evaluations were created in order for the Department to have a consistent approach to families who needed assistance accessing mental and behavioural health services. This committee works on increasing field awareness, trainings, specific cases, and systematic issues.

- Children’s Justice Act Task Force
 - The Children’s Justice Act (CJA) Task Force meets eight (8) to ten (10) times a year to review policies on the handling of cases, training of provider staff and the community, and medical consultations of cases involving child abuse and neglect. The CJA Task force hosts an annual conference for multidisciplinary team members across the state. The Task Force received a copy of the APSR and discussion took place on DCS objectives and goals that may intersect with CJA initiatives. Furthermore, the CJA Task Force was also provided instructions on how to view the CFSR Final Report and has been receiving regular updates related to Program Improvement Plan development.

- Regional Provider Meetings
 - These meetings occur monthly or quarterly depending on the region. The meetings are provider driven and focus around topic areas that are pertinent to the providers at that time. Discussions

may focus around referral or service issues, retention of staff/clients or review changes in service standards. The meetings also allow providers in the region to meet one another and network.

DCS will also continue collaborating with existing statewide associations such as Indiana Council of Community Mental Health Centers - Child and Adolescent Committee, Coalition of Family-Based Services, and the Indiana Chapter of National Children's Alliance. This facilitation includes monthly calls, yearly conferences, and break-out workgroups.

4. Commission on Improving the Status of Vulnerable Youth

DCS continues to collaborate with the Commission on Improving the Status of Vulnerable Youth (Commission). The law defines a “vulnerable youth” as a child involved with the Department of Child Services, Family and Social Services Agency (FSSA), Department of Correction (DOC) or Juvenile Probation. The Commission is comprised of an Executive Committee with 18 members from the executive, judicial, and legislative branches, and local government officials. Members of the Executive Committee include Mr. John Hammond from the Office of the Governor, Loretta Rush, Chief Justice of Indiana, Mary Beth Bonaventura, Director of the Indiana DCS, Representative David Frizzel, and Senator Erin Houchin. A list of additional members can be found at www.in.gov/children. The Commission was created to bring together all governmental agencies that work with vulnerable youth to address:

- Access, availability, duplication, funding and barriers to services.
- Communication and cooperation by agencies.
- Implementation of programs or laws concerning vulnerable youth.
- The consolidation of existing entities concerning vulnerable youth.
- Data from state agencies relevant to evaluating progress, targeting efforts and demonstrating outcomes.

The goal of the Commission is to promote information-sharing, best practices, policies, and programs concerning vulnerable youth. In addition to cooperating with other child focused commissions, the executive branch, the judicial branch, stakeholders and members of the community. DCS deputies serve on various sub-committees and present information to the executive committee and to subcommittees when requested.

Mary Beth Bonaventura, Director of the Indiana DCS, also serves on the Child Services Oversight Committee. Some of the other members serving include Representative Wendy McNamara (Chair), Senator Frank Mrvan, Hon. Stephen Galvin, and executives of the Division of State Court Administration, the Indiana Public Defender Council, the Indiana Department of Education, and the Indiana CASA/GAL program. The top priority for the Child Services Oversight Committee is “to support the well-being of Hoosier children by strengthening the Indiana Department of Child Services (DCS).” Among the topics the subcommittee has focused on in the last year are foster care recruitment efforts, DCS legislative agenda items, and DCS data updates/key benchmarks.

Don Travis, the DCS Deputy Director of Juvenile Justice Initiatives and Support, serves as co-chair of the Juvenile Justice and Cross-System Youth Committee that focuses on the promotion of interagency communication and collaboration to improve prevention, outcomes and address the unique and complex needs of Juvenile Justice and/or cross-system involved youth. Don Travis continues to meet with court, probation, and child welfare representatives throughout the state to educate them on Indiana’s Dual Status youth.

Dr. Leah Hemze-Mills, DCS Director of Research and Evaluation, serves on the Data Sharing and Mapping Subcommittee which focuses on sharing of data between agencies.

Sarah Sparks, DCS Assistant Deputy Director, Services & Outcomes, is a member of the Mental Health and Substance Abuse Task Force that focuses on identifying and supporting creative and effective methods of improving assessment, access to treatment, and wraparound resources for vulnerable youth and households in needs of mental health and substance abuse services.

Reba James, the DCS Deputy Director of Permanency and Practice Support, serves on the Educational Outcomes Task Force which addresses education issues affecting children in the juvenile justice and child welfare systems. Melaina Gant, Education Services Director, in the Permanency and Practice Support Division, was appointed Chair of this Task Force by Chief Justice Rush beginning in 2017.

Sam Criss, DCS Deputy Director of Services and Outcomes, serves as co-chair of the Child Safety and Services Task Force. The goal is to support the well-being of children by promoting a continuum of prevention and protection services for vulnerable youth and their families.

James Wide, DCS Communications Director, is a member of the Communications Committee that focuses on the development of processes for improved information sharing and promoting the work of the Commission.

As mentioned above, annual reports, member lists, meeting agendas, minutes, PowerPoint presentations, handouts, and other resources can be found on the website for the Commission on Improving the Status of Children, <http://www.in.gov/children>.

5. Older Youth Services Collaboration

In an effort to continue to evolve and improve upon older youth services programming, DCS meets with key stakeholders routinely to seek feedback on older youth programs to make adjustments/improvements. The Older Youth Services (OYS) Community is made up of youth accessing services, those who recently aged out of services, the DCS Older Youth Initiatives (OYI) team (program staff), the DCS Collaborative Care Case Management Team (3CM staff), older youth service providers, and other key stakeholders.

The DCS OYI team has started phase one (1) of implementing continuous quality improvement (CQI). The Independent Living Specialist, the Collaborative Care Division Manager and the Older Youth Services service providers have received CQI training on the Plan-Do-Study-Act (PDSA) model. This model for quality improvement provides an interactive four-stage problem-solving technique for continuous improvement of processes or carrying out change. To ensure our providers are following the fidelity of the model and to provide support to the CQI process, the DCS Older Youth Initiatives team has added a data analyst. DCS OYI team has moved into phase 2 of implementing CQI as each provider is responsible for implementing a CQI project.

DCS Older Youth Initiatives program is collaborating in an Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CoIIN) with the Indiana State Department of Health (ISDH) - Maternal & Child Health program. The CoIIN project focuses on adolescent and young adult health. This project emphasises well-being strategies and evidence-informed strategy measure to increase the quality of preventive services for adolescents and young adults. The collaboration includes the youth being a part of the Indiana CoIIN team for the

duration of the project.

The Older Youth Initiatives Manager, Independent Living Specialist, and OYI Operations Analysis have participated in various roundtables through Capacity Building Center for States to address Independent Living program system improvements and best practice. DCS has been an intricate part of the NYTD workgroup as a presenter in webinars providing information on NYTD evaluations, outcomes, and lesson's learned. Other workgroups include: Services and supports for youth adults in extended foster care, transition planning documentation. Indiana DCS has been a part of the planning committee for the National State/Tribal Chafee and ETV Coordinators Meeting which is being held on June 19th and 20th.

6. 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 of Indiana. 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 efforts to increase YAB participation and meet the needs of youth, YAB meetings are held in different locations across the State.

Over the past year, fourteen (14) YAB meetings were held with 84 youth participants. YAB members also participated in twenty (20) community engaging events. YAB events consisted of participating in a parenting conference panel, presenting at the 3CM/provider training, the Indiana Connected by 25 Board of Directors Meeting, GAL/CASA Annual Conference, and various other conferences and trainings. On July 1, 2016, DCS entered into a new contract with the same YAB vendor that had been used previously, Indiana Connected by 25, Inc.

The vendor is required to hire an adult facilitator to facilitate meetings which includes planning, preparation for meetings, recruitment activities, arranging transportation for youth, and other activities related to facilitating YAB meetings. The vendor manages five regional boards and one state board.

The YAB is designed to give youth ages 14 to 21 (or 23 if youth is receiving ETV funding), the opportunity to practice leadership skills and learn to be advocates for themselves and others. The goal(s) of YAB are to provide an avenue whereby youth in care can inform DCS staff, placement facilities, foster parents, policy makers, and the public on the issues that impact teens and young adults in the foster care system. Fostering YAB development and youth participation will also further enhance collaboration, cultural competence and permanent connections with other youth and adults as they engage in the YAB process. This program will also assist with preparing youth as they transition from adolescence to adulthood by recognizing and accepting personal responsibility, increasing well-being, and developing leadership skills.

Each Regional Youth Advisory Board will meet at the least 3 to 4 times annually. Meetings will include the following: (1) an orientation meeting and training for new members and as a refresher of the goals of the YAB as provided by DCS, the contractor selected to facilitate the YAB, and/or national consultants; (2) a discussion of ideas related to services provided to foster youth and develop recommendations to the State Older Youth Initiatives Manager or designee; and (3) a discussion about the YAB annual work plan and ways to implement this plan. Additional meetings can be held to address upcoming projects to meet the needs and goals of each regional board. Youth will be encouraged by DCS and supported to participate in other conferences or DCS events occurring

throughout the year and their involvement may exceed prescribed annual meetings. However, the YAB shall not exceed over 21 meetings annually, this includes the yearly conference.

At least one youth from each Regional Board will be selected to participate in one conference per year as a State-wide Youth Advisory Board member. The conference will be of the Board's choosing. The state-wide YAB youth will participate in a preconference meeting with an overnight stay to finalize plans for participation in the conference. State-wide board members will be supported by DCS to ensure the youth's full participation.

A childcare allowance of \$25 per meeting will be available for any participating YAB member that requires child care assistance for their children. For those with multiple children, additional amounts may be approved by DCS. Financial stipends of \$30 will be provided to each YAB member participating in meetings as well as hotel expenses and meals for overnight stays. The State mileage rate will be made available for transporting the youth to the meetings. A stipend of \$25 and hotel expenses will be provided for the youth's caregiver/transporter for overnight stays with the youth also. Sign-in sheets will be maintained for each meeting. They will be completed by the youth participants and include each participant's name, contact phone number, and address.

DCS will support conference calling capability, on occasion, to enable the YAB to continue to move their Work Plan forward, to meaningfully engage YAB members in planning activities and to further connections and relationship building among members and staff.

7. Additional Collaborations

In addition to the work occurring with the RSCs, DCS holds regular meetings with provider workgroups to monitor data, assess areas for improvement, and implement strategies to improve outcomes for families and children.

The current areas of focus for current provider workgroups include:

Community Mental Health Centers

- Improve access to mental health services for children outside the child welfare system through the Children's Mental Health Initiative. DCS has implemented access sites in all 92 counties with the opportunity to assist with wraparound services through the CMHC's and other Wraparound certified agencies throughout the State through the Children's Mental Health Initiative.
- Improve access and effectiveness of substance abuse treatment services.

Psychotropic Medication Advisory Committee

- The Indiana Psychotropic Medication Advisory Committee (PMAC) was launched in January, 2013. The PMAC is an oversight committee that meets quarterly to review the psychiatric treatment of DCS-involved youth, with a specific focus on psychotropic medication utilization patterns. This committee includes representatives from IUSM Department of Psychiatry, DCS, OMPP, FSSA, DMHA, pediatricians, social workers, psychologists, pharmacists, child advocates and other identified stakeholders. The PMAC monitors Federal legislation, reviews best-practice guidelines for psychotropic medication use, monitors Indiana prescription patterns, reviews formularies and makes policy recommendations to DCS and OMPP.
- Specific responsibilities of the committee include the following:

- Review the literature on psychotropic medication best practice (e.g., AACAP) and provide guidance to DCS, OMPP, IUSM and prescribing providers;
- Provide assistance to DCS in establishing a consultation program for youth in state care who are prescribed psychotropic medications;
- Publish guidelines for the utilization of psychotropic medications among DCS-involved youth, with revisions made on a semi-annual basis, as needed;
- Publish a DCS Approved List of Psychotropic Medications that contains a comprehensive listing of medications (generic and brand) approved for use with DCS-involved youth;
- Review DCS policies for requesting and obtaining consent to treat DCS-involved youth with psychotropic medications and make recommendations for change to DCS Permanency and Practice Support Division; and
- Identify non-pharmacologic, evidence-based mental health treatments for DCS-involved youth.
- 2017 PMAC membership:
 - Elayne Ansara, PharmD, Pharmacist, Roudebush VA Medical Center
 - Sirrilla Blackmon, Deputy Director, Division of Mental Health and Addictions
 - Melissa Butler, PhD, Clinical Psychologist, LaRue Carter State Hospital
 - Joseph Combs, Assistant Deputy Director, Indiana Department of Child Services
 - Lynn Doppler, MA, Chief Operating Officer, Youth Opportunity Center
 - Cathy Graham, Executive Director, Indiana Association of Resources and Child Advocacy
 - James Hall, PhD, LCSW, Professor of Pediatrics and Social Work, IUSM
 - Emily Hancock, RPh, PharmD, MPA, Chief Pharmacist, Office of Medicaid Policy and Planning
 - Lori Hines, RN, Nurse, IU Child Protection Program, Riley Hospital for Children
 - Leslie Hulvershorn, MD, Child Psychiatrist, Department of Psychiatry, IUSM
 - Reba James, Deputy Director, Indiana Department of Child Services
 - Thomas Lock, MD, Developmental-Behavioral Pediatrician, Riley Hospital
 - John Ross, RN, RPh, Pharmacist, Office of Medicaid Policy and Planning
 - Ty Rowilson, PhD, Clinical Psychologist, Indiana Department of Child Services
 - Sarah Sailors, Southern Executive Manager, Indiana Department of Child Services
 - Jennifer Tackitt, Program Director, Choices Coordinated Care Services
 - Kelda Walsh, MD, Child Psychiatrist, Department of Psychiatry, IUSM
 - Vinita Watts, MD, Child Psychiatrist, Centerstone Community Mental Health Center

Fatherhood Providers

- Improve engagement of fathers through inclusion in case planning, Child and Family Team Meetings, visitation, and services. DCS has implemented a process for incarcerated father's to have phone contact with their children through the JPay system. Monthly meetings are held with providers to continue developing the program and review data from the QSR and CFSR to identify opportunities for improvement.

Home-based Providers

- In 2015-2016, DCS worked with the home-based coalition subcommittee to develop a core set of curricula for all home-based workers. Qualifications and training were created for bachelor level staff who had

experience and could be promoted to a managerial role over home visiting staff.

- Improve communication and information sharing between providers and DCS.
- Improve training for home-based workers. The group piloted a core set of curricula that will be required for all home based workers.
- Update qualifications for home based providers and supervisors.
- Improve communication and information sharing between providers and DCS.

Indiana Association of Resources and Child Advocacy (IARCA)

- In 2016-2017, DCS and IARCA met approximately every other month, with specific focus on addressing capacity building, both in terms of expanding the availability of programs and in terms of expanding the service array.
- Address residential and LCPA rate setting issues
- Address capacity building within the public and private sector
- Improve quality of programs available in Indiana
- Address placement disruptions and requests for transfer of a child before completion of treatment
- One focus for the next year will be on workforce development for direct care workers within residential facilities, which has become a challenge for agencies as many workers have other employment options. At the annual IARCA Conference in the fall of 2017, a presentation will take place that discusses the recent Round 3 CFSR and program improvement plan (PIP) process so that service providers can learn how they can help improve the state's child welfare system. Additionally, service provider members that took part in the CFSR and PIP process will provide insight into what they learned.

Licensed Child Placing Agencies

- DCS continued the monthly telephone calls in 2016-2017, discussing a variety of topics including psychotropic medication administration, placement matching, recruitment, and foster parent training
- Improve quality of services provided to children placed in licensed foster home settings.
- Improve relationship and communication between DCS and LCPAs.

Residential Providers

- DCS continued the monthly telephone calls in 2016-2017, discussing a variety of topics, including psychotropic medication administration and consents, communication of Medicaid concerns, and feedback on proposed program service categories for residential facilities
- Improve access to high quality residential services
- Improve relationship and communication between DCS and residential providers.
- DCS has started a workgroup of providers who are currently serving youth who are victims of human trafficking, specifically sex trafficking. The group will focus on 1) developing best practices and service standard guidelines for consideration by DCS as they share treatment successes and setbacks, and 2) identifying gaps in the continuum of care for this population so that DCS can adequately address the gaps

CANS Steering Committee (DCS and Dr. Betty Walton, Division of Mental Health and Addictions)

- Delivery of CANS Education and Support to all Field Staff
- Development of CANS Super User Training for DCS Supervisors
- Development of reports for evaluation and tracking
- Continuous review of CANS projects such as the Breakthrough Series
- Participants on Steering committee include: Services and Outcomes Deputy, Field deputy, Managers of Data Management, Clinical Manager, Field Regional Managers – and the outside partner is Dr. Betty Walton from DMHA.
- Continued Collaboration with the Center for Child Trauma Assessment and Service Planning (CCTASP) and Family Informed Trauma Treatment Center (FITT) with partners from the Breakthrough Series Collaborative (BSC) specialty at Northwestern University Feinberg School of Medicine in their efforts to promote trauma-focused, family informed comprehensive assessment and applications in practice through the use of the CANS

Mexican Consulates

- DCS has been increasingly serving children in immigrant families, in which at least one parent or child are foreign born. In order to improve effective child welfare practices when working with these challenging cases, DCS established the International and Cultural Affairs program that is responsible for supporting DCS staff and collaborating with various foreign consulates. Systematization of procedures for collaboration has mainly been with Mexico as most of the foreign born children in DCS custody and the majority of the parents involved with DCS are Mexican nationals. DCS also collaborates with other consulates on a case by case basis.
- The International and Cultural Affairs Liaison holds meetings on a *monthly basis* with the Consulate of Mexico in Indianapolis. These meetings are mainly held with the assigned Consular agent of their Protection Department, Rosa Vidal Márquez. DCS has established a positive working relationship with the Mexican Consulate in Indianapolis and communication is frequent. These meetings focus on the review of relevant cases. Mexico also provides various types of assistance including, obtaining a home study for a parent/relative in Mexico who's considered for placement, repatriation procedures, contacting and verifying location of a parent in Mexico, referring to services in Mexico, establishing DNA paternity when father's in Mexico and obtaining vital records for Mexican Nationals among the most frequently used.
- The International and Culture Affairs Liaison also holds meetings periodically with the Consulate General in Chicago. These meetings are mainly held on a case by case basis with the assigned consular agent of the Protective Department, Nancy Valdez or Ana Munoz. Specifically, the counties of Adams, Allen, Benton, Cass, De Kalb, Elkhart, Fulton, Huntington, Jasper, Kosciusko, La Porte, La Grange, Lake, Marshall, Miami, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Wabash, Wells, White, Whitley. The remaining Indiana counties are under the jurisdiction of the Consulate of Mexico in Indianapolis.
- To promote effective collaboration in cases involving Mexican nationals DCS and Mexico developed and signed a Memorandum of Understanding (MOU) in 2011. Per this MOU the parties agree "...to join efforts to treat, with special care, the high number of Children in Need of Services (herein after "CHINS") cases involving Mexican minors located in U.S. territory, through the development of a bilateral mechanism that allows for the early identification of said minors and facilitates the exercise of the consular function

referred to in the Vienna Convention and the Bilateral Convention;”.

- Meetings held periodically with the Mexican Consulate offices are used to consult on specific cases and improve collaboration.

Indiana Office of Court Services (ICS)/Court Improvement Program

- Juvenile Detention Alternatives Initiative (JDAI) – DCS collaborates with the ICS (along with other state agencies) in the implementation and rollout of JDAI statewide.
- During the Round 3 CFSR, Angela Reid-Brown, Court Improvement Program Manager, participated as a reviewer and program improvement plan stakeholder.
- Dual System Youth (DSY) – As a certain percentage of youth are identified in both the juvenile delinquency and CHINS systems, DCS has collaborated with ICS on the implementation of pilot sites to develop policies, procedures, and best practices for dual status youth. Furthermore, new legislation will be going into effect on July 1, 2016 which DCS and ICS collaborated on which helps define dually identified, dually involved and dually adjudicated youth.
- Court Improvement Program Child Welfare Improvement Committee – Pursuant to ACYF-CB-PI-16-05, the following DCS representatives are new members of this multidisciplinary committee: Jane Bisbee, Deputy Director of Field Operations, Reba James, Deputy Director of Permanency Practice and Support, Kyle Gaddis, Federal Reporting and Compliance Manager, and LaTrece Thompson, Deputy Director of Staff Development. These DCS members are able to provide information to the committee around DCS initiatives and relevant updates.
- Court Improvement Program Collaborative Conference: Above & Beyond Helping Youth Achieve Permanency – On May 25, 2017, stakeholders from across the state, including many from the judiciary and DCS, participated in and/or attended this important event to meet and discuss the role everyone plays in helping Indiana youth achieve permanency.

Governor’s Task Force on Drug Enforcement, Treatment, and Prevention

- Director Bonaventura was a member of the Governor’s Task Force on Drug Enforcement, Treatment, and Prevention Task Force to evaluate the growing drug problem in Indiana. The Task Force was tasked with performing a statewide assessment by looking at enforcement, treatment, and prevention services and presenting recommendations to the Governor. A copy of the Task Force’s final Report can be found at http://www.in.gov/gtfdetp/files/Governors_Drug_Task_Force_Final_Report.pdf.
- Following the final report and pursuant to legislation, the Indiana Commission to Combat Drug Abuse was created and began meeting in December 2016. The new 18 member commission made up of mainly department heads is focused on directing policy and working with the legislature. Director Bonaventura will continue to be a member of this important Commission.

Indiana Protection for Abused and Trafficked Humans (IPATH)

- DCS is partnering with other Indiana agencies as a member of Indiana Protection for Abused and Trafficked Humans (IPATH) Task Force. DCS is working with IPATH to provide training on human trafficking throughout the state of Indiana. DCS also works with members of IPATH on individual cases to ensure collaboration

regarding interviews and services for victims and to assist in investigations and prosecution. Members of IPATH task force now include:

- Indiana Office of the Attorney General
- Department of Homeland Security (DHS), Homeland Security Investigations
- Federal Bureau of Investigations (FBI)
- Indiana Metropolitan Police Department (IMPD)
- Greenwood Police Department
- Elkhart Police Department
- Indiana Department of Child Services (DCS)
- Internal Revenue Services (IRS), Criminal Investigations
- Indiana State Police (ISP)
- Johnson County Juvenile Probation Department
- Marion County Prosecutor's Office (MCPO)
- Neighborhood Christian Legal Clinic
- Restored
- Purchased
- The Salvation Army DHQ, (the Ruth Lily Women and Children's Center)
- US Department of Labor, Wage and Hour Division
- United States Attorney's Office, Northern District (USAO – ND)
- Ascent 121

Indiana Supreme Court Commercial Sexual Exploitation of Children Assessment Group

- The Indiana Supreme Court established a Commercially Sexually Exploited Children (“CSEC”) Task Force in early 2016 in order to establish a statewide uniformed assessment tool and process for identifying and working with youth who are victims of human trafficking. Heather Kestian – Collaborative Care Manager, Corinne Gilchrist – Deputy Director of Placement Support and Compliance, Jane Bisbee – Deputy Director of Field Operations, Don Travis – Deputy Director of Juvenile Justice Initiatives and Support, and June Artis – Manager, Residential Licensing and Contract Compliance all represent DCS on the Task Force. Other members include representatives from the judiciary, probation and correction officers, law enforcement, prosecutors and public defenders, and other public stakeholders. DCS’ independent work on its assessment tool prior to creation of the CSEC Task Force has played a pivotal role in the overall work. The CSEC Group priorities of creating a user specific screening guide to assist law enforcement, medical practitioners, and teachers in identifying possible victims and providing hotline information have been substantially completed. The screening guides continue to be refined as pilot counties begin implementation.

SNAP Council (DCS, SAFY, Children’s Bureau, Villages, and Wendy’s Wonderful Kids recruiters)

- Presentation of prospective adoptive families for recommendation for Special Needs Adoption Program and review of children eligible for adoption

Case Commons/MaGIK Collaboration

- Discussions with Case Commons, a non-profit private organization launched by the Annie E. Casey Foundation and the developer of Casebook, occur on a regular basis with senior DCS management and with the DCS MaGIK Development and Maintenance team in order to continue identifying ways to further enhance the system to support improved outcomes for children and families and improved access to reliable data for reporting purposes.

II. UPDATE ON ASSESSMENT OF PERFORMANCE

Per the instructions on page 6 of Program Instruction ACYF-CB-PI-17-05, for Indiana's Update on Assessment of Performance (and Systemic Factors), please see Indiana's Round 3 CFSR Statewide Assessment submitted in April 2016 and the corresponding Final Report issued in early 2017. Indiana's CFSR Statewide Assessment and Final Report can be found on the DCS website at the following link: <http://in.gov/dcs/3883.htm>. Indiana is currently finalizing its PIP data plan in collaboration with the Children's Bureau Measurement and Sampling Committee (MASC). To measure PIP compliance, Indiana's PIP data plan will incorporate the CFSR Onsite Review Instrument while maintaining certain portions of Indiana's preexisting Quality Service Review (QSR) process.

III. UPDATE TO THE PLAN FOR IMPROVEMENT AND PROGRESS MADE TO IMPROVE OUTCOMES

As previously mentioned, Indiana completed Round 3 of the CFSR on June 6-10, 2016. A presentation was arranged in January of 2017 for Children's Bureau to present to DCS staff and selected child welfare stakeholders their findings from the review. Following the presentation, Indiana began formal PIP development with child welfare stakeholders who were split into teams that focused on safety, permanency, well-being, and probation. PIP development is ongoing and once approved will be incorporated into this section for future APSRs.

DCS was under an AFCARS Improvement Plan (AIP) as the result of the AFCARS Assessment Review (AAR) conducted by the Children's Bureau in 2008. While working through the AIP, Indiana began working towards a new information system. As a result, the AIP was suspended to allow Indiana to focus on this new system, and also because it was realized that the new system would help to alleviate some of the issues found with the old system that affected AFCARS reporting. In July, 2012 Indiana launched its new information system, Management Gateway for Indiana's Kids (MaGIK).

In 2013 Indiana voluntarily requested technical assistance (TA) to verify that MaGIK was accurately collecting AFCARS data and that the extraction code was accurately reporting the data. The National Resource Center for Child Welfare Data and Technology (NRC-CWDT) provided technical assistance, and a site visit was conducted in October 2013 under the auspices of the Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families (CB/ACYF/ACF). The purpose of the visit was to: (1) gain an understanding of aspects of State policy and practice that may impact the quality of AFCARS data; (2) evaluate the capability of Indiana's current data collection processes and case management system to provide accurate data reporting to AFCARS; and (3) present recommendations to help ensure that the AFCARS reporting process meets Federal requirements.

The TA resulted in a report of suggested changes to improve data quality and reliability. Indiana worked closely with the Children's Bureau to implement changes to its extraction code and any possible system changes. In early

2017 negotiations for a new AIP have begun to help transition Indiana to AFCARS 2.0. The AIP is still currently being reviewed. Updates regarding the National Youth in Transition Database (NYTD) are detailed in Section XII(B)(4).

A. SAFETY GOALS, OBJECTIVES AND INTERVENTIONS

Goal 1: Ensure the safety of children through timely informed decision-making beginning at initial assessment and continuing throughout the life of the case.

DCS core mission is to protect children from abuse and neglect. In order to ensure the Department is successful in fulfilling that mission, DCS used information from a variety of resources to evaluate its strengths and opportunities for improvement in the policies, processes, training, services and other resources the agency uses to ensure child safety.

The Biennial Regional Services Strategic Planning process is one example of the ways in which DCS identified areas of focus for the goals and objectives outlined below. Data evaluated by DCS regions as a part of the Biennial Regional Services Strategic Plan (BRSSP) process, and discussions with local stakeholders in reviewing this data, helped to identify service gaps, not only in individual regions, but allowed agency leadership to identify those gaps that existed throughout the State.

A few examples of data and information used to develop the objectives outlined in this section include:

- Results from the Indiana University Needs Assessment Survey for both FCMs and community members compiled as a part of Indiana’s Title IV-E Waiver Evaluation.
- Standardized Decision Making (SDM) Safety and Risk Assessment data, which identified a high frequency of substance abuse being identified as a risk factor in substantiated cases of abuse and neglect, consistent with information gathered through the BRSSP process, which supported service gaps in substance abuse assessment and treatment services.
- Review of Children’s Mental Health Initiative (CMHI) cases and discussions with the Multi-Disciplinary Team about service gaps for children who have very complex mental health, physical health and/or developmental delays / intellectual disabilities.
- Information from the Individual Training Needs Assessment (ITNA) Survey, as well as the FCM Field Mentors and FCM Supervisor Training Skills Assessment Scales on the effectiveness of new FCM training and ongoing training needs for experienced staff.
- The CFSR identified issues in both the timeliness of initial investigations and ongoing safety monitoring and evaluation. To reflect these issues, the goal has been updated with language to focus on both the timeliness of initial investigations and ongoing monitoring. Activities in the approved PIP plan will also reflect a commitment to improving in these areas.

OBJECTIVE 1.1 EXPAND UTILIZATION OF EFFECTIVE, PROVEN HOME-BASED SERVICES IN ORDER TO INCREASE THE NUMBER OF CHILDREN WHO CAN REMAIN SAFELY IN THEIR OWN HOMES AND TO REDUCE THE INCIDENCE OF MALTREATMENT FOR CHILDREN INVOLVED IN THE CHILD WELFARE SYSTEM.

a)Identify ways to monitor the utilization and effectiveness of services employed during the assessment phase.

This objective is ongoing. DCS has currently opened up a number of services that are provided in the assessment phase which can be a critical time for families and children. These services were made available in an effort to support families so that children and youth can be maintained at home and families are not entering the child welfare system. The services include:

- Homemaker
- Home Based Casework Services
- Home Based Therapy
- Crisis Response Homemaker
- Crisis Response Home Based Casework
- Crisis Response Home Based Therapy
- Homebuilders
- Group Counseling
- Family Counseling
- Individual Counseling
- Step 1: Clinical Interview and Assessment
- Psychosexual Assessment
- Child Hearsay Evaluations
- Provider Administered Non-Random Situational Drug Screens
- Outpatient Services
- Step 1: Substance Use Disorder Assessment
- Batterers Services
- Victim and Children Services
- Child Advocacy Center Child Interview
- Tutoring
- Services for Truancy
- Step 1: Assessment for Sexually Maladaptive Youth
- Psychosexual Assessment completed by an D&E provider
- Parent Education
- Father Engagement Services
- Visitation Supervision
- Global Services
- Community Partners for Child Safety

DCS is also working through Family Evaluations for children and youth with mental and behavioral health needs in order to ensure they have the opportunity to receive services at critical junctures as well. DCS allows for two months of the above services to be provided to families through Family Evaluations in order to ensure children and families have supports while linking to other appropriate service delivery systems. Activities to develop methods for the utilization and effectiveness will continue over the next year.

b) Train service providers on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Motivational Interviewing and Family Centered Treatment.

This objective is complete and implementation of training is ongoing. Family Centered Treatment Foundation, through a contract with DCS, trained service providers on family centered treatment in order to provide internal provider trainings when they have new staff join their agency. These programs were implemented as part of the Comprehensive Home Based Service array. DCS has tracked referrals to these programs from inception to date.

See table below for the number of referrals to each service. DCS also provided motivational interview training for Homebuilder practitioners and START team members.

c) Complete service mapping to ensure that children at high risk of maltreatment are recommended for the appropriate evidence-based service(s) based on the individually identified needs of the child and family.

This objective is complete. Service mapping is completed and enhancements are ongoing. See Service mapping section of this report for a full description. In addition, DCS Clinicians are providing consultation where there are questions or concerns regarding clinical risk factors.

d) Educate field staff on the availability and appropriateness of evidence-based services.

This objective is complete and implementation is ongoing. When Field staff utilize service mapping, the mapped recommendations contain a description of the evidence based model.

Number of Cases Referred: January 1 - June 6, 2017	
Children’s Mental Health Initiative	
Number of Clients Served	2,152
Comprehensive Home-Based Services	
Cognitive Behavioral Therapy	14
Family Centered Treatment	203
Intercept	61
Motivational Interviewing	131
Trauma Focused Cognitive Behavioral Therapy	40
Alternatives for Families Cognitive Behavioral Therapy	2

OBJECTIVE 1.2 EXPAND DCS SERVICE CAPACITY TO MEET THE NEEDS OF DCS INVOLVED CHILDREN WITH DEVELOPMENTAL AND INTELLECTUAL DISABILITIES, AS WELL AS THOSE WITH SIGNIFICANT MENTAL HEALTH ISSUES.

a) Collaborate with the Bureau of Development Disabilities Services to maximize access to available services and identify gaps that exist for children both within the child welfare and probation systems, as well as those outside of the systems in an effort to prevent their entry into foster care.

This objective is complete. DCS developed an Enhanced Multi-Disciplinary Team (EMDT) which consists of representatives from multiple Indiana agencies including DCS, Division of Mental Health and Addictions, Medicaid, Bureau of Developmental Disability Services, Division of Aging, and Department of Corrections. This group has been researching best practices related to serving this population effectively in the community.

The EMDT has selected a provider and DCS is in negotiations with that provider with the hope that the contract will be in place by the end of 2016. While the EMDT had originally planned to identify a provider, those plans were put on hold. However, select residential facilities did expand services to serve this population.

b) Collaborate with the Bureau of Development Disabilities Services (BDDS) and the Division of Mental Health and Addictions (DMHA) services to ensure children who are dually diagnosed have appropriate service access.

This objective is complete and collaboration is ongoing. The EMDT continues to meet monthly and research best practices and anticipates the pilot project will be helpful in determining appropriate services. This team was developed to ensure state agencies are coordinating services and children are not falling through cracks in service systems. One particular partner that will be added in 2017 is the Indiana Department of Education, which is a key partner in looking at early childhood education through post-secondary success.

c) Develop capacity within the Community Mental Health Center (CMHC) service system to provide high fidelity wraparound services to manage care and service access for children with mental health issues to prevent their entry into foster care.

This objective is complete. DCS continues to work with the DMHA and the CMHCs to implement high fidelity wraparound services. These services are currently available state wide. DCS has also reached out to the non-CMHC's throughout the State who provide high fidelity wraparound services. They are now providing services to children, youth and families in the CMHI in an effort to increase providers. DCS will issue another Request for Proposal if needed and appropriate to secure additional wraparound providers outside of the CMHC system.

d) Collaborate with DCS providers to develop interest in serving this population.

This objective is ongoing. DCS has been meeting with providers individually and discussing various needs on the monthly provider calls. In 2016-2017, DCS opened a new type of program service category, designed to quickly stabilize and provide diagnostic information for children in crisis. The program is called Stabilization and Diagnostic Services, and is a 60 day maximum program, with the goal being that the program serves children who are cycling in crisis but are not appropriate for acute admission. The program result should be stabilization, some skills building with the children, and a diagnostic evaluation and recommendation of the next step for the child. The program, which has a focus on children for whom there is some question as to whether developmental or intellectual disability exists, opened in late 2016 so long term results are not yet known. DCS also had other residential programs providing developmental and intellectual disability program service categories in 2016-2017.

e)Develop additional residential, group home, foster care and community-based service and treatment capacity.

This objective is ongoing. See a. for a description of the pilot program being planned for Central Indiana. Additionally, DCS is looking forward to exploring the kinship navigator authorized under the new Families First Act.

f)Ensure youth aging out of care have access to appropriate transition services for emerging adults.

This objective is ongoing. The Collaborative Care program ensures there is specialized case management of older youth cases. Processes and procedures are in place to transition youth into adult services provided by the Bureau of Developmental Disabilities Services. There is still a need to address youth transitioning from children’s mental health services into adult mental health services. DCS is working closely with the Managed Care Entities (MCE) to determine what role they may play in assisting with this transition and also with monitoring health services. The MCE’s are developing incentive programs to encourage youth to become more engaged in their health care and more consistent in their utilization of preventive services.

g)Expand expertise in infant mental health by supporting 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) to ensure that all Indiana families with very young children have access to well-trained providers in their home communities.

This objective is ongoing. DCS is collaborating with Mental Health America Indiana, the endorsement agency in Indiana, to provide the necessary reflective supervision to HFI mental health clinicians to encourage and promote obtaining the IAITMH endorsement and increase the endorsement among home visiting staff.

During the DCS hosted bi-annual conference - The Institute for Strengthening Families Institute - in April 2016, sessions were conducted by IAITMH, regarding infant mental health. The Institute is open to all home visiting programs throughout the state.

OBJECTIVE 1.3 RE-EVALUATE AND UPDATE TRAINING CURRICULUM FOR NEW FAMILY CASE MANAGERS TO ENSURE NEW FCMS HAVE THE BASIC SKILLS AND KNOWLEDGE TO ENSURE CHILD SAFETY AND SUPPORT POSITIVE OUTCOMES FOR CHILDREN AND FAMILIES.

a)Evaluate the role of peer coaches and field consultants in supporting new FCMS and helping to facilitate their skill development.

This objective is complete. Effective with the new Pre-service training design (January 2015), Peer Coach Consultants provide a 1 day training on Child and Family Teaming in Unit 2. The Peer Coach Consultants then provide oversight within the regions for the Peer Coaches as they train new cohort members as facilitators of Child and Family Team Meetings. This is now completed within pre-service training so that cohort members are trained facilitators prior to graduation from pre-service, instead of receiving their facilitator certification subsequent to pre-service training. Cohort members are then able to conduct CFTMs immediately upon being assigned a caseload.

b)Identify opportunities to maximize knowledge-based learning through online training.

This objective is complete. Effective with the new Pre-service training design (January 2015), there are 28 computer assisted trainings (CATs) for cohort members to complete throughout their 58 days of pre-service training. The CATs are completed at the base office of each participant and reviewed with their supervisor and mentor as part of the TOL Activities Checklist. Specific CATs are to be completed prior to specific classroom training units so that the learning achieved through completion of the CATs, discussions with the Supervisor and Mentor, and field observations can become a basis of discussion for the classroom activities that take place in each of the curricula areas. These various activities reinforce the various learning styles of adult learners.

In 2016, there were two additional computer assisted trainings (CATs) offered in Cohort training for a total of 30 CATs that are mandatory to be completed prior to graduation. By utilizing online training new FCMs are able to spend more time at their base county interacting with their peers, mentors and supervisors as they debrief their new development areas. Additionally there are online trainings accessible to experienced FCMs, supervisors, county directors and regional managers on the Enterprise Learning System. All staff are able to access these trainings in order to obtain training hours for their annual training requirement.

- c) Incorporate training on the safety and risk assessments into new FCM training to ensure that new FCMs have the skills they need to evaluate risk and ensure child safety.

This objective is complete. During Unit 1 - Activities at the base office, new FCMs observe an experienced FCM completing an assessment including a Safety, Risk and Family Strengths and Needs assessment in MaGIK. New FCMs will discuss their responses with the experienced FCM and the Field Mentor as part of the TOL Activities. This learning is reinforced during classroom activities using real case scenarios and facilitated classroom discussions.

Safety and Risk assessments continue to be part of the Transfer of learning (TOL) activities that are required in order to graduate from new worker Cohort training as stated above. Safety outcomes for children, as measured by the two most recent rounds of Quality Service Reviews, had scores of 99 percent and 98 percent respectively in Refine/Maintain. This indicates that Indiana continues to make good safety decisions for children. In addition to working with these assessments during TOL, and completing paper copies during classroom training, this fall the training module of MaGIK will have electronic copies of these forms to enable completion electronically. This will more closely replicate the “real world” process and eliminate the necessity of using paper forms in training.

- d) Incorporate training on the Child and Adolescent Needs and Strengths (CANS) assessment tool to ensure new FCMs have the skills to appropriately address child trauma and service needs particularly for targeted populations (children age 0-5).

This objective is complete. Prior to graduation, each cohort is required to complete the Child and Adolescent Needs and Strengths Assessment (CANS) Certification. This is completed as part of the TOL Activities, with oversight provided by the Supervisor and the Field Mentor. Once they are certified, new FCMs assist their Field Mentor, or an experienced FCM, complete a Comprehensive CANS and case plan for a family. New FCMs are assigned a couple of cases prior to graduation so they can apply what they have learned to actual cases under the guidance of their Supervisor and Field Mentor.

Completion of the Child and Adolescent Needs and Strengths Assessment (CANS) Certification continues to be a requirement prior to graduation from the cohort training. This certification is done in conjunction with the

Supervisor and Field Mentor during the TOL process. Once new FCMs are certified, these skills are applied to the cases assigned to them during training. A MaGIK report is generated that lists all cases that have not had a CANS in order to monitor CANS completion on each case. The quality of completion of CANS is monitored by supervisory oversight. In addition, a review of the CANS on cases that are presented to the Regional Placement Review Teams is completed as one of the case file documents. Three additional CANS trainings are offered to staff to ensure continuous improvement. CANS 101 and 102 are for both FCMs and supervisors. CANS 201 is for supervisors only.

The length of time a CANS certification is good for is dependent on the score the person received when they took the certification test (recertification range is from 6 months to 2 years). Individuals who are required to maintain CANS certification must recertify prior to their current certification expiring.

OBJECTIVE 1.4 IMPROVE ACCESSIBILITY AND EFFECTIVENESS OF SUBSTANCE USE DISORDER TREATMENT.

a) Document available evidence-based practices for the treatment of substance use disorders and determine service gaps, including services available for older youth.

This objective is complete and evaluation is ongoing. DCS partnered with Jeff Jamar, Behavioral Health Consultant for Children and Family Futures to conduct a survey of the Community Mental Health Center's (CMHC). The purpose was to survey Indiana's Community Mental Health Centers regarding the services they were providing to DCS clients who needed assessment and treatment for Substance Use Disorder (SUD). Several themes emerged from those surveys which were the focus of an all-day joint meeting in August 2016 with all Indiana CMHC leadership and DCS leadership to review these themes and to develop regional action plans based on that review. In addition, Dr. Nancy Young of Child and Family Futures was invited and presented on substance exposed infants and Medication Assisted Treatment (MAT).

b) Collaborate with Community Mental Health Centers to educate DCS and CMHC staff on the effects of substance use disorders on children, best practices in substance abuse disorder treatment, and to develop local initiatives to address service gaps and improve outcomes for families.

This objective is complete. This objective was completed during the annual meeting with the Community Mental Health Centers in July 2014. Nonetheless, collaboration continues as DCS and the CMHCs addressed ongoing efforts to combat these issues at a joint summer conference in August 2016 (see above).

c) Continue collaboration with the Commission on Improving the Status of Children Substance Abuse and Child Safety Task Force to (1) evaluate the availability of services; 2) determine the best evidence-based treatment programs, and 3) determine the best evidence-based prevention programs.

This objective is ongoing. As detailed in the Collaboration section above, DCS continues to participate with other stakeholders on this subcommittee. In addition, the Commission has released its Annual Report which can be reviewed at <http://www.in.gov/children/files/cisc-2017-annual-report.pdf>

d) Develop an annual, mandatory staff training on substance abuse disorder and the impact on children, particularly drug-exposed infants and young children (ages 0-5).

This objective is complete. This training has been developed and was mandatory for all staff beginning January 1,

2016. During the period of July, 2016 – June, 2017 Substance Use training was scheduled into the super regions around the state for easy accessibility to this mandatory training. Additionally, cohort members are required to complete a Substance Abuse CAT as one of their TOL activities prior to graduation.

e) Implement the Sobriety Treatment and Recovery Teams (START) program in appropriate communities.

This objective is complete and rollout is ongoing. DCS continues to work with its partners in rollout of the START program and the pilot counties are beginning to take on their first cases. The START program has been operating as a pilot program in Monroe County and is currently in the start-up phase in Vigo County. In addition to the START local committees which meet monthly, DCS implemented a START Central Steering committee to assist with the rollout and plan for additional communities. This committee focuses on statewide data as well as what is happening in the pilot communities, The committee is responsible for ensuring that the program is adequately supported from a central administration viewpoint. Also, through support from Casey Family Programs, DCS now has the support of a consultant from Child and Family Futures to assist substance use disorder providers to develop their services to meet the needs of child welfare involved families. Monitoring and evaluation activities are currently taking place and a third pilot location is under consideration utilizing data and input from regional partners.

f) Consider service mapping to available evidence-based practices to ensure that families are referred to appropriate services based on their individually identified needs.

This objective is not complete. Service mapping is in place, but does not yet include substance use disorder services. The estimated start date is January 2018. Furthermore, the PIP will include activities on introducing probation staff to service mapping in order to train them on how it might improve the selection of appropriate services.

g) Review and realign new employee competencies and learning objectives to identify ways to streamline training content and ensure consistency with policy and practice.

This objective is complete. As part of the new hire initiatives, DCS Staff Development completed new hire training curriculum enhancements that incorporated this objective.

OBJECTIVE 1.5 BUILD STAFF COMPETENCY IN ENGAGING, ASSESSING AND WORKING WITH DOMESTIC VIOLENCE (DV) OFFENDERS TO APPROPRIATELY EVALUATE RISK AND PROMOTE SAFETY.

a) Review and revise existing policy, practice guidance and training to more clearly align with best practice standards and eliminate inconsistent or confusing language.

This objective is complete. During the redesign of pre-service training in 2014 the review process for all curricula included a step for the Policy Unit to review the curricula, as well as included the opportunity for the design workgroup to review and include best practice and ask questions regarding policy areas that were unclear. This process served both to ensure that the curricula was consistent with policy and practice and also provided an opportunity for the Policy Unit to re-write those areas that might be unclear to end users.

Design Workgroups continue to be used to align policy, practice and training. For example, Supervisor Core was redesigned and implemented during this past report period. The workgroup used to assist with the redesign

included field managers, policy managers, curriculum designers, program managers, training supervisors and central office subject matter experts. This is a process that has been successful in improving our practice, policy and training products.

b)Expand DCS policy, practice and training to include an emphasis on working with DV offenders.

This objective is complete. DCS completed updates to DV training and working with DV offenders, including guidance on holding a CFTM when DV is identified within the family and prepping for a CFTM with the alleged offender when it has been determined to be safe to hold a CFTM with the offender and victim. Also included is the incorporation of the Power and Control Wheel and Equality Wheel. DCS Policies on this topic include:

- Policy Tool 4.3 – Suggested Interview Questions for the DV Offender
- Policy 5.7 – CFTM When DV is Identified
- Policy Tool 5.1 – Suggested Alternatives when it is not possible to have both parties present at a CFTM.

Training continues to be provided to both new cohorts and experienced staff on working with families when DV is present. DV offenders are afforded separate CFTMs and case planning participation when it is not safely possible to hold these together with the DV victim. A Domestic Violence E-Learning Course is part of the TOL activities required in order to graduate from cohort. A one day training for experienced staff titled “Advanced Domestic Violence” was held in the super regions around the state during 2016. This training is scheduled again during 2017. A panel discussion which included DCS staff and DV community advocacy group members was presented at the 2017 Annual Director’s Workshop.

c)Strengthen local / regional collaborations with DV victim advocacy programs to improve DCS practice consistency and to enhance safety for families.

This objective is ongoing. DCS is collaborating with regional stakeholder groups to develop best practices around this topic.

OBJECTIVE 1.6 EVALUATE THE DCS SERVICE ARRAY AND MECHANISMS FOR PROVIDING QUICK ACCESS TO SERVICES DURING THE ASSESSMENT PHASE.

a)Evaluate the availability, utilization and effectiveness of crisis services to ensure children can be safely maintained at home.

This objective is ongoing. DCS has currently opened up a number of services that are provided through the assessment phase which can be a critical time for families and children. These services were made available in an effort to support families so that children and youth can be maintained at home and not have to enter the child welfare system. The services include:

- Homemaker
- Home Based Casework Services
- Home Based Therapy
- Crisis Response Homemaker
- Crisis Response Home Based Casework

- Crisis Response Home Based Therapy
- Homebuilders
- Group Counseling
- Family Counseling
- Individual Counseling
- Step 1: Clinical Interview and Assessment
- Psychosexual Assessment
- Child Hearsay Evaluations
- Provider Administered Non-Random Situational Drug Screens
- Outpatient Services
- Step 1: Substance Use Disorder Assessment
- Batterers Services
- Victim and Children Services
- Child Advocacy Center Child Interview
- Tutoring
- Services for Truancy
- Step 1: Assessment for Sexually Maladaptive Youth
- Psychosexual Assessment completed by an D&E provider
- Parent Education
- Father Engagement Services
- Visitation Supervision
- Global Services
- Community Partners for Child Safety

DCS is also working through Family Evaluations for children and youth with mental and behavioral health needs in order to ensure they have the opportunity to receive services at critical junctures as well. DCS allows for two months of the above services to be provided to families through Family Evaluations in order to ensure children and families have supports while linking to other appropriate service delivery systems.

DCS will also leverage the CFSR findings and PIP development to continue to address service gaps identified, such as substance abuse, mental health, domestic violence, and services to mentor youth.

b) Improve monitoring of service provider response times.

This objective is not yet initiated. Anticipated start date is the fall of 2017.

OBJECTIVE 1.7 IMPROVE COMMUNICATIONS WITH SERVICE PROVIDERS TO BETTER ENSURE CHILD SAFETY.

a) Ensure appropriate information is provided when a family is referred to a provider.

This objective is complete. The Regional Service Coordinators have helped the regions transition into utilizing comprehensive programming that began implementation late 2014 in to early 2015. Coordinators have provided training to field staff on the comprehensive models and service mapping. The Program and Services unit has created tip sheets and questionnaires for field staff to utilize when making referrals, which helps ensure providers receive adequate information on the referral.

b) Ensure appropriate communication occurs between all service providers, formal and informal supports to collaborate for consistency and improved outcomes.

This objective is complete. The Regional Service Coordinators work as liaisons between local office staff and service providers, addressing any concerns/issues that might arise. The coordinators facilitate monthly/quarterly meetings with providers, in the regions they serve, to create a forum for providers to network, share successes, express their concerns and trouble shoot barriers or challenges specific to that region. Training on the child welfare system is provided to service providers as requested.

SAFETY MEASURES OF PROGRESS

Through implementation of the Goals, Objectives and Interventions outlined in this section of the CFSP, DCS will monitor, and anticipates improved outcomes related to the current and/or revised federal CFRS permanency outcomes:

- Absence of Recurrence of Maltreatment.
- Maltreatment in Foster Care.

DCS will also monitor and anticipates improved outcomes related key performance and practice indicator reports generated from MaGIK.

- Absence of Maltreatment after Involvement.
- Family Case Manager Visits.
- CHINS Placement.
- Safely Home, Families First.
- Re-Report of Maltreatment.

DCS will also monitor the impact of implementation of these goals, objectives and interventions on Safety and Behavioral Risk Quality Service Review Child Status Indicators. DCS also intends to develop additional reports and identify ways that technology can further support improved outcomes for children and families. As an example, DCS plans to identify strategies to better capture child visits completed by service providers. In addition, DCS plans to identify ways to measure utilization and effectiveness of proven, home-based services.

DCS continues to partner with Casey Family Programs in the implementation of the Eckerd Rapid Safety Feedback® model. Ongoing consultation calls are taking place as work continues on establishing a viable evaluation plan along with design and implementation strategies. The Eckerd model was highlighted in the final report of the

federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF).

Additionally, effective July 1, 2016, DCS implemented a new policy to prohibit screen outs of reports received for children under three (3) years old, per the recommendation of the CECANF. Therefore, all reports received by the agency for children under three (3) are assigned for an investigation.

B. PERMANENCY GOALS, OBJECTIVES AND INTERVENTIONS

Goal 2: Ensure each child achieves safe, timely and stable permanency options.

DCS believes that every child has a right to appropriate care, a permanent home and lifelong connections. The objectives outlined below include a number of strategies to strengthen the types of placement and permanency options available for children requiring out of home care, and putting systems and monitoring mechanisms in place to improve permanency outcomes and time to permanency measures.

DCS decided to focus on these objectives following an analysis of CFSR permanency related outcomes, QSR permanency data and in evaluating the status of the foster care and adoption programs during development of the Foster and Adoptive Parent Diligent Recruitment Plan. While in recent years, DCS has either met or exceeded the national standard in CFSR permanency composites, in the FFY 2013 AFCARS submissions, DCS permanency composite scores for composites 1, 2 and 3 fell slightly. These decreases, combined with a decrease in the number of completed adoptions in 2013, prompted the agency to look more closely at data impacting permanency outcomes for children in care as part of the CFSP planning process.

To allow for improved monitoring and analysis in this area going forward, many of these objectives include interventions related to data tracking or analysis and will be included in CQI efforts moving forward. Furthermore, the objectives below will be refined and adjusted as part of the recent Child and Family Service Review and implementation of any necessary program improvement plan.

OBJECTIVE 2.1 EXPAND PLACEMENT AND PERMANENCY OPTIONS, AND IMPROVE PLACEMENT STABILITY FOR CHILDREN IN KINSHIP PLACEMENTS.

a) Develop policy and procedures for the expansion of Indiana's definition of relative to include those with an established and significant relationship with the child.

This objective is complete. In response to the new sibling requirement in the Preventing Sex Trafficking and Strengthening Families Act, Indiana Law was modified effective July 1, 2015. More specifically, IC 31-9-2-107 was revised to add “any other individual with whom a child has an established and significant relationship” to the definition of relative. DCS Policy 8.48, Relative Placement, was revised to include this new law and requirement.

b) Evaluate system and fiscal application changes necessary to track and monitor use of the expanded definition of kinship care.

This objective is complete. As discussed above, Policy 8.48 Relative Placement was revised to include the new sibling definition required by the Preventing Sex Trafficking and Strengthening Families Act. In response to the goal, the Safely Home Family First report has been identified as a potential way to track these placements by adding an “other relative” section. Fiscal is also reviewing fiscal reports as a potential source for tracking relative and kinship

expenses.

c) Review and revise, as necessary, policies and procedures related to the Guardianship Assistance Program to include the expanded definition of kinship care.

This objective is complete. Policy 14.1 Guardianship Assistance Program (GAP) states: DCS will provide the Guardianship Assistance Program (GAP) to eligible relatives as defined in 8.48 Relative Placement for whom the permanency option of guardianship is in the best interest of the child and reunification and adoption are not feasible.

d) Evaluate resources available to kinship caregivers and revise policies, procedures and information systems to ensure these caregivers are well supported.

This objective is complete. Kinship is included in the definition of relative and all services and programs for relatives are also available to kinship caregivers.

e) Expand the use of resources (staff, financial and service) to provide support to and ongoing assessment of the needs of kinship caregivers.

This objective is ongoing. DCS continues to leverage relative support specialists and evaluate financial and service resources in furtherance of meeting this objective.

f) Improve utilization of the CANS to ensure children are placed and provided services according to their individualized needs.

This objective is complete. DCS implemented CANS in 2008-2009. To ensure sustainability, adequate and ongoing organizational supports were put in place through the development of CANS Consultants. Three CANS Consultants are assigned to various parts of the state, the North, Central, and Southern Regions. The CANS Consultants along with the Program Manager received certification to train the CANS from Dr. Lyons. This certification assisted the CANS Team in development of a series of internal trainings to Field Staff (CANS Education and Support). The first series was called CANS 101. The objective was to educate the field on how the CANS can be integrated into DCS practice (TEAPI) and supervision with discussion of the CANS Decision Models (algorithms) and finally where staff can go to help with CANS via the CANS Mailbox which is manned by the CANS Consultants. CANS 101 was completed with all field staff in September of 2014. The second series of CANS Education and Support was CANS 102. CANS 102 discussed the use of CANS to assess trauma related needs, identified and scoring behavioural and emotional symptoms of trauma, and service planning for trauma needs. CANS 102 was completed in February 2015.

Both CANS 101 and 102 continue to be offered on a quarterly basis in all DCS Regions for new field staff and for anyone who would like a refresher and/or needs to be recertified. CANS 201 which focuses primarily on DCS Supervisors as to not only their understanding of the CANS from a trauma perspective but also to their role and responsibility as a CANS Super User/Implementation Coach for their staff as it relates to CANS is was developed and now is being trained as part of the required ½ day training for all DCS Supervisors. As discussed in the Collaboration section, DCS meets monthly with DMHA to continue dialogue and efforts to improve the CANS.

Currently, in development is CANS 201 which will focus primarily on DCS Supervisors as to not only their understanding of the CANS from a trauma perspective but also to their role and responsibility as a CANS Super

User/Implementation Coach for their staff as it relates to CANS. As discussed in the Collaboration section, DCS meets monthly with DMHA to continue dialogue and efforts to improve the CANS.

OBJECTIVE 2.2 EXPAND PLACEMENT AND PERMANENCY OPTIONS, AND IMPROVE PLACEMENT STABILITY FOR CHILDREN IN FOSTER CARE PLACEMENTS.

- a) Implement the Structured Analysis Family Evaluation (SAFE) to evaluate families for adoption, foster care licensure, relative placement and reunification readiness.

This objective is complete. DCS licensing workers have been utilizing the SAFE home study format, and LCPAs are required to use the SAFE home study format with the families they license as foster parents in the new contract cycle that began January 1, 2017. DCS hosted five (5) trainings by the Consortium for Children to train licensing workers and supervisors of LCPAs in the SAFE home study model. Continuing each year, DCS plans to host SAFE home study trainings quarterly for staff turnover and to train promoted supervisors.

In addition, all adopt-only families (those not licensed for foster care but who wish to adopt from DCS) will have a SAFE home study pursuant to a contract change effective July 1, 2016.

- b) Expand use of resources (staff, financial and service) to provide support to and ongoing assessment of needs of foster parents.

This objective is ongoing. DCS is actively meeting and reviewing ideas for services and supports that will better meet the needs of foster parents. Future benchmarks will include implementation of identified supports based upon feedback from specialists working with foster parents and the monthly meetings with supervisors. DCS is also exploring the implementation of a foster parent portal through our case management system, in order to provide more immediate feedback and to allow for self-assessment. In a workgroup with foster parents, parents and staff indicated that foster parents—even when asked to provide information about their own needs—provide information related to the needs of the children they have in care, rather than their own needs for support. DCS will be utilizing a new vendor to assist with running the Foster Parent Appreciation Events throughout the state starting in SFY 2017.

- c) Improve utilization of the Child and Adolescent Needs and Strengths (CANS) assessment to ensure children are placed and provided services according to their individualized needs.

This objective is complete. Both CANS 101 and 102 continue to be offered on a quarterly basis in all Regions for all newly hired field staff as well as those who may need a refresher. CANS 201 which focuses primarily on DCS Supervisors as to not only their understanding of the CANS from a trauma perspective but also to their role and responsibility as a CANS Super User/Implementation Coach for their staff as it relates to CANS was developed and now is being trained as part of the required ½ day training for all DCS Supervisors. As discussed in the Collaboration section, DCS meets monthly with DMHA to continue dialogue and efforts to improve the CANS.

In order to measure progress in this area, DCS developed a report to measure improvement in CANS adjustment to trauma scores over the life of a case. DCS has been utilizing this reports and has seen improvement in the field's recognition of trauma by the decrease in "zero" scorings on the CANS.

OBJECTIVE 2.3 IMPROVE PLACEMENT STABILITY OF ADOPTED CHILDREN THROUGH PROPER IDENTIFICATION OF PLACEMENT OPTIONS BASED ON THE CHILD'S INDIVIDUALIZED NEEDS, AND BY PROVIDING SUPPORT FOR THAT PLACEMENT TO AVOID DISRUPTION.

a)Expand use of resources (staff, financial and service) to provide ongoing support to pre-adoptive parents.

This objective is ongoing. Family case managers utilize case resources and referrals to ensure that services are available to children and families preparing for adoption. SNAP specialist also provide ongoing support to pre—adoptive parents. Additional resource needs have not yet been determined.

b)Promote availability of post adoption services to increase the numbers of families engaged in post-adoption services, including trauma-informed trainings, to prevent adoption disruptions and dissolutions.

This objective is ongoing. A list of post adoption service representatives and Post adoption services brochures are available at all adoption events. DCS has provided training on post adoption services to DCS probation staff who have also been provided a supply of brochures. In addition, SNAPS and/or PAS providers present to local offices and/or attend CFTMs to discuss the availability of post adoption services. The 2014 & 2015 RAPT Conference were themed around trauma-informed (Building a Healing Home) care and both keynote & breakout sessions presented by state-wide and national trainers were held over 3 days. Attendance at the 2014, 2015, & 2016 RAPT conferences grew from 241 to 361 to 409 attendees.

A trauma training focusing on practical skill building for caregivers is being piloted in Region 15. RAPT Staff offers a 3 part series (4 hours each) training on Trauma for all resource families. Also, all three PAS providers have held 16 trauma-informed trainings in various regions throughout the state for families during the last SFY – most of these have been open to families not currently receiving PAS services in addition to their current PAS families.

c)Develop mechanisms to track and evaluate the post adoption service array to assess its overall utilization and effectiveness, including its interaction with the Children's Mental Health Initiative.

This objective is complete. In addition to monthly reports on each individual family receiving post adoption services, the three post adoption service providers also send quarterly reports which provide a summary of the number of new and renewed referrals, quarterly achievements and challenges, including systemic issues (navigating Medicaid issues, etc.). DCS has recently added the number of post adoption service cases which also have Child Mental Health Initiative (CMHI) involvement. Statewide, for calendar year 2014, 39 youth were referred to the CMHI, of which approximately 51% were accepted. For calendar year 2015, 20 youth were referred to the CMHI. DCS tracks post adoption services by family, not by child, so it is difficult to compare the number of children served. However, the families served increased from 200 families in 2012 to 331 in 2016.

OBJECTIVE 2.4 INCREASE THE EFFECTIVENESS OF FOSTER AND ADOPTIVE PLACEMENTS.

a)Expand resources available to foster and pre-adoptive parents.

This objective is ongoing. DCS has begun monthly in-service meetings with foster care supervisors, managers and regional managers in hopes of providing current information regarding available resources. The meetings also allow them to problem solve and develop plans around any barriers to the provision of support and resources to foster parents. DCS continues to educate staff about referral procedures for supportive services for foster parents and situations in which these would be appropriate. DCS has also expanded a training foster parent workgroup to

include topics such as supports and needs of foster parents more generally. This more formal mechanism of gathering feedback and providing a line of communication will assist DCS going forward in expanding resources in the way most beneficial for foster parents.

DCS also recently obtained a new foster parent liability insurance policy, which is providing more comprehensive coverage to foster parents than previously available. Every foster parent is automatically enrolled into this coverage when a placement occurs. This can be a meaningful support to foster parents if they incur costs and damages associated with their fostering experience.

Educational issues and fees can also be challenging for foster parents to navigate. Foster parents often don't understand whether a school fee should be assessed for children in their care, and who should be responsible for paying the fee. To assist in this regard, DCS has recently created new protocols for the Educational Liaisons to assist foster parents in handling issues related to school fees and equipment.

At DCS's Annual Training for LCPA licensing workers on May 2, 2016, DCS discussed needs of foster parents, provided training related to the reasonable and prudent parent standard, and provided training related to licensing statutes and regulations that had been areas for improvement in the last year.

b) Increase the effectiveness of matching foster children to resource homes.

This objective is ongoing. DCS has multiple resources and tools to assist in this regard. First, specialized staff members who work with families have a better knowledge of families' strengths and needs and can make placement matches more effectively. Additionally, MaGIK has a placement matching feature that allows for the filtering of foster homes with available capacity by various characteristics, such as age and gender preferences, special needs they can or are willing to accommodate, and location (down to school district). This feature can be very useful at quickly narrowing a potential list of options. At the end of 2016, DCS and our LCPA providers both undertook a "data cleanup" to assist in ensuring that this information was provided and is up to date. As mentioned in an earlier section, DCS is also exploring the potential for a Foster Parent Portal into our system so that foster parents can provide the most up to date information and see what information we have about their skills and preferences. DCS will continue to educate staff on the need to enter this data in foster parent resource profiles so that this feature can be maximally effective. MaGIK enhancements to the configurability of the characteristics entered into the system will allow for reports identifying areas of need by county and region. These reports are not yet completed.

In November 2016, DCS shared demographic data related to all children coming into care who were in need of non-related out of home placements. There was not a formal meeting to provide the data, but the information was shared with providers and DCS licensing staff who have access to the report on Foster Parent Recruitment.

In November 2015, DCS hosted a forum for all LCPA licensing workers to provide data on demographics of children needing out of home placements by case county. The data was also provided to our DCS licensing workers through the Regional Managers. This data looks at the information of the children who need foster care by the county where their case originated (rather than county placed). This data allows for targeted recruitment based upon the makeup of the children in need of out of home placement in the county.

As indicated in last year's report, DCS has a comparison report indicating the race demographics of foster children and foster parents in given counties. The report provides information statewide and by region and county. The

statewide information shows that a disparity remains between the distribution of foster homes that identify as Latino and children in need of out of home placement who identify as Latino, specifically a shift from 2.96% of foster homes as compared to 9.82% of placements in 2016 to 2.67% of foster homes identifying as Hispanic/latino origin as compared to 8.67% of placements.

To address this area for improvement, DCS continues to work on an additional contracted provider who can provide training and guides to foster families in Spanish language. DCS has also increased the number of pamphlets available in Spanish and will be looking for ways to reach the Hispanic community.

Speaking only as to pre-adoptive matches, DCS uses the SNAP process of sharing SNAP recommended home studies with FCMs and Child Social Summaries with SNAP recommended families to help gauge interest. A team approach was established to interview and select the most appropriate family to ensure that various professionals provide input on the match.

c)Minimize the number of disrupted placements.

This objective is ongoing. While DCS has matching capabilities to maximize the appropriateness of placements and supportive services to support placement challenges, there is currently limited information that can be extracted on the rate of placement disruption. As listed in an alternate section of this report, work continues on creating a reliable data report that would inform strategies to reduce the number of disrupted placements. Once meaningful data is available to track disruption episodes in aggregate form, DCS will be able to determine if efforts to better match children and foster parents and support placements are effective in reducing disruptions. In addition, the efforts to expand resources available to foster and pre-adoptive parents could prove beneficial in minimizing disrupted placements.

d)Maximize retention of resource families.

This objective is ongoing. In recognition that foster parents' satisfaction with fostering often relates to their interactions with agency staff, DCS is planning a practice in-service for all Family Case Managers in the last quarter of 2015 on the topic of engaging foster parents. The in-service will focus on reinforcing to staff their role in the foster parents' experience and provide information on utilizing practice skills when working with foster parents. As mentioned previously, the availability of RFCS as a liaison to necessary resources and supports should bolster DCS's efforts to retain resource families and successful placements. As mentioned above, DCS will be utilizing a new vendor to assist with running the Foster Parent Appreciation Events throughout the state starting in SFY 2017.

OBJECTIVE 2.5 EVALUATE THE STRUCTURE OF AND POLICY SURROUNDING THE USE OF THE CASE PLAN AND TRANSITION PLAN TO ENSURE IT SUPPORTS DEVELOPMENT OF GOALS THAT ARE IN THE BEST INTERESTS OF CHILDREN AND FAMILIES, AND FURTHERS TIMELY PERMANENCY.

a)Determine methods to ensure permanency goals are appropriate to the child's needs and the circumstances to the case and that the goals are with input from the youth and parent.

This objective is complete. Both the Developing a Case Plan policy 5.8 and the Transition Plan policy 11.6, communicate the importance of utilizing the Child and Family Team (CFT) meeting process to create plans for assessment, safety, service delivery, and permanency. A CFTM fulfils the requirement to hold a Case Plan

Conference, if all required parties are present. If a family chooses not to participate in the CFT Meeting process, a Case Plan Conference is held to develop the Case Plan. The Case Plan policy states: DCS will work with the parent, guardian, or custodian, extended family, child (if age and developmentally appropriate), and the CFT, if applicable, in developing the Case Plan. Policy goes on to state that when developing a Case Plan the Family Case Manager (FCM) will “Determine the Permanency and Concurrent Plans that are in the best interest of the child and ensure that the goals, objectives, and activities outlined in the Case Plan support the Permanency Plan”. For older youth the Transition Plan policy states: The plan shall be:

1. Youth-focused and developed with the assistance of the Family Case Manager (FCM) or Collaborative Care Case Manager (3CM) and members of the youth’s Child and Family Team (CFT);
2. As detailed as the youth elects;
3. An outline of the Older Youth Services the youth will receive;
4. Focused on short-term and long-term achievable and measurable goals;
5. Updated every six (6) months until the youth’s case is closed; and 6. Given to the youth at each update.

b) Determine methods to ensure case plans are completed timely and consistent with the court orders for permanency goals (no later than 60 days from the date the child entered foster care).

This objective is complete. To ensure that case plans are completed timely DCS requests that case plans be completed within 45 days of removal or disposition. The Developing a Case Plan policy 5.8 states: The Indiana Department of Child Services (DCS) will have a Management Gateway for Indiana’s Kids (MaGIK) approved Case Plan within 45 days of removal or disposition, whichever comes first for:

1. Every child who has been adjudicated a Child in Need of Services (CHINS);
2. All children with an open case type;
3. Children who are at imminent risk of removal; or
4. A Juvenile Delinquent or Juvenile Status (JD/JS) for whom DCS has been ordered to pay for the placement and the child is IV-E eligible.

c) Evaluate the existing case plan and transition plan to gather feedback on its current functionality and determine what information and or questions need to be revised or added to the Case Plan to ensure better outcomes for children.

This objective is ongoing as plans continue to be improved and programmed in to MaGIK. Both the Case Plan and Transition Plan are currently being revised. On June 28, 2017, the transition plan for successful adulthood form was programmed in MaGIK. The form will display only pages and questions relevant for the youth’s age beginning with age 14, then every 6 months until age 21. The form will also initially display 30 days prior to the youth’s 14th birthday so that it can be filled out ahead of time as needed for a CFTM, etc. An additional plan should be completed 90 days prior to the youth’s 18th birthday. Some data will be auto-populated from Casebook. A majority of the current case plan is completed in MaGIK but there are still a few sections that must be completed by hand and then uploaded into MaGIK. Programming for both plans in MaGIK continues and is an ongoing project. Due to the extensive nature of MaGIK programming, needed revisions to the Case Plan and Transition Plan are made to the forms to ensure compliance with Federal and State requirements. Current revisions include legislative

changes that are pursuant to the Preventing Sex Trafficking and Strengthening Families Act.

d) Determine methods to ensure case plan goals are updated in a timely manner (e.g., when changing a goal from reunification to adoption). Consider system monitoring efforts.

This objective is ongoing. The Developing a Case Plan policy 5.8 states “DCS will ensure that the Case Plan is updated at least every 180 days from the effective date of the previous plan and anytime there is a significant change (e.g., change in placement, identified needs, change in permanency plan, parents failure to participate in services, parents cannot be located, changes with parent’s income and employment, child’s income and resources, etc.)”. System monitoring efforts are being explored. PIP activities will also be developed to improve issues found in the CFSR regarding permanency goals not always being updated timely in the case file.

OBJECTIVE 2.6 IMPROVE ENGAGEMENT AND PARTICIPATION OF FATHERS AND PATERNAL RELATIVES.

a) Increase efforts to find fathers by utilizing available search tools and through referrals to the investigation unit.

This objective is complete and efforts are ongoing. The investigators utilize a variety of internet search tools, such as computer databases, Accurant, Federal Information Portal, Federal and State Department of Corrections, Federal and State Offender Registries, and the Indiana Bureau of Motor Vehicles. Social Media is utilized, including Facebook, Public Records, County Court Systems and records. FCMs make referrals to the Investigator unit through the KidTraks program when a need is recognized.

b) Increase utilization and effectiveness of father engagement services.

Analysis of this objective is ongoing. Service training is offered to field staff and new supervisor, which includes the availability and overview of Father Engagement services. In addition, a father engagement call is held monthly which allows providers the ability to trouble shoot issues and brainstorm solutions with other father engagement providers across the state. Quarterly, father engagement providers submit data on served clients. Information collected includes, successful visits, attended CFTMs, attended case plan conferences, successful contacts with incarcerated fathers, successful placements with the referred father, and genogram completion with the referred father. Genogram completion has assisted with identify paternal relatives who may be utilized as possible placement options, and assisted the father in identifying potential supports and CFTM participants.

c) Increase engagement of fathers in child and family team processes, case planning activities, visitation and service provision.

This objective is ongoing. DCS continues to work with the father engagement providers to develop strategies to increase engagement. In November 2016, DCS held a provider retreat with Father Engagement providers, DCS staff and Fathers who have been involved with the program (panel discussion). This offered an opportunity for clients, providers and DCS to hear about successes and challenges of the program. In addition, DCS has incorporated the JPay system this year. JPay is database that allows incarcerated fathers to send and receive email, video, and text messages for a fee. Although JPay is underutilized at this time, it opens the door for fathers to communicate with their children by other means than in person visitation.

d) Engage paternal relatives as informal supports and placement and permanency options.

Analysis of this objective has not yet been completed.

OBJECTIVE 2.7 IDENTIFY AND IMPLEMENT STRATEGIES TO BETTER TRACK AND MONITOR CHILD / PARENT VISITS.

a) Evaluate strategies for capturing parent / child visits supervised by either DCS or provider staff for both CHINS and Juvenile Delinquency cases.

Analysis of this objective has not yet been completed.

b) Implement technology solutions to support consistent monitoring of visits.

Analysis of this objective has not yet been completed.

PERMANENCY MEASURES OF PROGRESS

Through implementation of the Goals, Objectives and Interventions outlined in this section of the CFSP, DCS will monitor, and anticipates improved outcomes related to the current and/or revised federal CFSR permanency outcomes:

- Improved Placement Stability and/or Reduction in the number of placement and adoption disruptions.
- Decrease in the length of time to permanency for all permanency options.
- Permanency in 12 months for children entering foster care
- Permanency in 12 months for children in foster care for 2 years or more
- Re-Entry into Foster Care

Since piloting PRTs in June 2011, DCS has completed 1,020 round tables. Of the 418 (41%) of these PRT cases have closed with 64% of these closed cases achieving the “Gold Standard” of legal permanency through reunification, adoption, or legal guardianship. 66% of PRT’s have improved at least one Permanency Status Level.

DCS will also monitor and anticipates improved outcomes related to the following Quality Service Review Indicators.

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

DCS also intends to monitor the utilization of kinship placement options, as well as post adoption services and consistent with its goals related to continuous quality improvement, will identify and implement strategies to further improve outcomes based on data trends.

DCS recently engaged consultants from Katz Sapper and Miller (KSM) to build a permanency model that identifies cases that are close to permanency or should have already achieved permanency to see what characteristics the cases have in common. After identifying commonalities, DCS will work to develop strategies to minimize the number of cases not achieving permanency timely, specifically as it applies to the Permanency in 12 months (12-23

months & 24+ months). DCS recently began the rollout of the dashboard tool and has piloted it in three (3) DCS Regions – Regions 3, 5, and 9.

DCS Central Office and KSM will continue to 1) incorporate new enhancements to the dashboard tool based on user feedback to deliver a workflow application that identifies outlier involvements and facilitates review and informed intervention on identified outlier involvements by regional management teams and 2) formulate and execute a strategy for rolling out the application to the regional management teams.

C. WELL-BEING GOALS, OBJECTIVES AND INTERVENTIONS

Goal # 3: Ensure the well-being of children and families through holistic and individualized practice

During the 2010-2014 CFSP, DCS implemented a number of new services and created several specialized staff functions all designed to further well-being for children involved with the child welfare system. Many of the objectives outlined in this goal are designed to continue moving forward with strategies put in place during the prior CFSP. These objectives focus on improving and/or evaluating how we are using the services and staff resources we put in place in 2012 and 2013, as opposed to implementing new strategies to improve child well-being. Many of the programs and services identified in the objectives below are very new for the agency, and as a result, DCS needs to devote resources during the early years of the 2015-2019 CFSP towards identifying ways to track and evaluate the effectiveness of these programs in improving outcomes for children and families, and identify additional ways to measure child well-being.

OBJECTIVE 3.1 CONTINUE EXPANDING THE AVAILABILITY AND USE OF EVIDENCE-BASED AND EVIDENCE-INFORMED PRACTICES TO ENSURE CHILD AND FAMILY NEEDS ARE BEING MET.

a) Document and train staff, CASAs, Judges and Probation on available evidence-based programs and target populations for these services.

This objective has been completed. Presentations have been provided to judges, probation and CASAs regarding the evidence based programs that are being supported by DCS. Additional training will be provided regarding how Service Mapping will assist in the selection of services.

b) Improve the effectiveness of residential programs by requiring all residential programs to utilize an evidence-based program and auditing provider compliance with the program model.

This objective has been completed. The Residential Liaisons (RL), in the Permanency and Practice Support Division, work closely with DCS Residential Licensing/Contract staff. The RL is responsible for assessing, reviewing, and monitoring the quality of programming and clinical services provided to DCS children and adolescents in residential care. The RLs conduct annual contract compliance residential program reviews for assigned facilities using the Residential Programs Clinical/Quality Indicators Checklist. A quarterly review schedule was developed in collaboration with providers to ensure that all facilities receive a review. Visits may also be scheduled on an "as needed" basis, in response to feedback from Clinical Services Specialists, Residential Licensure/Contract Staff and/or Field Staff. Residential Liaisons coordinate residential reviews, summaries of findings, recommendations for

improvement and other survey activities with DCS Residential Licensing/Contract Staff. Any concerns, findings and/or recommendations for improvement are integrated with information from the Contract/License Audit Tool.

RLs provide consultation to residential providers regarding trauma-informed, evidence-based practices and provide guidance, as necessary, to assist providers in meeting the expectations outlined in the DCS Contract. The RLs also work closely with members of the Clinical Resource Team to resolve identified concerns regarding specific DCS youth in placement and keep members of the Clinical Resource Team apprised of any concerns or trends involving specific residential providers. The RLs also assess provider capacity regarding evidence-based services for DCS youth on an ongoing basis and provide input to the Clinical Services Manager, the Deputy Director of Placement Support and Compliance and/or the Deputy Director of Programs and Services regarding needed services. On a quarterly basis, the RLs meet with the Clinical Services Manager to discuss residential providers' progress in implementing evidence-based programming (e.g., TF-CBT). As part of ongoing audits, when it is determined that an entity is not in compliance with contract and license requirements, the facility must develop and implement a plan of correction (POC).

c) Improve the effectiveness of community-based programs by contracting for services that utilize an evidence-based program and auditing provider compliance with program model.

This objective has been completed. DCS monitors compliance and provides technical assistance with program models for the following evidence based practices:

- Trauma Focused Cognitive Behavioral Therapy through the contract with Cincinnati Children's Hospital
- Family Centered Treatment through the contract with Family Centred Treatment Foundation
- Child Parent Psychotherapy through the contract with Child Trauma and Training Institute
- Homebuilders through the contract with the Institute for Family Development

The above mentioned evidence based program models utilize service logs, which allow DCS to monitor model implementation. The DCS audit team ensures each agency implementing an evidence based program is certified and received the appropriate training to implement the model.

d) Collaborate with stakeholders to address unmet service and placement needs through provider engagement.

This objective is complete. As part of the Biennial Regional Services Strategic Planning process conducted in the fall of 2015, providers and community stakeholders were asked to participate in focus groups that worked to identify the needs and create an action plan around the selected topic areas of prevention, substance abuse disorder treatment, preventing maltreatment after involvement and obtaining permanency for children in care 24+ months.

In August 2015, DCS held a forum with all residential providers in order to discuss increased areas of need. Specifically, Director Bonaventura and Deputy Director of Placement Support and Compliance met with leadership of facilities to provide data on difficult to place children. The data was manually developed through collaboration with the Clinical Services Specialists, and identified two specific populations: aggressive teens with co-occurring psychiatric or medical needs, and children under the age of 10 with significant behavioral and emotional needs. In response, DCS met with several providers about possible residential programs that might serve these teens with

severe aggressive behaviors. DCS hopes to implement a program for these youth in the next year.

DCS also worked with Casey Family Programs on gathering information on evidence-based or evidence-informed practices for foster homes from other states and jurisdictions that have implemented new programs. Following several productive calls, DCS issued a Request for Information in January 2015 seeking innovative solutions for children under the age of 10 who have aggressive or antisocial behavior problems, or other social, emotional, or mental health needs that lead to difficulty in finding appropriate placements. DCS hopes to move forward with implementation of an evidence-based treatment foster care model in the next fiscal year, following a Request for Proposals.

Over the last year, DCS has had several programs open for children with developmental/intellectual disabilities, which is an area of focus. These programs should add to the array of necessary services for children in care.

DCS is also working on developing a structured way to ensure that victims of human trafficking are receiving appropriate care that is focused for their specific needs. Current efforts include development of a residential service standard for programs that would like to serve the population of human trafficking victims, and educating the providers on human trafficking.

Lastly, as part of the PIP development process, numerous stakeholders from the service provider community, local DCS offices, probation, and the courts were involved in helping provide guidance on how service and placement needs could be addressed.

e)DCS-involved youth who are identified as having significant needs associated with trauma (i.e., CANS “adjustment to trauma” item score = 3) will receive evidence-based, trauma-informed services to enhance their well-being.

This objective is complete. Service Mapping, which was deployed in 2015, provides service recommendations. Children who have experienced trauma as documented by the CANS are provided service recommendations to EBPs which can address trauma. In addition, DCS Clinicians are providing consultation for these cases to ensure the child’s needs are being met. Service Mapping continues to be refined and improved in order to expand and increase its use among FCMs.

OBJECTIVE 3.2 ENHANCE STAFF CAPACITY TO UTILIZE SAFETY, RISK AND CANS ASSESSMENTS IN CONJUNCTION WITH ONE ANOTHER TO IDENTIFY UNDERLYING NEEDS OF CHILDREN AND FAMILIES, ENSURE APPROPRIATE CASE PLANS ARE ESTABLISHED, AND TAILORED SERVICES ARE PROVIDED.

a)Improve staff capacity to effectively assess trauma and the behavioral health and placement needs of children and youth to identify appropriate services through use of the Child and Adolescent Needs and Strengths (CANS) assessment tool.

This objective is complete. Certified and Trained CANS Consultants developed and implemented CANS 102. CANS 102 discussed the use of CANS to assess trauma related needs, identified and scoring behavioural and emotional symptoms of trauma, and service planning for trauma needs. CANS 102 was completed in February 2015. CANS 201 has been developed and focuses primarily on DCS Supervisors as to not only their understanding of the CANS from a trauma perspective but also to their role and responsibility as a CANS Super User/Implementation Coach for

their staff as it relates to CANS.

- b) Improve assessment of the child and family's needs through utilization of the Safety and Risk Assessments and ensure results are being used to guide development of the case plan.

This objective is ongoing. DCS has engaged Eckerd Kids, in collaboration with Casey Family Programs, in implementing the Eckerd Rapid Safety Feedback® model (<http://www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/>). The Eckerd model was highlighted in the final report of the federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF). Furthermore, the improvement of the Safety and Risk Assessments will be part of Indiana's finalized program improvement plan.

- c) Utilize the assessment tools to map to appropriate services to meet the individual needs of the family and child.

This objective is complete. The service mapping system utilizes information from the Child and Adolescent Needs and Strengths assessment as well as the Structured Decision Making tool for Risk Assessment to develop specific, evidence based program/service recommendations.

- d) Explore methods to improve participation and engagement of service providers in child and family teams and case planning activities.

Analysis of this objective has not yet been completed.

- e) Consider training and appropriate use of case plan goals associated with building social capacities, self-esteem, coping skills and re-establishing and maintaining relationships.

Analysis of this objective has not yet been completed. However, ongoing enhancements to the DCS case plan will positively impact the development and success of goals identified.

- f) Improve the utilization of contracted providers to offer more in-depth assessments for trauma, bonding and attachment, psychological evaluations, and independent living skills.

This objective is ongoing. Utilization of services is evidenced through service mapping. Service mapping ensures appropriate cases are mapped to comprehensive services like Child Parent Psychotherapy and Trauma Focused Cognitive Behavioral Therapy. The Program and Services unit clarified the diagnostic and evaluation service standard so the correct tools would be used for bonding and attachment and trauma assessments. DCS also has Clinical Consultants available to field staff to consult on cases, make recommendations and act as a liaison between field staff and providers. As previously mentioned, a focus of the PIP will be improving the use of services, including the utilization of Service Mapping.

OBJECTIVE 3.3 IMPROVE PARTICIPATION AND ENGAGEMENT OF CHILDREN AND CAREGIVERS IN CHILD AND FAMILY TEAMS, CASE PLANNING ACTIVITIES AND SERVICE PROVISION.

- a) Explore methods to engage children and youth in child and family teams, case planning activities, and service provision.

Analysis of this objective has not yet been completed. However, development of the PIP will include strategies around improving overall engagement through all case related activities for each participant.

- b) Explore methods to engage noncustodial parents, kinship caregivers, foster parents, and pre-adoptive

parents in child and family teams, case planning activities, and service provision.

Analysis of this objective has not yet been completed. However, development of the PIP will include strategies around improving overall engagement through all case related activities for each participant.

OBJECTIVE 3.4 EVALUATE THE IMPACT OF TRAINING AND APPROPRIATE USE OF CASE PLAN GOALS ASSOCIATED WITH BUILDING SOCIAL CAPACITIES, SELF ESTEEM, COPING SKILLS AND RE-ESTABLISHING AND MAINTAINING RELATIONSHIPS.

a) Identify ways to track whether nursing services staff are improving timely access to medical and dental care for children in care.

Analysis of this objective is ongoing. It is the role and responsibility of Family Case Managers (FCMs) / Field Operations to ensure that every child in out-of-home care is provided with health care services necessary to meet the child’s needs (e.g., physical, mental, dental, visual, auditory, and developmental). According to policy 8.25 Health Care Services, children receive the following initial screens/exams: A general health exam within 10 days of placement unless exceptions apply as outlined in separate policy, 8.29 Routine Health Care; (This exam should also include screens for dental, visual, auditory, and developmental health) and an initial dental examination and cleaning within 90 days of placement unless exceptions apply as outlined in separate policy, 8.29 Routine Health Care.

Upon receiving a Referral request, the DCS Nurse Consultants can assist with improving access to medical care, treatment, and dental care by: assisting the FCM to and with communication with the Primary Care Physician (PCP) as well as other health providers and facilities; reviewing medical records and providing summaries based on physician orders and making recommendations based on approved standards of care; interpreting medical terminology and laboratory findings; and attending / participating in meetings, staffings, care conferences, CFTMs, and PRTs that will provide essential information to continue to improve health / medical and dental care for children.

b) DCS Clinical Services Specialists will provide clinical consultation, as requested by the FCM, for any youth rated a 3 on the CANS “adjustment to trauma” item.

This objective is complete. All youth are screened for trauma using the CANS. DCS has developed a monthly report that identifies those youth rated a “3” on the CANS “adjustment to trauma” item. The Clinical Services Specialists review this report monthly and generate a notification email to each FCM with one or more youth listed. The FCMs can then generate a referral for clinical consultation with the Clinical Services Specialist, if they need assistance in planning for needs associated with trauma.

c) Evaluate the impact of the education liaisons with regard to school attendance and graduation rates, incidence of suspension and expulsion and attendance in post-secondary education.

Analysis of this objective is ongoing. The Education Liaison (EL) Director has been actively working with DCS legal, the Practice and Policy Support Deputy Director, and the Department of Education (DOE) legal department to establish a MOU to obtain access to the Student Testing Number (STN) database with intent to use EL referred youth’s STN to track academic progress, enrolment, and graduation status. Although the MOU is not yet in place,

DCS has been working collaboratively with DOE on other matters, including the implementation of ESSA. In addition, the team has created a plan to work collaboratively with DOE as they begin their plan to implement the new requirements of the Every Student Succeeds Act (ESSA) as they pertain to the graduation rates and academic growth of foster youth. The EL Director has begun communication with DOE to request participation in DOE preparation meetings.

The Education Liaison team is working with the KidTraks team to begin implementation of measurable outcomes based on the referral reasons for each child referred to the EL team. This will allow a data driven report to be cultivated identifying the impact the EL involvement has on the child's education and DCS' case plan. A request for specific data fields and reminders to update the fields has been submitted to be added to MaGik Casebook with the intent to efficiently track graduation rates, attendance, grade promotion/retention and grade level including post-secondary accomplishments.

d) Evaluate frequency with which investigators are locating additional family members, which result in additional family supports and / or permanency options for children in care.

This objective is ongoing. The Permanency & Practice Support Division's CY 2015 Plan was to determine what needs to be measured and how it should be measured. For CY 2015, DCS Investigators processed approximately 32,092 referrals from Field staff and located approximately 30,543 individuals. CY 2016 investigators processed 54,232 referrals and located approximately 48,809 individuals (95% success rate). Work continues to identify a reliable process for drilling down on the above data and establishing a methodology for verifying the success of locating family members.

WELL-BEING MEASURES OF PROGRESS

Through implementation of the goals, objectives and interventions outlined above, DCS will the monitor the measures outlined below to determine well-being outcomes for children and youth.

- Permanency and Practice Support reports related to the number and impact of referrals to nurses, clinical services specialists, investigators and education liaisons.
- CANS outcomes and compliance reports.
- Well-being Quality Service Review Child Status Indicators,
- Appropriate living arrangement,
- Physical Health,
- Emotional Status,
- Learning and Development,
- Pathway to Independence.

D. CONTINUOUS QUALITY IMPROVEMENT (CQI) GOALS, OBJECTIVES AND INTERVENTIONS

Goal #4: Promote a culture of learning whereby staff at all levels of the agency consider ways to improve practice, programs and policy.

OBJECTIVE 4.1 DEVELOP A POLICY AND ORGANIZATIONAL STRUCTURE TO BUILD

SYSTEM CAPACITY TO BEGIN USING CQI AS THE METHOD FOR EVALUATING AND IMPROVING CHILD WELFARE PRACTICE.

This objective is ongoing. During SFY 2015, DCS was successful in developing a decision-making structure within the executive staff and field staff through the multi-disciplinary CQI Steering Committee and workgroups tasked with achieving goals supporting the CQI process and larger DCS objectives.

DCS aspires to promote a culture where staff at all levels consider ways to improve practice, programs and policy. In order to achieve this, DCS is approaching CQI as a philosophy to implement policies, programs, and practices that drive continued efforts to support and maintain quality services on behalf of children and families in Indiana. DCS recognizes the need and value of integrating qualitative and quantitative data to provide a more comprehensive view of the agency's strengths and areas for improvement. The approach examines and involves all areas of the agency in a two-way exchange whereby CQI needs are identified, objectives are formed, and constant evaluation occurs throughout.

At the core of the CQI approach is the development of an organizational culture that supports continuous learning. DCS has already begun implementing a variety of data evaluation techniques to more closely align the agency to a culture of learning and discovery. Through the use of consultants, in conjunction with state resources, DCS has begun to analyze and learn from data with targeted management staff. This is just the first step in shifting the agency's culture.

DCS is always working to achieve improved outcomes for children and families, which it does by reviewing existing and emerging research and by analyzing data to continually guide and inform its practice. Data gathered, analyzed, and shared for the Title IV-E Waiver evaluation both support CQI efforts and permit DCS to make necessary changes to policy, programs, and practice through data-informed decision-making. The Title IV-E Waiver serves as a tool for targeted system improvements. The flexibility of the Title IV-E Waiver allows DCS to remain anchored in a general theory of positive change on behalf of children and families in Indiana.

The Department is evaluating progress in achieving its CQI goals and objectives from a completion perspective as opposed to a more quantified data analysis method. To evaluate the agency's progress, DCS will monitor its success by developing a policy and organizational structure to support its utilization of CQI. In addition, the agency will develop a process and monitor progress for identifying opportunities to utilize CQI to further analyze problem areas and identify strategies for improvement.

1. CQI Structure

The structure of CQI is such that it lends itself to weighting potential initiatives, measuring current and projected performance, and evaluating impact and outcomes. The agency is actively monitoring progress toward training agency personnel in CQI methodologies and project management best practices. The Continuously Quality Improvement Division now has an additional nine staff members who were trained in a Six Sigma Green Belt Certification program through Purdue University over the course of several weeks in March 2017. In addition to these staff members, staff from the Services and Evaluation and Outcomes divisions as well as the Child Support Bureau attended this formal training over the course of ten weeks in the first quarter of 2017.

The CQI Division is now part of the umbrella Evaluation and Outcomes Division to further align the work the agency

does with a continual feedback process of measuring data-informed decisions.

2. Organizational Structure

Since June 2015, DCS hired a Director of Continuous Quality Improvement along with a Director of Evaluation and Outcomes. The Director of Continuous Quality Improvement is chiefly tasked with deploying CQI utilization at all organizational levels, making recommendations to drive initiatives, and to chair the CQI Steering Committee. The Director of Evaluation and Outcomes has responsibilities focused on data management and analysis within all DCS applications, research into effectiveness of programs and services, and an overall data strategy for the agency. DCS remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and a broader service array.

DCS has routinely monitored the effectiveness of the Practice Model in order to establish the goals and direction of the agency, Waiver spending, training, and service delivery. To further support these efforts; DCS is implementing a Continuous Quality Improvement (CQI) process that will serve as the foundation for setting agency priorities, structure for internal and external collaborations, and interventions as well as the continuum of service provision. DCS is committed to developing a CQI approach that will serve as the basis for evaluating and improving child welfare practice and will incorporate this objective into the PIP.

3. CQI Steering Committee

DCS established a CQI Steering Committee, chaired by the Director of Continuous Quality Improvement, to set agency priorities and oversee implementation and ongoing activities regarding DCS initiatives. The CQI Steering Committee is comprised of the executive staff from all DCS divisions, demonstrating the agency's commitment to continuous quality improvement and implementation of effective interventions and services to children and families. The CQI Steering Committee has been involved in establishing CQI structure as core to prioritizing initiatives, and monitoring and tracking of implemented interventions and services delivered. The CQI Steering Committee will continue to monitor and shape the CQI efforts driving interventions and service delivery.

The Steering Committee was the primary oversight body for the Child and Family Services Review and the development of the larger Program Improvement Plan. This group has been added to the agency's Strategic Innovation Group which acts as the primary coordinating body for improvement initiatives whether they be broader, agency related, or more intricate improvements within specific divisions.

DCS Administration partnered with several external consultants to assist in evaluating the agency's qualitative and quantitative data sets, as well as providing recommendations for priority setting to the CQI Steering Committee. DCS partnered with Case Commons, Casey Family Services, Katz, Sapper, and Miller (KSM) Consulting, Indiana University, and Deloitte Consulting LLP.

4. Data Analysis

DCS utilized a number of resources, including contracts with Case Commons and Katz, Sapper and Miller Consulting (KSM) to conduct an in-depth analysis of MaGIK data to assess entry and exit cohorts. The data

revealed that children in care remained relatively stable even though there was a marked increase in the number of assessments, many of which were unsubstantiated. More recent analysis indicates that the rate of increase in new assessments is slowing down. Moreover, analysis has identified a new trend of increasing open cases and the agency is beginning to analyze agency data to identify the root cause(s) of this increase.

Casey Family Programs partnered with DCS to assist the agency in determining why more children were entering the system and what other contributors have resulted in an increase in children under state supervision. A team of agency executives reviewed existing intake practices, processes, supporting policies, completed safety/risk assessment tools and substantiation/case decisions to determine the cause of increased caseloads. As a result, three counties (Lake, Allen, and DeKalb) were identified to assess differences in how decisions are made and to determine an effective strategy for improvement. In the fall of 2015, Casey Family Programs co-facilitated county stakeholder meetings with local DCS management, DCS executives, DCS Central Office staff, and external partners (service providers, judges, etc.) to gain a better understanding of the data and formulate action plans. To further explore data and impact change in county caseloads, each of these counties has selected PDSA team members to begin working on a goal to reduce children/youth entering the system. In July 2015, Casey Family Programs and the Director of Child Welfare Outcomes met with local PDSA team members from Lake, Allen, and DeKalb counties, DCS Executive staff, DCS PQI staff, and DCS Service Consultant staff to review quantitative and qualitative data with teams and kickoff the use of PDSA Cycles as a CQI model for DCS. These PDSA groups are scheduled to report their goals, progress, and results to the CQI Steering Committee routinely. The PDSA training was combined with a modified Six Sigma methodology to create a home-grown CQI program. Using this methodology, CQI staff engaged with Field Operations to pursue initiatives which seek to create positive and lasting change from outcomes centered around children and families. These initiatives use a data-centered approach to identify areas for improvement at the outset and again utilize data to show meaningful change in whatever process change was sought. Additionally, the CQI Steering Committee has evolved to the Innovation Strategy Steering Committee which, in addition to oversight for CQI, shall set broader direction for innovation for the agency. The majority of the initiatives should be completed by the end of calendar year 2017. They consist of 5 project team meetings over the course of 10-12 weeks wherein CQI tools are outlined/trained on/completed/reviewed at every project team meeting. These project teams in Field Ops are cross-functional consisting of varying levels of responsibility i.e. FCM, Supervisor, DM, LOD etc. The long-term plan is that the participants in these teams will then get enhanced training to be able to lead projects on their own moving forward with CQI staff acting in less of a facilitator role and more in the vein of mentor who will aid the project lead by shepherding them through the process from start to finish. Once the agency achieves critical mass with employees who have gone from learning and contributing to outright leading, there will be a broader skillset throughout all levels of the agency.

KSM Consulting was hired to review DCS' current organizational structure and data/reporting tools and to identify opportunities for improvement. KSM Consulting identified the location of all internal quantitative and qualitative data sets. They have made recommendations to the CQI Steering Committee to improve data quality and consolidate data sources to address federal/state reporting needs. Reporting needs include AFCARs and NCANDS, CFSP, NYTD, APSR, the state's "Good to Great" Plan, Practice Indicator reports, Governor's Key Practice Indicators, and Title IV-E Waiver Reports. KSM designed a roadmap to assist the CQI Steering Committee in setting priorities for implementation of recommendations. KSM's recommendations include the following:

- Implementation of a robust data management initiative and supporting roles

- Cleansing existing applications and database infrastructure
- Creating a centralized analytics platform

5. Indiana University (IU)

QSR Process and Data

Indiana University (IU) staff completed work with DCS PQI staff to match previous rounds to new data tables for Round 4 and returned previous converted rounds to the PQI team. IU staff also completed work with PQI staff to redesign the database to capture data consistent with all previous rounds of the QSR. PQI is working to match MaGIK identification numbers to all File Maker data files for combined data analysis with MaGIK data.

Expansion of QSR Indicators

In spring 2015, IU staff worked with PQI staff to expand several QSR Indicators. The expanded indicators will measure mothers, fathers, children/youth, and resource parents separately using current timeframes and the last 12 months to assess consistency in the fidelity of practice over time to the TEAPI Model. Furthermore, CFSR questions regarding safety, timely initiation, preventative services, permanency, and quality of FCM contacts were added to the end of the QSR Protocol for the following reason:

- DCS can measure the above mentioned questions similarly to the CFSR tool,
- DCS can obtain reliable qualitative data,
- Data obtained, from the established QSR process, can inform the CQI Steering Committee and field management staff on progress toward federally set goals before, during, and after the CFSR in 2016, and
- Data can be utilized to assess improvement for Indiana's Program Improvement Plan.

PQI is currently working on a plan to train reviewers on changes to the QSR Protocol. Changes to the QSR Protocol will be integrated into related PQI and Staff Development trainings.

Indiana's recent Round 3 CFSR renewed the discussion between DCS and Probation representatives to integrate the review of probation cases into the QSR process. Plans are being made to incorporate work related to the Program Improvement Plan as a foundation for finalizing a probation QSR process.

DCS also expanded QSR Indicators to align them with the Child and Family Service Review (CFSR) Onsite Review Instrument (OSRI). This includes expanding the following indicators:

- Team Formation,
- Team Functioning,
- Assessing and Understanding the Child,
- Assessing and Understanding the Family,
- Intervention Adequacy.

These indicators will measure current practice over the past 90 days, as well as over the past 12 months. Further, mother, father, child, and resource parents will be rated individually during both time frames. Work is currently focused on how to integrate current QSR processes with the CFSR Onsite Review Instrument as part of the PIP case monitoring process.

The Office of Data Management (ODM) is developing DCS reports from MaGIK and data validation questions which have been added to the RPS tool in order to measure federal requirements. These qualitative and quantitative data reports, in conjunction with other DCS reports, will assess practice and monitor progress toward improvements.

Title IV-E Waiver Project

Indiana University partnered with DCS to develop and monitor the IV-E Waiver Demonstration. The Waiver period is for five years, beginning July 1, 2012 and has been extended to March 31, 2018. Through the Waiver, DCS has utilized innovative methods to ensure families are provided with services that meet their needs and, when possible, allow children to remain safely in their home. Waiver funding is integral to the agency's delivery of services. Waiver funding enables DCS to offer an expanded array of concrete goods and services to help families succeed. These types of services are typically only available through other funding sources. Some of the concrete services supported by Waiver funding include: payment of utility bills, vehicle repairs, before/after school care, respite care, baby monitors, and cleaning of the home environment. These are valuable services for families that often prevent the need for removal. For new programs funded by the Waiver, DCS will move towards a CQI driven method of evaluating service needs, quality of services, and the impact that those services have on child and family outcomes.

The CQI Steering Committee has been involved in establishing CQI as core to services delivered under the Waiver. The CQI Steering Committee will continue to monitor and shape the CQI efforts driving service delivery. In addition to the CQI Steering Committee, there are several work groups that help support the Waiver.

6. Deloitte Consulting LLP

DCS commissioned Deloitte Consulting, LLP to conduct a Caseload and Workload Analysis. The Caseload and Workload Analysis assessed the current state of DCS field operations and evaluated the caseload standards in light of existing agency practices, activities, and performance. Included in this assessment was an analysis of DCS' current practices set against leading national child welfare practices that are aligned with improvement in caseload management and service delivery. Deloitte provided a prioritized roadmap and profile for each recommended option that DCS should consider implementing to improve its ability to meet future caseload standards while improving services to children and families.

Based on the Deloitte recommendations, the CQI Steering Committee identified the following priorities:

- Hire additional field staff for compliance with the 1:12 and 1:17 caseload ratios
- Improve organizational efficiencies
- Enhance staff training on use of existing technologies
- Improve data-driven decision making

7. Work Groups

In addition to the CQI Steering Committee, work groups were assigned to assess qualitative and quantitative data results from consultants and DCS reports and identify next steps toward achieving each of the agency's goals for safety, permanency, well-being and CQI. Executive staff were assigned as Leads for the identified goals and objectives. Current work groups have been established for Family Centered Treatment (FCT) team, Enhanced Multidisciplinary team, CANS Committee team, Substance/CMHC team, Placement Permanency Options and Supports team, Foster Care Supervisors/Managers team, Post Adoption/SNAP/LCPA/Service Providers team, Placement Matching team, Concurrent planning team, Case Plan and Transition Plan team, Father Engagement/Providers/Investigators/Field/Legal team, CQI Central team, Evidence Based Practices and Service Mapping team, Collaborative Care Management team, Waiver Communications and Training Team, and Practice Model Refresh team. Each Lead initially determined internal staff representatives needed to serve as group members

and sub group members. External stakeholder group members are selected according to objective goal and member's subject matter expertise. Leads establish a subgroup specifically assigned to CQI to monitor, track and adjust strategies related to implementation, communications, logistical issues, and fidelity to models chosen. The subgroup reports findings to the work group. Leaders report progress and findings to the CQI Steering Committee. Currently, Leaders have been assigned to all agency goals.

a) Identify regions for deployment of continuous quality improvement training centered on tool usage, data examination, and root cause analysis. Objectives which align to the Biennial Regional Strategic Services Plans and the Child and Family Services Plan will be identified and regional staff will be charged with making progress while working in tandem with the Directors of Continuous Quality Improvement and Outcomes and Evaluation along with the Performance and Quality Improvement Unit.

This objective is in progress. The CQI team developed a survey which was programmed and analyzed by the IU evaluation Team. Over 375 responses were received to the survey which assessed how likely they were to use data and reports to analyze and review their work. Regions will be selected to develop objectives and receive CQI training from the overall CQI group.

b) Establish policy work group to define and draft agency policy around CQI including administrative structure, quality data collection, and processes for ongoing case reviews, data analysis and dissemination, and providing feedback.

See Work Group section above. This Objective has not been completed and will be completed in conjunction with upcoming PIP.

c) Engage stakeholders around CQI including revisiting the composition of and role of regional service councils.

This objective is ongoing. Preparation for the upcoming biennial planning for RSCs to take place in the fall of 2017 will include data packets that provide region specific info. This data will be used to evaluate services and develop new 2-year plans for each region.

d) Implement a train the trainer on CQI processes for performance and quality improvement staff and regional coordinators so they can serve as CQI experts on the regional teams.

The preliminary stages of this objective have been completed.

e) Provide support to service providers as they identify ways to incorporate CQI processes into their way of doing business.

This objective has not been completed. DCS provided a comprehensive statewide data presentation to regional, county, and central office staff in the fall of 2015. The purpose of this was to further analyze and examine data trends so that they could be further incorporated into strategic planning and communicated with local providers. A similar data package will be provided to regions as part of the biennial planning process beginning this fall.

OBJECTIVE 4.2 EVALUATE CURRENT QUALITY IMPROVEMENT AND QUALITY ASSURANCE POLICIES AND PROCESSES AND IMPLEMENT STRATEGIES TO FURTHER ENHANCE THESE SYSTEMS AND INTEGRATE THEM INTO THE LARGER AGENCY CQI MODEL.

a) Continue development of a QSR process for collaborative care.

Work on objective 4.2(a) continues. The DCS OYI team completed phase one (1) of implementing continuous quality improvement (CQI). The Independent Living Specialist, the Collaborative Care Division Manager and the Older Youth Services service providers have received CQI training on the Plan-Do-Study-Act (PDSA) model. This model for quality improvement provides an interactive four-stage problem-solving technique for continuous improvement of processes or carrying out change. To ensure our providers are following the fidelity of the model and to provide support to the CQI process, the DCS Older Youth Initiatives team has added a data analyst. DCS OYI team is moving into phase 2 of implementing CQI as each provider is responsible for implementing a CQI project. Meetings between Collaborative Care staff and PQI continue to ensure a thorough process is put in place and a statistically valid pull can be achieved with sufficient dedicated staff. Over the past year, a baseline was completed using 90 cases in order to provide initial trends to Collaborative Care staff. Work is currently focused on incorporating data into the electronic workbook used by PQI staff.

b) Continue further development of automated QAR reports.

Work on objective 4.2(b) continues as validation of the automated QAR reports is ongoing. Initial QAR reports have completed the mapping and data pull verification stages. The reports were released during the summer 2015. QAR reports will be similar to other DCS reports which inform the agency of results on a statewide level, as well as to the employee level for all regions.

The automation of ongoing cases and Older Youth Services cases for QAR reports remains under construction in MaGIK. “Real time” and quarterly reports became available in MaGIK in the fall of 2015 and validation continues to occur. The reports will enable supervisors to monitor cases and make changes to them on an ongoing basis. The reports will assist FCM Supervisors in engaging in ongoing conversations with FCMs on areas of strength and those needing improvement. The statewide data will be used to track progress and make adjustments to current strategies.

Automated assessment and ongoing data reports are in the initial phases of development. The most critical QAR questions will be measured in MaGIK. After these reports are rolled out and refined, additional questions will be added to the QAR in MaGIK .

OBJECTIVE 4.3 IMPROVE UTILIZATION OF INFORMATION SYSTEMS AND DATA FROM A VARIETY OF SOURCES TO SUPPORT THE MANNER IN WHICH THE AGENCY ASSESSES SYSTEM PERFORMANCE TO SUPPORT SYSTEM IMPROVEMENT.

a) Improve manner in which we structure our data to provide more timely access to satisfy individual data requests.

This objective has not been completed. DCS has adopted the Plan-Do-Study-Act (PDSA) CQI model. Additional projects have been identified and will be implemented as data becomes available.

b) Build staff capacity to utilize data for decision-making.

This objective is ongoing. As discussed in the Organizational Structure section above, DCS hired two new positions since June of 2015. The Director of Continuous Quality Improvement is chiefly tasked with deploying CQI utilization at all organizational levels, making recommendations to drive initiatives, and to chair the CQI Steering Committee. The Director of Evaluation and Outcomes has responsibilities focused on data management and analysis within all DCS applications, research into effectiveness of programs and services, and an overall

data strategy for the agency. DCS has also received preliminary recommendations on data strategy from KSM Consulting which include an organizational redesign and restructured data model. Implementation of these recommendations is ongoing, but has led to identification of new key performance indicators which will further be displayed in a dashboard format. Moreover, routine reexamination of critical juncture points within the life of particular involvement types is being analyzed so that the agency can develop estimates of the life of an involvement type. DCS continues to allocate resources to position itself to be able to increase the agency's ability make data informed decisions. As mentioned previously, the newly initiated Innovation Strategy group will help lead the agency's efforts in this endeavor.

c) Integrate qualitative and quantitative data to provide a more comprehensive view of child welfare system strengths and areas for improvement.

This objective has not been completed. See Data Analysis section above.

CQI MEASURES OF PROGRESS

DCS continues to measure progress on the CQI goal from a completion perspective instead of a more quantified data analysis method. DCS has successfully made initial steps implementing CQI into its organizational structure. With the addition of the Director of Continuous Quality Improvement, DCS hopes to continue integration of CQI by capturing additional data, streamlining reports, implementing data modelling, and developing management dashboards to facilitate more real-time decision-making and further analysis of progress on all of the CFSP goals and objectives. During FFY 2014-2015, DCS successfully developed a decision-making structure within the executive staff and field staff through the CQI Steering Committee and workgroups.

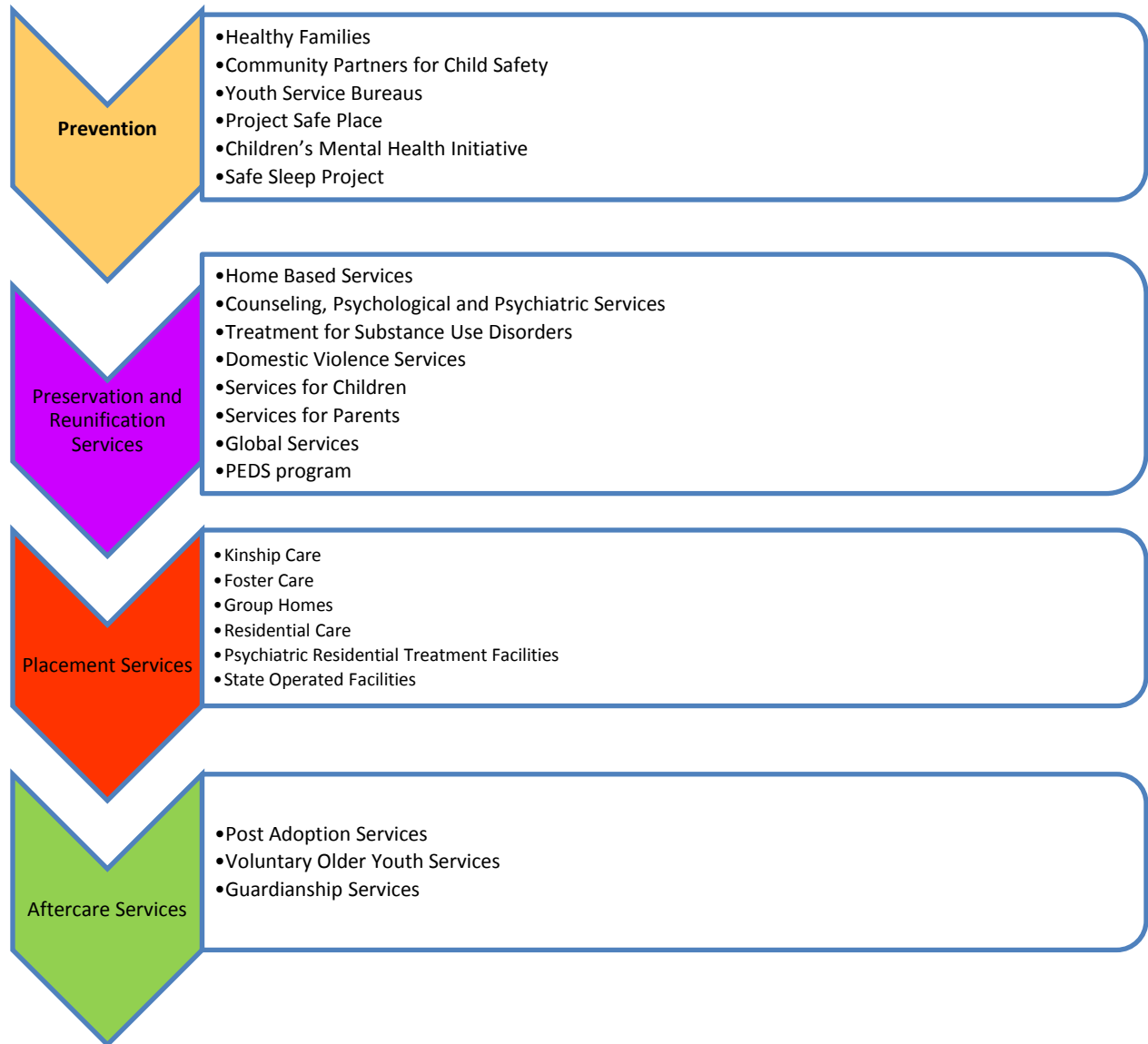
DCS remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and a broader service array. DCS has routinely monitored the effectiveness of the Practice Model in order to establish the goals and direction of the agency, Title IV-E Waiver spending, training, and service delivery. To further support these efforts, DCS is implementing a Continuous Quality Improvement (CQI) process that will serve as the foundation for setting agency priorities, structure for internal and external collaborations, and interventions as well as the continuum of service provision. DCS is committed to developing a sustainable CQI approach that will serve as the basis for evaluating and improving child welfare practice and using data analytics to inform targeted and timely interventions for children and families to improve safety, permanency and well-being outcomes.

After assessing its CQI program following Round 3 of the CFSR, DCS continues to explore the viability of creating advisory councils with key stakeholders groups to formalize the feedback loop mechanism. Multiple advisory councils would be made up of stakeholder groups that would meet regularly and provide direct feedback to the CQI Steering Committee on proposed initiatives, targeted issues brought forth by DCS, and general feedback that the advisory council may want to bring to the attention of the agency.

IV. UPDATE ON SERVICE DESCRIPTION

A. CHILD AND FAMILY SERVICES CONTINUUM (45 CFR 1357.15(N))

DCS provides a full continuum of services state-wide. Those services can be categorized in the following manner:



1. Prevention Services

Kids First Trust Fund

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. Kids First funds 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 statewide network. This fund supports 31 Youth Service Bureaus to provide a range of programs including: Teen Court, Mentoring, Recreation Activities, Skills Training, Counseling, Shelter, School Intervention, and Parent Education.

Project Safe Place

This fund, created by Indiana statute, provides a statewide network of safe places for children 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 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 this service 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, collaborate with Indiana University, Goodwill Industries of Central Indiana, Riley Child Development Center, Women, Infants, and Children (WIC), and the Early Learning Advisory Council (ELAC) 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. The Children’s Mental Health Initiative 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 or find gaps in the service array. 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.

The Children’s Mental Health Initiative is collaboration between DCS and the local Access Sites, Community Mental Health Centers and the 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 can be more flexible than 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: The Children's Mental Health Initiative is a voluntary service. The caregiver must be engaged in order to access services.

The CMHI started as a pilot project in 2012 and has 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.

2. Preservation and Reunification Services

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 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>

Future service enhancements include continued expansion of the home-based service array.

Services currently available under the 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>
<p>Homemaker/ Parent Aid (HM/PA) (Para-professional)</p>	<p>Up to 6 months</p>	<p>1-8 direct face-to-face service hours/week</p>	<p>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.</p>
<p>Comprehensive Home Based Services</p>	<p>Up to 6 months</p>	<p>5-8 direct hours with or on behalf of the family</p>	<p>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</p>

			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.
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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 Evidence Based Practice (EBP) model in service implementation, which include but is not limited to, Motivational interviewing, Trauma Focused Cognitive Behavioural 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 	<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>

	are returning from incarceration or residential placement	
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. 	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.
TFCBT – Trauma Focused Cognitive Behavioral Therapy	<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 	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.
AFCBT – Alternative Family Cognitive Behavioral Therapy	<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 	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.
ABA – Applied Behavioral Analysis	<ul style="list-style-type: none"> ● Children with a diagnosis on the Autism Spectrum 	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>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>
<p>CBT-Cognitive Behavioral Therapy</p>	<ul style="list-style-type: none"> ● Children and adults ● Depression ● Anxiety ● Cognitive distortions ● Unlearn negative emotional and behavioral reactions 	<p>This program offers approaches to assist clients in facilitating many types of behavior change including cognitive distortions which tend to reinforce feelings of anger and self-defeat. CBT is based on the premise that negative emotional and behavioral reactions are learned, and the goal of therapy sessions are to help unlearn these unwanted reactions and learn new ways of reacting. This model has been proven effective with youth and adults who have significant depression or anxiety, those who lack motivation, and those who need mental health treatment to safely change behavior. It can assist parents who appear to be unmotivated in taking initiative on behalf of their children, largely due to history and pattern of being a victim of childhood neglect/abuse, dysfunctional family patterns, domestic violence, or sexual assault. In addition, it can also</p>

		be effective in addressing inappropriate discipline, and assisting with children who are noncompliant, have learning disabilities, social anxiety or bullying behaviors
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Sobriety Treatment and Recovery Teams

DCS is currently piloting a promising practice program that has shown very positive outcomes with families in Kentucky. The program combines a specially trained Family Case Manager, 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 two active Family Case Managers, two Family Mentor and one Treatment Coordinator in Monroe County. DCS expanded this program to Vigo County in 2015 and the county currently has three Family Case Managers, one Family Mentor and one Treatment Coordinator, with the ability to add an additional two Family Mentors. The program in Vigo County is currently serving 15 cases and interviews are ongoing in becoming fully staffed with family mentor applicants. Refining of collaboration practices with Hamilton Center are also ongoing. A current third site is being determined by the Central START team and has been narrowed down to two locations with due diligence currently being performed to ensure the appropriate resources are in place for successful implementation.

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. A-CRA 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 A-CRA 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/behavioural rehearsal is a critical component of the skills training used in A-CRA, 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 A-CRA 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 trained a cohort of 28 therapists to provide Child Parent Psychotherapy. This first cohort of trained therapists included 9 teams of 3 therapists from within the CMHC network and one additional DCS clinician. These therapists completed their training in May 2014 and received a year of consultation through the Child Trauma Training Institute as they began to fully implement the model. The second cohort of twenty three CPP clinicians started in 2014 and completed their year of consultation in June 2016. DCS will evaluate the need and ability to train additional clinicians to ensure service availability for children in need. DCS has trained approximately 500 clinicians throughout the state to provide TF-CBT. These clinicians are employed by Community Mental Health Centers, residential treatment providers (for youth), and community-based providers. This large number of clinicians trained by DCS will expand the availability of TF-CBT and will ensure that TF-CBT is available for children and families in need.

Parent Child Interaction Therapy

DMHA continues to train therapists at Community Mental Health Centers on 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 Behaviour Disorders may be classified as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD), depending on the severity of the behaviour 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.

Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) Services

Community Based/Prevention providers have clauses in their contract with DCS which contain assurances that include the following mandate:

“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

<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf> 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. The Guidebook is located at: <http://www.in.gov/dcs/files/LGBTQPracticeGuidebookFinalforOnlineViewing.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/> . The providers are required to track completion of the training requirement on an on-going basis and completion is verified during a DCS contract audit.

Providers required to comply with the above are:

- Cross-Systems (CSCC)
- Community Partners (CP)
- Home-Based
- Community Mental Health Centers (CMHC's)
- Older Youth Services (OYS)
- Healthy Families Indiana (HFI)

Specific Services/Programming:

- Home-Based Services
- Extra Special Parents (Regions 7, 11, 13, 14, 15, 16, 17, 18):
- Groups and home-based casework for LGBTQ Youth

Older Youth Services:

- Indiana Youth Group (Regions 9, 10, 11, 12, 14).
- Broker services via community based program for youth who have self-identified LGBTQ and who are in need of additional supports. Program provides support, drop-in center programming and other referrals for youth enrolled.

Foster Care

DCS will continue to provide access to foster homes throughout the state. Foster homes are licensed through DCS and through licensed child placing agencies. More detailed information can be found in the Foster and

Adoptive Parent Licensing, Recruitment, and Retention section.

Kinship Care

DCS remains committed to securing the most family-like setting for a child when removal from the home occurs. DCS will first consider placing a child with an appropriate noncustodial parent. If placement with a noncustodial parent is not possible, DCS will look to relatives. DCS changed statute effective July 2014, to include in the definition of “relative,” “any other individual with whom a child has an established and significant relationship.” DCS is in the process of establishing policy and practice around the new statutory definition.

DCS utilizes Relative Support Specialists to assist in supporting relative resources. These staff are relatively new, thus their duties are still being formalized. The Specialists main duties are to inform the relative care placements of support services available to them to promote child permanency, stability and well-being. DCS ensures appropriate services are in place for both the child and the relative caregiver. DCS continues to monitor the relative placement to ensure a safe environment with appropriate supervision is being provided.

Adoption Services

See Services Description, Adoption Promotion and Support Services below for additional information on the types of Adoption Services provided.

Independent Living: Older Youth Services

The service array for Independent Living is described in detail in Section VII, Chafee Foster Care Independence Program.

B. SERVICE COORDINATION (45 CFR 1357.15(M))

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 following partnerships, ultimately supporting communities and families at the local level.

1. Indiana State Department of Health

The Indiana State Department of Health (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, a number of partnerships have been formed between DCS and ISDH in an effort to better coordinate federal and state resources.

Statewide Safe Sleep Program

There is continued forward movement on the coordination of safe sleep education and outreach efforts as well as the formal Memorandum of Understanding (MOU) through which the providers become crib distribution sites for the Safe Sleep program in their local communities. The Indiana State Department of Health (ISDH) has begun several partnerships with community organizations and have increased the distribution sites that cover the entire state.

DCS has purchased Infant Survival Kits for families with an infant at risk for SIDS or sleep-related death. The kits, which include one infant portable crib aka Pack N' Play (PNP), a fitted sheet with safe sleep message printed on it, a wearable blanket, a pacifier and printed safe sleep recommendations) are provided to families in need, upon request. In partnership with ISDH and internal and external stakeholders, this program has been implemented across the state of Indiana. As a result of this collaboration, over 10,000 cribs have been distributed to parents since the First Candle National Crib Campaign began in 2008. As the program advanced, it became apparent that the crib distribution and delivery of the safe sleep education needed to be monitored and recorded to measure outcomes. Demographic information is collected on the recipients of the kits, as well as noting what staff person completed the safe sleep education.

Prior to the onset of this collaboration, there were 100+ distribution sites across the State. With a network this large, it was difficult to obtain accurate demographic information. This led to the revamping of the program through a series of phases. The number of distribution sites was decreased to 23 regional locations during the initial phase. This helped provide a more manageable network through which we could ensure accurate tracking of kit distribution and compliance with the submission of demographic information. Determination of distribution site location was assisted by the geographic boundaries set for the 18 DCS regions. Consistent tracking systems were developed and implemented and the distribution sites are adjusting to reporting timely outcomes. On May 18, 2015, oversight for the Safe Sleep Collaborative at ISDH moved from the Maternal and Child Health Division to the Indiana State Child Fatality Review Program. This change in oversight was made because infant safe sleep environment is so closely tied to child fatality review, and will provide consistent and ongoing support for the ISDH Safe Sleep Coordinator.

The second phase of this collaboration was to work closely with the distribution sites to develop organization and oversight. The Safe Sleep Coordinator accomplished this task by providing consistent and uniform guidance on best practices for distribution, education and the collection of reportable information. This level of management improved accountability for both the distribution sites and the program coordinators. It helped track to whom the kits were being disbursed and whether or not they were also receiving appropriate education. This systemic improvement helps us gather evidence-based data to determine the greatest areas of need.

The third phase addressed the inconsistent education that caregivers were receiving with their kits. In an effort to standardize the messaging, the Safe Sleep Coordinator, in conjunction with the Indiana State Child Fatality

Review Program, developed a webinar to “Train the Trainer” and instruct the distribution sites on what education components they should be offering to each kit recipient. These components include teaching the caregivers safe sleep practices for their infants, the importance of early and adequate prenatal care and avoiding tobacco and drug use while pregnant and/or caring for an infant. To date, over 530 Safe Sleep Educators have taken part in the training and received certificates of completion.

Program Plans:

The total number of Safe Sleep distribution sites has reached 141 and all 18 DCS regions are represented. The Child Fatality Review team will continue working with the Maternal & Child Health epidemiology team to address racial and economic disparity in sleep related deaths, actively seeking agencies in regions with high SUID (Sudden Unexplained Infant Death) rates to join the program, increase the quality of data collection in order to link the safe sleep data with the birth and death records, as well as the ongoing evaluation of the Safe Sleep Program. Moving forward, the continuation of this program will be handled solely by ISDH.

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 as DCS Prevention clients and/or those at risk for involvement in DCS intervention services, as outlined in more detail below.

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health):

In 2012, ISDH MCH with co-lead DMHA, was awarded Project LAUNCH bringing together key stakeholders including State and Local child-serving agencies and parents to create the State Young Child Wellness Council (YCWC). The YCWC developed a vision that states: Indiana Project LAUNCH envisions a State where all individuals responsible for the care and development of children before birth to age 8 years are supported to promote optimal social and emotional wellness in all children leading to healthier families and safer communities. Indiana Project LAUNCH is tasked with piloting initiatives that focus on family strengthening and parent skills training, screening and assessment, integration of behavioral health into primary care settings, mental health consultation, and enhancing home visiting. Home visiting programs are being enhanced through building competency of those providing home visiting services. Trainings in Motivational Interviewing, Trauma-Informed Care Approaches, Mental Health First Aid, and the Georgetown Model of Mental Health Consultation have been provided to a variety of home visitors in the Southeastern region including HFI, First Steps, and Head Start. A mental health consultation initiative (distinct from the model used within MIECHV) will serve as a support to home visitors, children and their families.

Project LAUNCH uses three guiding principles: The Holistic Perspective, Public Health Approach and Ecological Framework to improve young child wellness. Councils on Young Child Wellness engage key players across child serving systems. Indiana has a local and state Young Child Wellness Council that meet regularly. Councils unite stakeholders at state, territory/tribal and local levels across child-serving systems to create shared vision of

Young Child Wellness.

The local Indiana community implementing LAUNCH uses the ASQ and ASQ-SE to screen children in early childhood systems. The local child care resource and referral are trained and have trained educators in the community to use these developmental screening tools. The local hospitals and pediatricians in the local area also administer the ASQ and ASQ-SE screening tools for children, in their offices. Stakeholders that sit on the LAUNCH state council also participate on several governor-appointed Early Learning Advisory Groups that focus on developmental screening and assessment. Having partners sit on both and state and local advisory groups ensures that there is not duplication of work.

Enhanced Home Visitation

A Project LAUNCH committee that the DCS Prevention Manager and MIECHV Coordinator are actively engaged with 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 southeastern corner of the state. Further enhancements included the use of the evidence based curriculum, Incredible Years® with families who are eligible.

Home visiting staff in the region received 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, received mental health consultation that will serve to bolster their knowledge and continually serve families in the most effective manner. Such partnerships and collaborations further demonstrate the strength and positive impacts of the DCS Prevention relationship with ISDH have had to further larger prevention efforts for Indiana families and children.

Early Childhood Comprehensive System (ECCS)

The purpose of the ECCS Impact program is to enhance early childhood systems building and demonstrate improved outcomes in population-based children's developmental health and family well-being indicators using a Collaborative Innovation and Improvement Network (COIIN) approach. An additional goal of the ECCS Impact grant is the development of collective impact expertise, implementation and sustainability of efforts at the state, county and community levels. The overall aim of this project is that within 60 months, the identified community will show a 25% increase from baseline in age appropriate developmental skills among their community's 3 year old children. Secondary aims include:

- Strengthen leadership and expertise in continuous quality improvement (CQI) and support innovation among state and community early childhood systems
- Achieve greater collective impact in early childhood systems at the state, county and community levels, with common aims, shared metrics and measurement systems, coordinated strategies, continuous

communication, and a backbone organization at the state, county and community levels

- Develop primarily two-generation approaches to drive integration of early childhood services within and across sectors
- Develop and adopt a core set of indicators to measure Early Childhood system processes and outcome indicators that measure population impact around children’s developmental health and family well-being
- Test innovative Early Childhood system change ideas, develop spread strategies and adopt new policies for sustaining the systems developed during this project that improve children’s healthy development and family well-being

The stated goals will be achieved through the following activities:

1. Existing partnerships and collaborations
2. Integrating Help Me Grow into ISDH’s MOMs Helpline
3. Sharing CoIIN activities and results
4. Facilitating Collective Impact at the state, county and community levels
5. Sustainability

ISDH MCH is partnering with the Indianapolis Near Eastside and IndyEast Promise Zone, which is also a community receiving Maternal, Infant and Early Childhood Home Visiting (MIECHV), to participate in the ECCS CoIIN. Through this partnership, Indiana’s ECCS Impact team and local community will receive intensive, targeted technical assistance from the National ECCS CoIIN Technical Assistance Center in order to develop collective impact expertise. In addition, ISDH/MCH proposes to contract with Help Me Grow National Center to receive technical support to expand and integrate the evidence-based model within the existing MCH MOMs Helpline. This integration will provide a centralized telephone access point for connecting children ages 0-8 and their families to services and care coordination, child health care provider and community outreach to support early detection and intervention and data collection system.

Early Learning Advisory Committee:

Established by the Indiana General Assembly in 2013, the Early Learning Advisory Committee (ELAC) has membership that 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 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 pre-kindergarten programs.
4. Recommending to the Division procedures, policies, and eligibility criteria for the Early Education Matching Grant program.

Maternal Infant Early Childhood Home Visiting (MIECHV)

As stated previously, 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. As co-leads of the federal grant, DCS and ISDH collaborate with Indiana University (IU), Goodwill Industries of Central Indiana, Riley Child Development Center (RCDC), Women, Infants, and Children (WIC), and the Early Learning Advisory Committee at the state agency level to achieve MIECHV goals.

Indiana's Maternal Infant Early Childhood Home Visiting (MIECHV) Innovation grant is to strengthen and improve the delivery of MIECHV funded home visiting programs through the coordination of community resources and early childhood systems such as child health, behavioral health and human services. Through this award, ISDH/MCH and Department of Child Services (DCS) will expand the services provided by the existing MCH MOMs Helpline and implement the evidence-based model of Help Me Grow (HMG), for the purpose of maximizing the continuum of services for women of child-bearing age through families with children. This will provide a centralized telephone access point for connecting families to services and care coordination; child health care providers and community outreach services to support early detection and intervention; and a data collection system that will inform gaps and barriers within these services.

Evaluation Advisory Board (EAB) and the Indiana Home Visiting Advisory Board (INHVAB)

As part of the MIECHV partnership between DCS and ISDH, Indiana created the MIECHV Evaluation Advisory Board (EAB) 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 NFP to review and advice on the MIECHV evaluation studies being completed in Indiana. The INHVAB includes stakeholders from DCS, ISDH, and Office of Medicaid Policy and Planning, Division of Mental Health and Addictions, and Office of Early Childhood and out of School Learning for the purpose of identifying aspects of the MIECHV project that should inform policy for home visiting within Indiana. The INHVAB also serves as the oversight committee for MIECHV Continuous Quality Improvement (CQI) development and activities. DCS leaders believe that these advisory boards not only provide 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. The majority of these INHVAB state partners are also members of the ECCS State Advisory Team. In order to align efforts and minimize meeting fatigue with state partners, it was decided to combine the INHVAB and ECCS State Advisory Team

meetings. The initial joint meeting held on April 17, 2017 provided an excellent audience for the sharing of information across Early Childhood efforts including MIECHV and Project LAUNCH. Attendees of the combined meeting felt that the combined meeting worked well therefore it was agreed that the groups would continue to meet in this manner.

Local Safe Sleep

At the local level, the Safe Sleep Program Staff will continue to look for opportunities to establish a footprint in communities disproportionately affected by high SUID rates. The DOSETM (Direct On-Scene Education – an innovative program to help eliminate sleep related infant death due to suffocation, strangulation or positional asphyxia by using First Responders to identify and remove hazards while delivering education on-scene during emergency and non-emergency runs) training sessions brought in new community partners committed to tackling the high SUID rates in their counties. ISDH will continue to provide strong foundation, consistent safe sleep messages, technical assistance and resources to those counties.

2. 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.

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. CMHI became available Statewide in March 2014. The purpose of the CMHI is to build a continuum of care for children with complex mental or behavioral health needs who are at risk for entering the child welfare or juvenile delinquency system. DCS, in collaboration with the Division of Mental Health and Addiction (DMHA), will serve children and the families through a practice model of high intensity wraparound to keep children in their own homes and communities. The wraparound model has proven results in the State of Indiana through the Community Alternative for Psychiatric Residential Treatment Facilities (CA-PRFT) Waiver, and is now offered to children and families regardless of financial ability or insurance. Wraparound Facilitators are assigned to each family from local Community Mental Health Centers. Their role is to facilitate access to both community based and residential services, therefore eliminating the need to enter the child welfare or juvenile delinquency system for the sole purpose of accessing services. The CMHI creates a process that is easy to access, multiagency, and strength-based. This is a major change in Indiana, as historically these families were unable to access services without an open child welfare or probation case and court involvement.

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.

Housed in DFR, the Indiana Bureau of Child Care is funded by the Child Care and Development Fund (CCDF) and Temporary Assistance to Needy Families (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.

Indiana Head Start

Also housed in DFR, the Indiana Head Start Collaboration Office (IHSCO) and the 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 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. An updated assessment was completed in 2015 and can be found at www.in.gov/fssa/files/2015_Needs_Based_Assessment.pdf. 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.

First Steps

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) was invited to and participated in ICC quarterly meetings. In addition, many First Steps providers regularly participate in the training opportunities available through the Institute for Strengthening Families.

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.

3. Additional Collaborations Furthering Service Coordination

Governor's Domestic Violence Prevention and Treatment

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. In 2014 the Prevention Manager (CBCAP Lead) was invited to serve on the council.

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 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 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 \(RCDC\)](#)

RCDC 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 RCDC 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 RCDC has been critical in establishing future plans for support of DCS Field Staff and ensuring workers are able to receive and maintain the IAITMH Endorsement.

Systems of Care

Systems of Care meet within local communities and are composed of community agencies, schools, law enforcement, prosecutors, families, and others who focus on ensuring that services are available in the community to meet the needs of families. Systems of Care play a critical role in implementation of high fidelity wraparound that is funded through Medicaid or the Children’s Mental Health Initiative. High fidelity wraparound is aimed at preventing youth with high mental and behavioral health needs that may otherwise be placed in residential placement an alternative by providing targeted individual services and family support services. Other services include residential as well as state operated facilities for those children who cannot be safely served in the community.

Regional Service Councils

The Regional Service Councils and Regional Service Coordinators both work to enhance the coordination of services. The original purpose of the Regional Services Council was 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 (See Collaboration section for a complete description). 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.

4. Provider Workgroups

DCS has worked to engage service provider partners through continued meetings and workgroups. For example, DCS will continue its Yearly CMHC/DCS Collaboration Conference, ongoing meetings with the Community Mental Health Centers, and Regional Collaboration Meetings between local DCS offices and the CMHC’s. 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.

Support Groups

The success of these groups has led to the planned expansion into additional support groups including services such as Cross System Care Coordination, Child Parent Psychotherapy, and Diagnostic and Evaluation Services. DCS will continue collaborating with existing statewide 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 (Child Advocacy Centers).

Community-Based Providers and IARCA

DCS will continue to elicit feedback from a Community Based Provider workgroup regarding referrals, billing, 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 for 2018, on capacity building for difficult populations, on eliminating placement disruptions, and on access to psychiatric residential treatment centers, among other things. 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. DCS continues to work with IARCA on building a collaborative public-private partnership that can address the needs of the children in our care, such as ensuring service providers are able to play a central role in PIP implementation.

For a complete description of collaborative efforts, please review the Collaboration section under General Information above. Many of these efforts are described in more detail in previous sections.

C. SERVICE DESCRIPTION (45 CFR 1357.15(O))

Each region identifies the services needed for their families, and then DCS contracts with agencies through a fair bid process. As part of this identification of services, the regions utilize service data including contracted agencies, service utilization, and service outcome reports to determine which service gaps need to be addressed. These DCS contracts include the specific services and the counties where they will be provided. The service standard defines the family population as a family involved in the Child Welfare or Juvenile Delinquency systems. Additionally, the DCS services standards have been amended to include language ensuring that Lesbian Gay Bisexual Transgender and Questioning youth will have services provided in a culturally sensitive manner. The pertinent language in the service standards is as follows:

Cultural and Religious Competence.

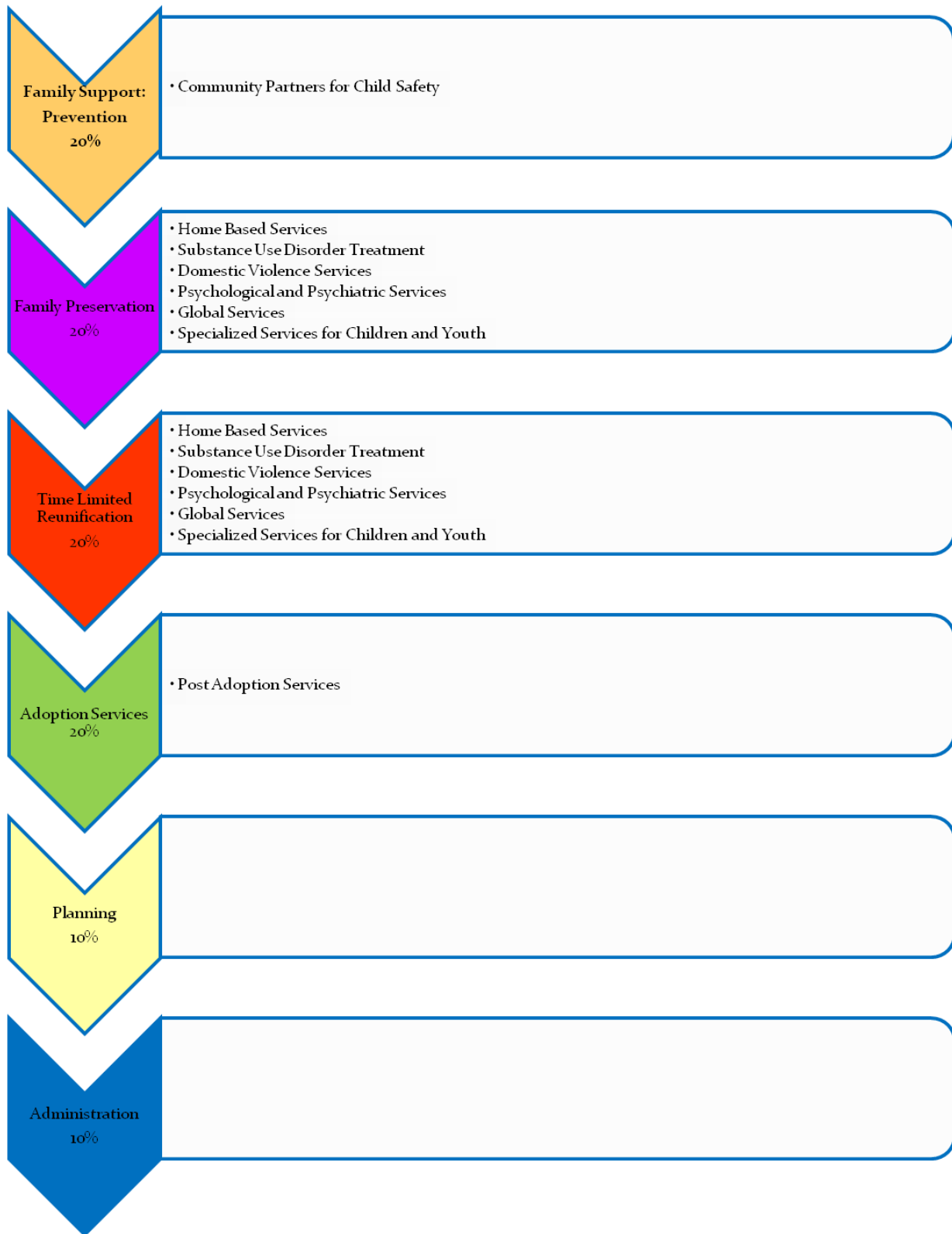
Provider must respect the culture of the children and families with which it provides services. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences. All staff also must be aware of and sensitive to the sexual 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.

Information is provided in Service Array Section regarding strengths and gaps in service. DCS has chosen to spend 20% in each of the Title IV-B subpart 2 service categories. DCS continues to allot 10% in planning and 10% in administration. If these funds are not utilized in these areas, the excess will be put back into services. The visual below depicts this breakdown in service categories.



1. Family Preservation (20%)

This category is designed to provide services for children and families to help families (including pre-adoptive and extended families) at risk or in crisis, including services to assist families in preventing disruption and the unnecessary removal of children from their homes (as appropriate). They help to maintain the safety of children in their own homes, support families preparing to reunify or adopt, and assist families in obtaining other services to meet multiple needs.

Reunification services are also included in this category which could assist children in returning to their families or placement in adoption or legal guardianship with relatives. These services may include follow-up care to families to whom the child has been returned after placement and other reunification services.

Services may include but are not limited to:

- Home Based Services
- Substance Use Disorder Treatment
- Domestic Violence Services
- Psychological and Psychiatric Services
- Global Services
- Specialized Services for Children and Youth

The Service section includes a description of available services.

Services are restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

2. Family Support (20%)

This category is designed to cover payment for community-based services which promote the well-being of children and families and are designed to strengthen and stabilize families (including adoptive, foster, and extended families). They are preventive services designed to alleviate stress and help parents care for their children's well-being before a crisis occurs.

Services may include, but are not limited to: Community Partners for Child Safety. The Service section includes a description of these services.

3. Time Limited Family Reunification (20%)

This category covers services and activities that are provided to a child placed in a foster family home or other out-of-home placement and the child's parents or primary caregiver in order to facilitate reunification of the child safely and appropriately within a timely fashion. These services can only be provided during the 15-month period that begins on the date the child is considered to have entered out-of-home care.

Services may include but are not limited to:

- Home Based Services,
- Substance Use Disorder Treatment,
- Domestic Violence Services,
- Psychological and Psychiatric Services ,
- Global Services,
- Specialized Services for Children and Youth.

The Service section includes a description of available services.

Services are restricted to those children who meet the eligibility for this category and meet the following criteria:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

4. Adoption Promotion and Support Services (20%)

Services and activities available are designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children. Such services and activities are designed to expedite the adoption process and support adoptive families. This includes preparing the child for adoption with regard to loyalty, grief, and loss issues related to their birth family, as well as evaluating a prospective adoptive family and making a recommendation regarding appropriateness of the family to adopt special needs children.

Target Population

- 1) Foster parents and the foster/relative children in their care that have expressed an interest in adoption.
- 2) Pre-adoptive parents and adoptive parents with recently adopted children.
- 3) Long term adoptive parents experiencing challenges with their adopted children.
- 4) Families who have successfully completed the Resource and Adoptive Parent Training (RAPT) and are interested in adopting.
- 5) Families who are interested in parenting children who have suffered abuse or neglect.

- 6) Families who are interested in adopting children with serious medical and/or developmental challenges, older children, and sibling groups who are in the custody of the State of Indiana.

Desired Outcomes

- 1) Minimize the number of disrupted foster/relative placements.
- 2) Minimize the number of disrupted pre-adoptive and adoptive placements.
- 3) Ensure that prospective adoptive families and children free for adoption are adequately prepared for adoption.
- 4) Ensure that each prospective adoptive family is informed of issues related to children with special needs and that informed choices are made when matching children free for adoption and adoptive families.
- 5) Increase the number of adoptive parents available for special needs children.
- 6) Decrease the number of children waiting for adoptive parents.
- 7) Decrease the number of disrupted adoptions.

Based on the benefits of the Child and Family Team Model and the CANS assessment, the post-adoption service standards were restructured in 2011 with the goal of creating cross-system coordination and adoptive family-centered care for service delivery. Services provided to families include a comprehensive strength-based assessment. This service is based on the belief that children and their families are remarkably resilient and capable of positive development when provided with community-centered support, defined by what is in the best interest of the child. It is meant to provide a comprehensive system of care that allows families to find support after adoption.

To put these beliefs into practice, DCS has developed a delivery system for post adoption services that involves three regionally based contractors. Contractors SAFY, Children's Bureau, and The Villages continue to provide post-adoption services to families in the State of Indiana. These 3 agencies provide Care Coordinators located in various regions within the state to oversee intake referrals and provide support to families. The services provided to the client may include, but are not limited to the following: behavioral health care services, respite, parent/child support groups, trauma training, and other services and/or necessary items approved by DCS.

D. SERVICE DECISION-MAKING PROCESS FOR FAMILY SUPPORT SERVICES (45 CFR 1357.15(R))

DCS selects agencies and organizations to provide services through a Request for Proposal (RFP) process. RFPs are issued broadly for services every 4 years. DCS released a Request for Proposals for most Prevention and Community Based services in the fall of 2014 and awarded new contracts to providers which began July 1, 2015 and are still currently in effect.

E. POPULATIONS AT GREATEST RISK OF MALTREATMENT (SECTION 432(A)(10) OF THE ACT)

Those children at high risk for maltreatment who do not have involvement with the Department of Child Services are served through prevention services including Healthy Families Indiana and Community Partners for

Child Safety. These programs are described in the Service section above. The Healthy Families Indiana process of identifying high risk families is described below.

1. Healthy Families Indiana (HFI)

HFI is credentialed by Healthy Families America as a multi-site statewide program. HFI is an evidence-based, voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education. Best practice shows that providing education and support services to parents around the time of birth and continuing afterwards significantly reduces the risk of child maltreatment.

To be eligible for HFI, families must be referred either prenatally (no earlier than the 6th month of pregnancy) or shortly after birth of the target child and fall at or below 250% of the federal poverty level. Additionally, families must be identified at increased risk for child maltreatment as determined by the Parent Survey Process (formerly the Kempe Family Stress Checklist). Referred families are initially screened by HFI assessment staff utilizing the Parent Survey Process with a Fifteen Item Screen that measures risks based on marital status, employment status, income, housing, phone, education, emergency contacts, substance abuse history, prenatal care, history of abortions, history of psychiatric care, abortion sought or attempted, adoption sought or attempted, marital or family stresses and history of or current depression.

If a family screens positive, the Parent Survey Process continues to Assessment including an in-depth conversational interview by HFI assessment staff with expectant or new parents to learn about their individual experiences, competencies and strengths. HFI staff are trained to engage the family conversationally, weaving in ten areas of focus (parent's childhood experience, lifestyle behaviours and mental health, parenting experience, coping skills and support system, current stresses, anger management skills, expectations of infant's development, plans for discipline, perception of new infant, and bonding and attachment). After the assessment interview is complete, the HFI assessment staff supervisor reviews and scores the results. Potential HFI clients must score above 40 to be eligible for HFI services.

If families score 25 or above and have any of the risk factors outlined below, they may also be offered services. Additionally, if families score 25 or above and have additional risk factors, they may also be offered services.

- Safety concerns expressed by hospital staff,
- Mother or father low functioning,
- Teen parent with no support system,
- Active untreated mental illness,
- Active alcohol/drug abuse,
- Active interpersonal violence reported,
- Cumulative score of 10 or above or 3 on question #10 on the Early Postpartum Depression Scale,
- Target child born at 36 weeks gestation or less,

- Target child diagnosed with significant developmental delays at birth, or
- Family assessment worker witnesses physical punishment of the child at visit.

F. SERVICES FOR CHILDREN UNDER THE AGE OF FIVE (SECTION 422(B)(18) OF THE ACT)

DCS will continue to monitor and support new initiatives which work towards reducing the length of stay for children under 5:

- The Fatherhood Initiative has focused on engaging Fathers in the case plan and increasing their parenting capacity.
- The START program focuses on keeping the child in the home while increasing the accessibility and support for substance using parents. The program will continue to expand throughout the state.
- DCS has trained a cohort of 28 therapists to provide Child Parent Psychotherapy.
- DCS Comprehensive Service supporting the usage of evidenced based models, PCIT will increase in its availability throughout the state.
- DCS has enhanced the Diagnostic and Evaluation Service Standard to include an Attachment and Bonding Assessment.

1. Fatherhood Initiative

The Fatherhood Initiative has focused on engaging Fathers in the case plan and increasing their parenting capacity. This effort potentially allows the father or paternal family to be a possible permanency option for the child. One future enhancement could be focusing on co-parenting facilitation for non-traditional families in an effort to increase cooperation and communication between the parents.

2. Substance Abuse Treatment and the START Program

START specifically works to increase permanency for children birth – 5 while improving access and availability to substance use services for the caregiver. This is a multi-team approach, including a close collaboration between DCS and the CMHC. The CMHC employs a Treatment Coordinator who provides immediate substance use assessments, provides oversight of client treatment plan, and ensures communication with DCS and the mentor about client progress. Another component, the START Mentor, can support the substance using parent through the recovery process.

The program supports the Safely Home, Families First initiative by providing the services and support needed for the parents while in the treatment and recovery process, so they may safely parent their child. Currently there are three active Family Case Managers, 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 considering expansion of this program into a neighbouring county.

During the biennial planning process in 2015, DCS regions identified service areas of improvement including

substance use treatment. The START program will continue to expand throughout the state, but other modalities will be researched and considered to work with children with parents affected by substance use. DCS will contact all contracted substance use treatment providers and gather information related to their service availability, treatment modalities, and feedback. Furthermore, regions will update the status of substance abuse services in their biennial reports during the fall 2017. This information will be used to continue the state's efforts in enhancing this service array.

3. Service Mapping

For those families involved in the child welfare system, DCS initiated Service Mapping (described in detail in previous sections). Service Mapping utilizes the Risk Assessment and CANS to identify those families who are at high risk of repeat maltreatment. Using a developed algorithm, Service Mapping will create service recommendations for evidenced-based models most appropriate for the child and family based on their unique needs.

While there are evidence-based models that will be mapped for the entire age range of children, there are specific models available for young children. These evidenced-based models will include Child Parent Psychotherapy and Parent Child Interactive Therapy. Recognizing the unique needs of this age group, DCS identified specific evidenced-based models, and contracted with agencies for both Child Parent Psychotherapy and Parent Child Interactive Therapy to serve children birth to age 5.

Service Mapping will continue to be evaluated and enhanced through collecting and analyzing service recommendations. The recommendation data along with service referral trends, will provide insight into service gaps within the state, and allow for opportunities to assist in targeted service development.

4. Child Parent Psychotherapy

DCS' first cohort of trainees consisted of 28 therapists and DCS initiated a second cohort of 15 therapists. The first cohort of trained therapists includes 9 teams of 3 therapists from within the Community Mental Health Center network and one additional DCS clinician. These therapists completed their training in May 2014, but received another year of consultation through the Child Trauma Training Institute as they began to fully implement the model. Out of the 15 therapists in the second cohort, 9 achieved the certification. DCS has partnered with Casey Family Programs to continue to evaluate the need and ability to train additional clinicians to ensure service availability for children in need. In 2016, DCS continued to work with Casey to have consultation calls and nine additional clinicians received their certification. Those clinicians that received their certification have provided positive feedback on how the training has helped them serve children and families they work with.

5. Parent Child Interactive Therapy

Indiana Family and Social Services Administration – Division of Mental Health and Addiction (DMHA) has trained therapists at CMHCs on 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. The model 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.

6. Attachment and Bonding Assessment

DCS has enhanced the Diagnostic and Evaluation Service Standard to include an Attachment and Bonding Assessment. Contracted agencies were made aware of the service expectation, and began providing this service to children throughout the state on 3/1/2014. The Attachment and Bonding Assessment is used to determine the quality and nature of the bond from the child to the child's caretaker. Recommendations are focused on the child's need that include ways to foster and improve the relationship and attachment quality.

G. SERVICES FOR CHILDREN ADOPTED FROM OTHER COUNTRIES (SECTION 422(B)(11) OF THE ACT)

Post adoption services provided for children adopted from other countries is the same as services provided to children adopted in the United States. If a child, previously adopted in a foreign country, comes into the care of DCS, their eligibility for services would be the same as any other child who comes into the care of DCS. This is not true as it relates to adoption subsidies as most children adopted from foreign countries are not usually in the care of the Indiana Department of Child Services prior to the adoption, and therefore do not meet eligibility requirements.

V. PROGRAM SUPPORT

All training is coordinated through the Deputy Director of Staff Development and is incorporated in the DCS Training Plan. The recent expansion of post-training surveys has assisted in measuring the effectiveness of training programs. All training and technical assistance provided to local office and regional manager is included in the DCS Training Plan.

As discussed within this APSR, DCS has developed a position and hired Directors of Continuous Quality Improvement and Outcomes and Evaluation. These positions will be integral to measurements of performance

through development of reports and data to assist in meeting agency goals and objective. Additionally, these two positions will play a central role in evaluating and measuring the PIP and will continue to work closely with the Children’s Bureau Measuring and Sampling Committee and the Capacity Center for States

DCS collaborates with Indiana University for evaluation of programs and training, including the evaluation of Indiana’s IV-E Waiver program. DCS has a research and evaluation division to assists with any research needed to assist with goals and objectives. MaGIK will be updated as necessary to add fields and data necessary to measure performance. The DCS Quality Assurance procedures are currently being updated to add additional indicators to assess the quality and accuracy of data. As DCS prepares to implement its Program Improvement Plan from the recent Round 3 CFSR, additional reports and data will be developed.

VI. CONSULTATION AND COORDINATION BETWEEN STATES AND TRIBES

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. The Band also extends through four southwest Michigan counties – Berrien, Cass, Van Buren and Allegan. Despite the Pokagon Band’s move to Dowagiac, Michigan, DCS continues to recognize the Pokagon Band as Indiana’s only federally recognized Tribe.

DCS has also worked with other tribes as Native American children have come into the DCS system to ensure that the heritage of children with tribal connections is maintained. DCS remains committed to continually working to expand the knowledge of staff regarding native culture and ensuring collaboration and coordination with tribes, their tribal courts, and families of children with tribal connections.

Pokagon Band

DCS has established partnership/collaboration semi-annual meetings with representatives from the Pokagon Band.

The first semi-annual collaboration meeting for 2016 was held June 28, 2016, hosted by DCS and held at the St. Joseph County local office. In attendance were DCS staff Reba James, Deputy Director of Permanency and Practice Support; Joseph Combs, Assistant Deputy Director of Permanency and Practice Support; A. Colburn (for W. Hornbacher) DCS Legal; James Pippin (for J. Bisbee) DCS Regional Manager; Sheryl Alyea, DCS ICWA Coordinator; and Pokagon staff Mark Pompey, Director of Social Services; and Annette Nickel, Legal.

Significant discussion was had around the issue of how statistically unlikely it is that Indiana ‘Pokagon’ counties have minimal involvement/cases with Indiana DCS. Pokagon staff previously reported that they have around 360 households in Indiana. The meeting was held in St. Joseph County to ensure maximum DCS participation. Ideas and strategies were discussed for ensuring awareness within DCS’ staff in the two Indiana regions serving the six Pokagon Indiana counties. Additionally, DCS Attorney A. Colburn shared that DCS Legal had initiated a pilot program that might aid DCS in their ICWA data reporting.

DCS has continued to provide education to its staff for improved identification of ICWA eligible children/cases which will result in more accurate and consistent feedback for data/statistics. Director Pompey and Presenting Officer/Prosecutor Annette Nickel had previously offered to meet with the staff of the six Indiana counties. DCS Deputy Director of Field Operations, Jane Bisbee, invited them to speak at the Directors' regional meeting for Indiana's DCS Regions 2 and 3 which include coverage for the 'Pokagon' counties. Several DCS management staff from DCS Regions 2 and 3, including the Regional Managers and the North Executive Manager of Field Operations, met on November, 1, 2016, with Pokagon staff in Dowagiac, MI for an on-site visit to enhance their knowledge of Pokagon's Child Welfare Program and Court Services and to establish an additional working relationship within DCS.

At the second collaboration meeting held December 5, 2016, at the Cass County, Indiana local office, DCS learned that the Pokagon Band purchased 166 acres of land in St. Joseph County, South Bend, Indiana. DCS understands that within the borders of the purchased land will be Pokagon's jurisdiction. DCS will collaborate with Pokagon to establish and memorialize necessary protocols to be followed by DCS's staff, including DCS Hotline staff, when receiving any reports of abuse and/or neglect within the borders of Pokagon's jurisdiction. Also discussed was the ongoing need for foundation, enhanced, and follow-up education for the DCS Field Staff regarding ICWA responsibilities. Updates on the DCS Multicultural Teams progress, as well as training plans were shared. Pokagon staff introduced their new Social Services Supervisor, Karen Michaels, who has previous experience within Michigan's state child welfare system.

Indiana Native American Indian Affairs Commission

The DCS ICWA Coordinator maintains an open line of communication with Director Kerry Steiner. DCS obtained permission to reproduce NICWA brochures, The Indian Child Welfare Act: A Family's Guide, and provided them to Director Steiner for use at 2016 Pow Wows and Gathering events for attendees.

Director Kerry Steiner was a guest speaker for the DCS Multicultural Super Region Teams' meeting May 18, 2016 and shared her knowledge of ICWA and the AI/AN populations within the state.

1. Ongoing Coordination and Collaboration with Tribes

The state currently meets with the Pokagon Band of Potawatomi semi-annually to collaborate, share ideas, provide feedback and address any concerns regarding ICWA cases involving their members, as well as other ICWA and tribal related information. Both Social Services Director Mark Pompey and Presenting Officer Annette Nickel have utilized the DCS ICWA Coordinator as their point person to contact at any other time throughout the year to discuss any challenges or needs regarding specific cases.

During the first half of 2016, DCS received questions from field staff concerning DCS obligations when a child member of the Miami Nation of Indiana, a non-federally recognized tribe, enters the state system. The DCS ICWA Coordinator reached out to the Miami Nation of Indiana in May of 2016 via a tribal council member with the intent to gather feedback and discuss their suggested best practice ideas. Through this Council connection,

Erin Oliver, who is also an attorney by profession, confirmation was provided that sending notifications to the Miami Nation of Oklahoma was appropriate. Council member Oliver stated that she would contact the Miami Nation of Oklahoma to initiate a protocol and provide them a contact within the Miami Nation of Indiana for purposes of identifying and confirming membership. Due to the large number of Miami Nation of Indiana members that are also members or eligible for membership with the Miami Nation of Oklahoma, best practice of sending Notification to the Miami Nation of Oklahoma will be recommended for approval as best practice for DCS. Work continued through the remainder of 2016 to refine and improve communications with the Miami Nation of Indiana.

DCS ICWA Coordinator also discussed with Council member Oliver the need for AI/AN foster families and foster care recruitment within the tribe. Council member Oliver invited DCS foster care recruitment staff to Council to give a presentation which might initiate a collaborated plan to get tribe members to step up and help fill that gap. She also invited DCS to set up an information booth for foster recruitment at their tribal events to help engage their membership to consider fostering. DCS foster care recruitment management staff and the ICWA Coordinator met and discussed a plan. Unfortunately, DCS foster care recruitment staff have not yet met with the Miami of Indiana Council. In November 2016 the DCS ICWA Coordinator reached out to the BIA (Debra Burton) for clarification of the ICWA placement preference definitions, specifically U.S. Federally Recognized tribal foster homes vs. non-Federally Recognized tribal foster homes. No definitive answer was provided, however it was suggested that each tribe would have to approve the placement in any specific circumstance. DCS staff (ICWA Coordinator and Foster Care Recruitment staff) need to reconvene to discuss a plan to move forward. The DCS ICWA Coordinator will then pursue collaboration with the Miami of Indiana Council to establish a time for DCS Foster Care Recruitment Management staff to meet with them for the purpose of establishing some teaming ideas to engage the Miami of Indiana members to become better educated on DCS foster care licensing requirements and the need for their participation.

2. Child Welfare Services and Protections for Tribal Children

The state's International and Cultural Affairs (ICA) page on the DCS Internet site is available to the public. Updates and resource information are posted for public use. Contact information is posted on the site for questions and requests regarding entering into IV-E agreements. A IV-E agreement template is also available for use. To date, no requests have been received by the state. DCS policy (2.12) outlines this information and is also available to the public through our public website. The DCS Permanency and Practice Support (PPS) Division has initiated a project which is currently underway to develop their own information page containing an introduction of each PPS program and expanded information. This will also include the International and Cultural Affairs program which encompasses ICWA.

DCS Local Office Attorneys (LOAs) are responsible for providing proper and timely notifications to the tribe(s) about DCS involvement, per DCS policy 2.12. Accompanying the new policy were updates in MaGIK in early 2017 that included new fields and validations that require users to answer a question whether the victim is a

member of a Native American tribe (including those on the federally recognized list and those that are not). Moreover, when a selection is made, the user will be prompted to verify the person's Native American membership, including whether a letter was received from the tribe, an ID card was presented, etc.

The latest (Dec 2016) ICWA policy revision (DCS Child Welfare Policy 2.12) provides clarification for the FCM's responsibility. In policy there is a form 'Indian Status Identification' that the FCM completes with the family when determining potential ICWA eligibility. The local office attorney utilizes this information to complete proper notification. DCS Policy was updated effective 12/01/2016 to be in alignment with the new ICWA regulations.

The FCM completes a Permanency and Practice Support (PPS) referral in KidTraks under International and Cultural Affairs (ICA) for each potential or identified ICWA child for tracking purposes, per Policy 2.12

3. Assessment of Ongoing Compliance with ICWA

DCS continues to make every effort to remain compliant with all ICWA requirements in 25 USC 1900 et seq., 25 CFR 23 et seq, and 45 CFR 1355-1357.

DCS continues to notify Indian parents, tribes, and Indian custodians of state proceedings and their right to intervene. The notification responsibility remains with each local office attorney for a more timely notification process and the above mentioned enhancements to MaGIK are aimed at improving ICWA identification by FCMs and producing data that can better track compliance. DCS also continues to offer placement preferences and respect the tribe's decisions.

DCS attorneys and family case managers have worked with various tribes throughout the United States. When a child of tribal heritage becomes involved with the Indiana child welfare system, DCS notifies the tribe per ICWA requirements. The attorney and family case manager collaborate with tribal representatives to determine how to proceed, to include them in all aspects of the case, and to transfer jurisdiction to the tribe or place the child with tribal members, if requested.

DCS also implemented a referral system for the Permanency and Practice Support (PPS) Division. The PPS referrals for ICWA are being utilized for ICWA tracking within Indiana. During this past year (July 2016 to June 5, 2017) 104 referrals have been received for potential or confirmed ICWA eligible children. Although not yet a reliable number, it has given some measureable data to continue to improve upon. PPS has also opened up communication from within DCS and are utilizing QSR alerts and AFCARS comparisons in ICWA cases. DCS is also utilizing already existing Permanency Roundtables (PRTs) for identifying and reviewing ICWA cases and as a means of checks and balances for identification and services. Shortly before the MaGIK enhancements cited above, starting in the Fall of 2016, DCS Legal began using its new Quest case management system in tracking person attribute of Native American and Case attribute of ICWA notice sent. In Quest, the user is prompted to enter this information when setting up a case detail and person detail in the system.

In addition, DCS initiated the development of Multi-Cultural (MC) Teams that will exist as interim level supports

between the field staff and DCS Administration. These teams will be managed by the International and Cultural Affairs Program Liaison within the Permanency and Practice Support Division. The teams will be able to provide support, reviews, data and statistics, from a regional level, for the state for both immigration and ICWA cases. Each team received one-on-one trainings to address the AI/AN populations within their specific Regions and Super Regions. In May 2016, the six teams met together again in Indianapolis where they received a presentation from the Director of the Indiana Native American Indian Affairs Commission (INAIAC), specific to ICWA. The afternoon was spent finalizing the individual development of the six Super Region teams. The teams are comprised of DCS staff, including case managers, supervisors, directors, a collaborative care manager, and a regional manager, all of which volunteered to meet the need and help close the gap regarding identification and data gathering concerning our ICWA children/cases. Although the number of volunteers has decreased since the program's inception due to position changes, employment departures, additional responsibilities, etc., the remaining volunteers/teams remain committed to the initiative. Mailboxes and notice to the field staff need to be developing and put in place. The goal to activate the teams is the summer of 2017 following the International and Cultural Affairs Overview presentation to the northern third of the state which will include Regions 1, 2, 3, 4, 5, and 6.

DCS will continue to implement new ways of tracking ICWA cases to improve the accuracy of our data. The CHINS Tribal Association report was implemented and developed to report out information specific to AI/AN children and tribal membership. This information is streamed from MaGIK through the child's demographics. A barrier remains for tracking accuracy due to the demographics being client self-reported. However, the report has provided DCS with yet another method to utilize for each reported and/or identified case. Most recently, in MaGIK/Casebook demographics, an ICWA verification box was added and includes the type of verification, as well as the date of verification. The Preliminary Inquiry form was also updated to include specific ICWA questions to help with earlier identification. With the updated ICWA regulations, DCS legal will be able to better track ICWA cases through the court records as well.

4. Notification of State Proceedings

The state continues to notify Indian parents, tribes, and Indian custodians of state proceedings and their right to intervene. This responsibility was given to each local office attorney in order to expedite and provide a more timely notification process.

5. Tribal Right to Intervene

The Pokagon Band and their attorney, judges and social services personnel are aware of their right to intervene in Indiana juvenile court proceedings involving children in their tribe and of their ability to request a transfer of proceedings to their tribal court. Indiana juvenile court judges are also aware of these rights.

Indiana's ICWA Notification Form is served on tribes by the DCS local office attorneys and includes language informing the tribe of their right to intervene, and/or have the proceedings transferred to the Tribal Court.

The ICWA Tribal Transfer of Jurisdiction Tool was added to the DCS Child Welfare Policy Manual, Chapter 2.12, for DCS staff's guidance. The IV-E State Plan Amendment which included the Tool was approved in 2015 and is included within policy regarding the transfer of proceedings to the jurisdiction of a tribe.

6. Continued ICWA Compliance

DCS will make every effort to remain compliant with all ICWA requirements in 25 USC 1900 et seq., 25 CFR 23 et seq, and 45 CFR 1355 – 1357.

As stated above, DCS will continue to work with all tribes and specifically with the Pokagon Band of Potawatomi Indians. DCS will continue to maintain ongoing communication and meetings with tribal officers and members. DCS will also continue to coordinate information regarding services and other information that may be of assistance to a tribe. DCS will continue its integration of meaningful supports for improved identification of ICWA eligible children, and will continue to refine and improve interactions with American Native tribes in order to ensure that tribal heritage is maintained.

DCS is utilizing already existing Permanency Roundtables (PRTs) for identifying and reviewing ICWA cases and as a means of checks and balances for identification, compliance and services. In addition, the state has initiated the development of Multi-Cultural Teams that will exist as an interim regional level support between the field staff and DCS Administration. These teams will be managed by the International and Cultural Affairs Program Liaison within the Permanency and Practice Support Division. Ongoing presentations, training and education will continue to occur for DCS staff, which includes, verbal, written, computer assisted, and face-to-face delivery. Policy has also been updated to include some of the current language from the Guidelines. Input by International and Cultural Affairs was provided for updating the curriculum for 'Cultural and Diversity' training for experienced workers. The updated 'Experienced Worker Culture & Diversity' curriculum was recently completed and finalized. The International and Cultural Affairs (ICA) Liaison and the ICWA Coordinator provided face-to-face overviews of the ICWA updates and responsibilities to 64 field staff in regions 13, 16, 17, and 18 in January 2017, and again to 83 field staff in regions 7, 8, 9, 11, and 12 in March 2017. ICA staff plan to cover the remaining regions over the next few months. The MC team members were asked to attend their region's ICA Overview in order to have field staff familiarize themselves with their MC team point person. Attendees for the Overview received a follow-up electronic folder containing many pertinent and helpful ICWA resources. Attendees also received DCS training hours for their Overview attendance. In reflection, ICA staff identified that many of the attendees were new case managers to DCS, which is indicative that the Overview presentation will need to be on-going. This training, along with the technology improvements, will enhance DCS' ability in meeting and tracking its compliance with ICWA notices.

7. Discussions regarding Chafee Foster Care Independence Program

The Pokagon Band cares for their youth and they are not interested in CFCIP. DCS will continue to discuss the CFCIP with the Pokagon Band as collaborative meetings take place throughout the year.

8. Exchange of CFSP and APSR

Approved copies of the CFSP and subsequent APSRs are provided to officials of the Pokagon Band. Social Services Director Mark Pompey reviews these and has provided helpful feedback to which DCS makes the necessary changes accordingly. When new plans/reviews are completed, these will also be exchanged during the semi-annual meetings.

9. Title IV-E Funding for Foster Care, Adoption Assistance and Guardianship Assistance Programs

DCS will follow established procedures for the transfer of responsibility for placement and care of a child to a Tribal Title IV-E agency or Indian Tribe with a Title IV-E agreement. DCS provides additional instruction for DCS staff to follow in the event that the Tribe wishes to enter into an agreement. Policies explaining this procedure can be found in DCS Child Welfare Policy Manual, Chapter 2.12 and the ICWA Tribal Transfer of Jurisdiction Tool can be found within that same policy. DCS is prepared to enter into negotiations with any federally recognized tribe to share IV-E benefits.

VII. MONTHLY CASEWORKER VISIT FORMULA GRANTS AND STANDARDS FOR CASEWORKER VISITS

DCS requires that family case managers have monthly face-to-face contact with all children under DCS care and supervision and those who are at imminent risk of placement. This includes children and their families participating in an Informal Adjustment (IA). These contacts/visitation must occur in the home. The FCM must document the visit and any new information gained (e.g., health, educational services) in MaGIK within one (1) business day following each visit with the child, and parent, guardian, or custodian.

During critical episodes involving the child and/or family (e.g., potential risk of removal, new child abuse and/or neglect (CA/N) allegations, potential runaway situations, pregnancy of the child, lack of parental contact, etc.), contact must be made within 24 hours of receiving knowledge that a crisis has occurred. The Family Case Manager (FCM) will monitor and evaluate the situation, as well as convene the Child and Family Team (CFT), to assess whether the situation warrants additional services or supports to the family.

While monthly visits conform to DCS policies, best practice indicates a need to see the child on a more frequent basis early on to ensure monitoring and adherence to Visiting and Monitoring of Plans, Family Support/Community Services/Safety Plan (SF 53243), for example, as determined by the Child and Family Team Meeting process.

DCS utilizes the Monthly Caseworker Visit Formula grants in the support of caseworker salaries, training and development of supportive case management practices and outcomes.

FEDERAL MONTHLY CASEMANAGER CONTACTS PROGRESS REPORT

A chart of Monthly Family Case Manager Visits is listed in the report below which is designed to show a running

total of Federal standards for FCM contacts for the year-to-date months within the current federal fiscal year. This report is used to determine the progress of FCM contacts throughout the year. It provides a monthly breakdown of FCM children with whom FCM's have visited and with whom FCM's have visited in the child's home setting. As evidenced in the chart below, Indiana has met the federal requirement for contacts since 2015.

Monthly Family Case Manager Visits							
	Children with Contacts				Children with Contacts in Home Setting		
Month	Contacted Children	Total Children	Percentage		Contacted Children	Total Children	Percentage
October 2014	11298	11907	94.89%		9332	11298	82.60%
November 2014	11408	12154	93.86%		9224	11408	80.86%
December 2014	11642	12188	95.52%		9557	11642	82.09%
January 2015	11637	12279	94.77%		9655	11637	82.97%
February 2015	11844	12478	94.92%		9705	11844	81.94%
March 2015	12072	12632	95.57%		10015	12072	82.96%
April 2015	12539	13068	95.95%		10192	12539	81.28%
May 2015	12652	13363	94.68%		10259	12652	81.09%
June 2015	12794	13384	95.59%		10950	12794	85.59%
July 2015	12895	13445	95.91%		11012	12895	85.40%

August 2015	13039	13556	96.19%		10513	13039	80.63%
September 2015	13320	13889	95.90%		10676	13320	80.15%
October 2015	13553	14340	94.51%		11143	13553	82.22%
November 2015	13775	14590	94.41%		10894	13775	79.09%
December 2015	13871	14445	96.03%		11329	13871	81.67%
January 2016	13977	14552	96.05%		11090	13977	79.34%
February 2016	14150	14670	96.46%		11560	14150	81.70%
March 2016	14272	14769	96.63%		11671	14272	81.78%
April 2016	14588	15098	96.62%		11677	14588	80.05%
May 2016	14813	15306	96.78%		12056	14813	81.39%
June 2016	14931	15410	96.89%		12816	14931	85.83%
July 2016	15213	15741	96.65%		13050	15213	85.78%
August 2016	15439	15901	97.09%		12285	15439	79.57%
September 2016	15968	16416	97.27%		12736	15968	79.76%

VII. ADOPTION AND LEGAL GUARDIANSHIP INCENTIVE PAYMENTS (SECTION 473A OF THE ACT)

Adoption incentive payments continue to be used to provide a wide spectrum of services and supports to adoptive families and children. A majority of payments are used to pay for adoption and recruitment programs including adoption education events, adoption program development, media events, and projects to inform the public of children waiting to be adopted.

DCS continues to train and educate community partners and mental health providers on the effects of trauma and how it impacts the healthy attachment of children to their families. DCS's contractual relationship with the Children's Bureau (CB), to train and educate community partners and mental health providers on the effects of trauma and its impact on healthy attachment for children and their families, began in 2009. The evidence-based curriculum focuses on a trauma-informed method of addressing attachment issues in children and the training provides information on the biological effects of trauma on the brain, therapeutic interventions that can be effective, and a suggested curriculum that can be implemented for support groups.

The Indiana Heart Gallery, referenced above in the Adoptive Parent Recruitment section, is also implemented through adoption incentive payments. This traveling photographic exhibit showcases remarkable professional portraits of and stories about foster children in Indiana – all of whom long for loving and safe homes. The dramatic photos put a face on a sometimes invisible need and remind families that adoption can change lives. DCS also continues to use adoption incentive payments to contract with AdoptUSKids for online recruiting and national exposure, associated with the Specials Needs Adoption Program (SNAP).

IX. CHILD WELFARE WAIVER DEMONSTRATION ACTIVITIES (APPLICABLE STATES ONLY)

A. WAIVER FRAMEWORK AND ACTIVITIES

DCS has had the benefit of participating in a Child Welfare Waiver Demonstration Project (herein referred to as 'Indiana's Waiver project') since 1998 and partnering with IU for evaluation services (as set out in more detail below). DCS' waiver was extended in 2003, 2005, 2010, and then again in 2012. On September 14, 2012, the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), approved the Waiver Terms and Conditions for an extension of the State's waiver demonstration project. DCS accepted the Terms and Conditions on September 27, 2012. The waiver period is for five years, beginning July 1, 2012. Negotiations with ACF on revised waiver terms were completed during 2016 and the amended terms and conditions were formally approved during Q3 of 2016. DCS anticipates being able to leverage the Waiver to enhance its ability to successfully implement and complete PIP initiatives.

The original waiver (1998-June 2012) allowed for only a limited target population to participate in services. However, Indiana's 2012 waiver extension includes all children served by DCS under the age of 18 and their families, as well as a broader array of services. The extension enables waiver service provisions to more closely mirror DCS' TEAPI practice model (Teaming, Engaging, Assessing, Planning and Intervening.) The flexibility of

Indiana's waiver project better aligns the State's system of care with desired outcomes and DCS' overall philosophy of "Safely Home, Families First."

In conjunction with Safely Home, Families First, Indiana's Waiver project targets both Title IV-E eligible and Title IV-E ineligible children and youth who are at risk of or in out-of-home placement and their parents, siblings and caregivers of those children. Specifically, the target population served will include the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or Child in Need of Services (CHINS) status.
- Children and their families with IAs have the status of CHINS or Juvenile Delinquency Juvenile Status Offense (JD/JS).
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

Through Indiana's Waiver project, DCS has utilized innovative methods to ensure families are provided with services that meet their needs, and whenever possible, allow children to remain safely in their home. Funding flexibility is integral to the agency's delivery of services and enables DCS to offer an expanded array of concrete goods and services to help families succeed. These types of services include: payment of utility bills, vehicle repairs, before/after school care, respite care, baby monitors, and cleaning of the home environment. These are valuable services for families that often prevent the need for removal.

Indiana's Waiver project also allows the State to invest in an improved and expanded array of in-home and community-based family preservation, reunification and adoption services. DCS has implemented new services thanks to Indiana's Waiver project's flexibility such as: a Children's Mental Health Initiative, a family evaluation/multi-disciplinary team, Child Parent Psychotherapy, Sobriety Treatment and Recovery Teams, and comprehensive home-based services, such as Family Centered Treatment, Motivational Interviewing, and Trauma-Focused Cognitive Behavioral Therapy.

Child Parent Psychotherapy is an evidence based model which focuses on providing services to families with children age 0-5 who have experienced significant trauma. Services are provided in the home with the caregiver(s) and child, and works to improve the caregiver's understanding of the effects of the trauma and build a strong relationship between the caregiver(s) and child to reduce the effects of the trauma. The program is especially effective with children who have been exposed to domestic violence and/or child abuse.

Sobriety Treatment and Recovery Teams is a promising practice model currently being utilized in Kentucky and is being piloted in Indiana. The program is intended to alter the child welfare and service approach to serving parents with substance use disorders with children under the age of 3. The service includes a triad approach with a specially trained Family Case Manager, a Family Mentor (someone with experience in the child welfare system and a history of addiction), and a Treatment Coordinator. This team provides quick access to assessment and services, as well as increased support and monitoring.

Additionally, Trauma Focused Cognitive Behavioural Therapy (TF-CBT) is another evidence based practice model that is being provided as a component of DCS' Comprehensive Home Based Services. DCS will be utilizing service mapping to identify appropriate families to participate in this service. Children who have experienced significant trauma and have a non-offending caregiver who is able to participate in services will be included in the target population. Children are identified utilizing the Child and Adolescent Needs and Strengths Assessment. DCS has provided TF-CBT training opportunities for therapists throughout Indiana since 2014. Currently Indiana has 45 certified TF-CBT clinicians. They can be found at <https://tfcbe.org/members>. The certification process requires the clinician be licensed and includes training, coaching and consultation which can take up to 2 years to complete. It is unknown the number of those in process who will become certified. DCS has provided Trauma Focused - Cognitive Behavioral Therapy (TF-CBT) training opportunities for therapists throughout Indiana during SFYs 2014 and 2015. The Indiana Division of Mental Health and Addition (DMHA), the Indiana Association of Resources and Child Advocacy (IARCA) and other agencies also provided training during this time period. DCS does not have data for every person taking part in the training, but estimates the number in process to be greater than 500.

The purpose of Indiana's Waiver project remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and a broader service array. As such, the waiver allows DCS to use a Continuous Quality Improvement (CQI) process as the foundation for their continuum of service provision. DCS has routinely monitored the effectiveness of the practice model in order to establish goals and direction with regards to waiver spending and service delivery. DCS is committed to developing a CQI approach that will serve as the basis for evaluating and improving child welfare practice. For new programs funded by the waiver, DCS will move towards a CQI driven method of evaluating service needs, quality of services, and the impact that those services have on child and family outcomes. Funding flexibility already supports the DCS practice indicators, including:

- Reduced use of substitute care,
- Increased use of relative care,
- Increased placement in own community,
- Reduced use of residential placement,
- Reduced number of placement moves,
- Increased sibling placements,
- Reduced length of stay,
- Increased permanency,
- Increased child & family visits, and
- Reduced incidence of repeat maltreatment.

With a shift in focus to a CQI driven approach, waiver services will be further embedded in our quality improvement processes. As outlined in Goal 4 and associated objectives, we are implementing a CQI approach based on the use of regional CQI teams, engagement of stakeholders, increased education of staff on CQI,

provision of CQI support to service providers, improvement in the manner in which data is structured, development of staff capacity to use data for decision making, and the integration of qualitative and quantitative data to provide a comprehensive view of strengths and areas for improvement.

At the core of our CQI approach will be the development of an organizational culture that supports continuous learning. As stated in Positioning Public Child Welfare Guidance, this is important because: “A well-trained, highly skilled, well-resourced and appropriately deployed workforce is foundational to a child welfare agency’s ability to achieve best outcomes for children, youth and families it serves.”¹ In partnership with the Michigan Public Health Institute (MPHI) Center for Healthy Communities, DCS will provide key CQI staff and regional coordinators with quality improvement training and technical assistance support during the implementation of CQI. The goal of the training is to educate staff on the basic theory and strategies of quality improvement, the Plan-Do-Study-Act (PDSA) model, and key quality improvement tools. Staff will also learn how to train other CQI staff on the content of the training. Once staff is equipped with the information from the training, they will serve as DCS CQI experts and will train and provide technical assistance to other DCS staff and/or providers so that all staff on the CQI team, as well as those providing core DCS services, will have a common foundation from which to implement CQI.

A Steering Committee was developed to oversee the implementation and ongoing activities of the waiver. The Steering Committee is comprised of executive staff and Deputies from all DCS divisions, demonstrating our commitment to waiver services and the importance of the funding to our organization’s service delivery. The Steering Committee has been involved in establishing CQI as core to services delivered under the waiver. The Steering Committee will continue to monitor and shape the CQI efforts driving service delivery.

In addition to the Steering Committee, there are several work groups that help support the Waiver.

1. Communications and Training

The Communications and Training work group is responsible for maintaining the communication plan that encompasses all levels of internal and external stakeholders, as well as facilitating any training necessary to ensure the success of the Waiver.

In alignment with the CQI goals, members of DCS attended a CQI training to help implement the Plan-Do-Study-Act (PDSA) CQI model. The Steering Committee presented this model to the Regional Managers in November. At that same meeting, the Steering Committee, along with IU, presented a review of basic Waiver information, an update on the Waiver evaluation, and provided region-specific data from the 2013 and 2014 FCM survey studies and concrete service data.

¹ Positioning Public Child Welfare Guidance can be found at: www.ppcwg.org

The Indiana University (IU) Evaluation Team presented updated data to the Regional Managers (RM) during their meeting in April 2015 and then to additional DCS regional and central office staff during the statewide data presentation in September 2015. Data presented included concrete service distributions, the Quality Service Review (QSR) data regressions, and the RM interview findings. Through this process of dissemination of findings, the field had a great deal of input and feedback resulting in editing the Family Case Manager (FCM) survey. In early June 2016, the IU Evaluation Team is again surveying field case managers to monitor progress in the implementation of IV-E Waiver and DCS Continuous Quality Improvement efforts.

The IU Evaluation Team presented the community survey data to the Deputy Directors and the Regional Managers (RM) during their meetings in February 2016. Presented were data from service providers, the court (Judges/CASA/GAL/Prosecutors/Probation), and clients (Bio Parents/Foster Parents/Relative Caregivers/Youth). This sharing of data provided the field with insight into other stakeholders' perceptions of services being delivered and was a catalyst for ongoing informed discussions.

2. Fiscal Accounting and Reporting

The Fiscal Accounting and Reporting work group is responsible for all tasks related to cost allocation, fiscal accountability, and reporting for Indiana's Waiver project. The work group has responsibility for assessments of Waiver impact on Title IV-E eligibility and cost allocation systems, as well as internal accounting and reporting systems. This team also monitors financial and caseload data and trends to ensure the cost neutrality provisions of the terms and conditions are met.

The Fiscal Accounting and Reporting work group continued to compile baseline financial data for presentation in the mid-term Child Welfare Waiver Demonstration Project report. This work group and ACF also discussed reconciling the cost neutrality provisions in Indiana's Waiver Terms and Conditions, to the reporting format in Part 3 of the modified CB-496 Foster Care Financial Report. Finally, the work group researched trends in spending for out-of-home care versus in-home care, as well as shifts in placement types from residential care to less restrictive placement types since expansion of the Waiver Demonstration Project in 2012.

The Fiscal Accounting and Reporting work group worked on modification of the Quarterly Payment Schedule during the last half of 2015. The work group continued to monitor trends in spending for out-of-home care versus in-home care, as well as shifts in placement types from residential care to less restrictive placement types since expansion of the Waiver Demonstration Project in 2012.

3. Evaluation

The Evaluation work group is responsible for maintaining a partnership with the Evaluation Team from I U. The Evaluation work group will also submit ongoing reports in support of the Waiver. The Evaluation team also includes two sub-groups: an FCT sub-study work group and a Data work group. The Evaluation work group continued monthly meetings for the overall evaluation, monthly data meetings, and bi-weekly FCT sub-study work group meetings. The majority of the Evaluation Team's effort during the Fall of 2015 involved the

development, programming, implementation, and analysis of the community surveys. The Evaluation Team additionally provided support to the PQI team to implement a community survey during the QSR process. As part of the Biennial Regional Services Strategic Plan (BRSSP), the Executive Team produced a statewide data presentation for DCS Local Office Directors, Regional Managers and Central Office Managers who participate in the planning process in September 2015 that included a number of data points, including DCS' ranking in its Federal Data Profile. The BRSSP process includes an evaluation of the local child welfare service needs and a determination of appropriate delivery mechanisms. Each Region does a needs assessment, community meetings, review of data, and public hearings.

In addition to its own CQI process, DCS has contracted with the Indiana University School of Social Work to evaluate the effectiveness of the waiver. The evaluation will test the hypotheses that an expanded array of in-home and community-based care services available through the flexible use of Title IV-E funds will:

- Reduce the number of children who enter out-of-home placement;
- Increase the number of children who exit out-of-home placement to permanency;
- Reduce length of time to permanency;
- Decrease the incidence and recurrence of child maltreatment; and
- Enhance child and family well-being.

DCS will utilize the findings of the external evaluator and our CQI process in combination to improve the waiver services provided to the children and families that we serve. The most recent survey of FCMs related to ongoing evaluation of the effectiveness of the waiver was distributed in June 2016.

One of the most important products that has been developed as a result of Indiana's Waiver project is Service Mapping. DCS is in the fortunate position, as a result of Indiana's Waiver project, of being able to greatly enhance its community based service array. DCS has chosen to do this by enhancing the service array with multiple Evidence Based Practice models. With this expansion, and each EBP having a specific target population, the service array has 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 Family Case Managers 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 system utilizes information from the Child and Adolescent Needs and Strengths assessment as well as the Structured Decision Making tool for Risk Assessment. In addition the Family Case Manager 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, 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 out of 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 which are

essentially summarizing what services would have been mapped had they been available in the community.

Service Mapping is a critical part of the CQI of services and as DCS looks to make improvements, the focus will be on the outcomes of children, youth, and families. The Service Mapping engine will be altered as more information becomes available as to the success of the families involved in the various services. One option would be 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 as well. The process for providing these updates is ongoing and informed by DCS' program evaluation efforts.

Programs will be evaluated to determine their effectiveness with specific target populations. The Family Centered Treatment Sub study is one example of how a program evaluation is tied to service mapping because results from this study may expand or eliminate programs or alter the target population served by this specific EBPs. In addition to evaluating at the program level, DCS will evaluate at the provider level and this information will allow for comparison between providers. Additionally, these evaluations 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.

Service gaps will be identified and closely monitored by DCS. The information gathered 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.

In 2016-2017, the Evaluation work group continued monthly meetings for the overall evaluation, FCT, and CQI. The IU Evaluation Team supported the CQI group by editing, programming, distributing, and analyzing the CQI readiness survey. The Evaluation Team additionally provided the distribution of a survey to parents and youth who are a part of the QSR process.

B. COORDINATION WITH TITLE IV-B & OBJECTIVES

DCS coordinates the use of IV-B funds with IV-E waiver dollars through use of a matrix that details how each program or service is funded. Examples of services funded by IV-B, but not by the waiver, include post-adoption services, child/parent support services, community partner services, and fatherhood engagement services. DCS continually reviews the matrix to ensure that resources are maximized to best serve children and families. The Waiver Steering Committee ensures that waiver activities align with the DCS' strategic plans and CFSP goals.

X. QUALITY ASSURANCE SYSTEM

Information on DCS' Quality's Assurance System can be found in DCS' Round 3 CFSR Statewide Assessment Quality Assurance System Systemic Factor and in the Update to the Plan for Improvement and Progress Made to Improve Outcomes -Goal #4 above.

Currently, Indiana uses the Quality Service Review (QSR) to measure case progress in application of the practice

model. The QSR is near the end of the fifth round of reviews having assessed safety, permanency and well-being for over 500 cases statewide. The QSR Protocol, with additionally added CFSR Indicators, will conclude round five as of July 2017.

Due to federal requirements to utilize the Onsite Review Instrument (OSRI) for PIP monitoring and completion, Indiana intends to redefine the review process during the PIP. A random statewide pull of eighty open and closed cases which include, Probation cases, in-home and out-of-home CHINS cases and Informal Adjustment cases will be used to establish a baseline for PIP completion. Cases will be reviewed with key participants interviewed each year beginning in the baseline year of 2018.

Indiana will complete the OSRI tool on Items 1, 3 – 6, and 12-15 in the Online Monitoring System (OMS) as required. In addition for cases pulled, Indiana will continue to utilize the QSR Indicators to measure Role and Voice, Team Formation and Functioning for 90 days and 12 months, Assessing and Understanding for 90 days and 12 months, Long-Term View, Child and Family Planning Process, Planning and Transitions and Life Adjustments, and Intervention Adequacy for 90 days and 12 months as defined in the QSR Protocol until PIP completion.

XI. CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) STATE PLAN REQUIREMENTS AND UPDATE

A. SUBSTANTIVE CHANGES TO LAW AND REGULATIONS EFFECTING ELIGIBILITY FOR CAPTA

There have been no substantive changes in Indiana law or regulations that would affect Indiana's eligibility for CAPTA, create any complications in complying with CAPTA regulations, or require changes to Indiana's State Plan.

B. SIGNIFICANT CHANGES IN APPROVED CAPTA STATE PLAN

The State of Indiana has not made any significant changes from the State's previously approved CAPTA plan in how the State proposes to use funds to support the 14 program areas.

C. USE OF CAPTA FUNDS

CAPTA funds were utilized in conjunction with Title IV-E Foster Care, Title IV-E Adoption, and Title IV-B, Subpart 2 to support Case Management (case workers and data management) and material assistance payments for concrete services.

D. CRP ANNUAL REPORTS

Indiana Law requires 3 Citizen's Review Panels, a Foster Care Advisory Board, a Child Fatality Review Team and a Child Protection Team. Each panel serves a 3 year term. The foster care advisory board is the only panel that can extend the length of their term beyond three years. DCS had decided to alter the reporting period for

Citizens Review Panels to an annual basis to assist new panels in their report preparation. This will also assist DCS in having completed reports and associated responses for APSR reporting periods.

1. Foster Care Advisory Board

The 2016 Hendricks County Foster Care Advisory Board CRP Annual Report is attached as **Attachment 1**. Their report provided an update on the activities of the CRP performing a thorough analysis of DCS' assessment process. The DCS Response to their report, dated June 28, 2017, is attached as **Attachment 2**.

A new foster parent advisory council has taken over citizen review panel duties and will likely focus on researching and making recommendations around foster parent training, recruitment/retention, and other foster parent related activities.

2. Child Fatality Team

Upon receiving notification from the Monroe County Child Fatality Team that they would be unable to perform their obligations as a Citizen's Review Panel, DCS worked with the State Child Fatality Review Program Coordinator with the Indiana State Department of Health, Gretchen Martin, to identify a new team. In May 2016, the Knox County Team expressed interest and agreed to be Indiana's new Citizen's Review Panel. Information on the role and responsibilities of the Citizen's Review Panel have been shared with their chairperson, Melissa Haaff. As their team was just getting up and going, the decision was made to formally start their citizen review panel duties on January 1, 2017 along with the other two panels. In the meantime, a presentation was provided to the entire team on citizen review panel background and duties. The team has indicated that they will likely focus on safe sleep related infant deaths as they have reviewed a number of cases with those circumstances.

3. Child Protection Team

The 2016 Switzerland County Child Protection Team CRP Annual Report is attached as **Attachment 3**. Their report focused on workforce recruitment and retention and recommendations around increasing funding and reducing caseloads. The DCS Response to their report, dated June 27, 2017, is attached as **Attachment 4**.

The Monroe County Child Protection Team is the new citizen review panel, effective January 1, 2017. A presentation was given to them in February on the role and responsibilities of the citizen review panel.

E. STATE LIAISON OFFICER INFORMATION

The State Liaison Officer is Kyle D. Gaddis, Indiana Department of Child Services, 302 W. Washington St. Room E306, Indianapolis, IN 46204: Kyle.Gaddis@dcs.in.gov. Information regarding CAPTA can be found on the DCS website at www.in.gov/dcs/2329.htm. A link to DCS Administrative Policies and CAPTA forms can be found at www.in.gov/dcs/2539.htm.

F. UPDATE ON SERVICES TO SUBSTANCE-EXPOSED NEWBORNS

Substance-exposed newborns is an issue of great concern for the state of Indiana. The traumatic effects of substance abuse during pregnancy on a newborn and at many stages later in life is being seen more often by DCS.

Pursuant to Indiana's mandatory reporting law, all hospital employees are mandatorily required to report instances of child abuse and neglect. Indiana Code 31-33-5-1 contains Indiana's mandatory reporting requirement and reads "in addition to any other duty to report arising under this article, an individual who had reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this article." Per IC 31-33-5-2, if an individual is required to make a report in the individual's capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, the individual shall immediately notify the individual in charge of the institution, school, facility, or agency or the designated agent of the individual in charge of the institution, school, facility, or agency and the that individual shall report or cause a report to be made." The issue of hospital reporting is an ongoing topic with the Neonatal Abstinence Syndrome Subcommittee (a description of this subcommittee can be found below).

In addition to the State law for mandatory reporting, Indiana Code 31-34-1-10 reads that "a child is a child in need of services if: (1) the child is born with : (A) fetal alcohol syndrome; or (B) any amount, including a trace amount, of a controlled substance or a legend drug in the child's body; and (2) the child needs care, treatment, or rehabilitation that: (A) the child in not receiving; or (B) is unlikely to be provided or accepted without the coercive intervention of the court. Indiana Code 31-34-1-11 reads that "a child is a child in need of services if: (1) the child: (A) has an injury; (B) had abnormal physical or psychological development; or (C) is at a substantial risk of a life threatening condition; that arises or is substantially aggravated because the child's mother used alcohol, a controlled substance, or a legend drug during pregnancy; and (2) the child needs care, treatment, or rehabilitation that: (A) the child in not receiving; or (B) is unlikely to be provided or accepted without the coercive intervention of the court."

New legislation was passed that will go into effect July 1, 2017 that amends IC 31-34-1-10 to include Neonatal Abstinence Syndrome (NAS) and clarify testing mechanisms. The updated statute will explicitly state that infants born with NAS or controlled substances in their bodies, including positive tests of the blood, meconium, and urine, are considered a child in need of services.

Indiana Codes 31-34-1-12 and 31-34-1-13 provide an "exception for mother's good faith use of a legend drug and use of a controlled substance according to prescription."

Each DCS local office has established a relationship and protocol with their local hospitals to ensure a plan of safe care that provides for proper referrals and services being put in place when necessary. Furthermore, local DCS staff provide training on child abuse and neglect to local hospitals. Regional Child Protection Plans also include agreements between hospitals and DCS on reporting child abuse and neglect. While the policies and procedures mentioned herein are currently in effect, DCS Executive and Field Staff will continue to monitor and

evaluate the agency's response to substance exposed newborns to ensure the plan of safe care includes the most up-to-date best practices. DCS monitors service utilization reports along with risk and safety assessments and safety plans to monitor plans of safe care and identify frequency of use. Reports and data are continuing to be enhanced to better capture the services and safe care plans that are put in place and to meet the upcoming data element requirements that will be required to be provided in upcoming NCANDS submittals.

DCS Field Management provides regular guidance to regional and local field staff on this issue as well, such as:

- If a newborn and/or mom test positive, a DCS assessment (investigation) and a substance abuse screen of the mother *must* be completed;
- If an assessment is substantiated on a positive newborn, an IA CHINS will be filed unless the Regional Manager determines otherwise;
- If the mom tests positive at delivery, a drug screen must be performed after discharge from the hospital;
- If a drug positive newborn assessment is going to be unsubstantiated, the Regional Manager must be notified and receive the Assessment Report before any decision is finalized.

Related to the issue of substance-exposed newborns, beginning July 1, 2016, DCS will prohibit screen outs of reports received for children under three (3) years old, per the recommendation of the federal Commission to Eliminate Child Abuse and Neglect Fatalities. Therefore, all reports received by the agency for children under three (3) will be assigned for an investigation. DCS is also performing public service campaigns to remind the public of their mandatory duty to report. Examples include developing a website that has been setup with training information (<https://reportchildabuse.dcs.in.gov/>), social media campaigns (including YouTube videos and Twitter), and partnering with local media outlets to inform the public.

Indiana recognizes that this issue is not just isolated to the child welfare system, but has significant impact on other state systems. There are many task forces at the local levels as well as the state level working to address these issues. DCS has programs in place to assist pregnant mothers involved in the child welfare system who have been identified as having addiction issues. Furthermore, DCS is increasing its support of providers by:

- Providing technical assistance through a consultant from Child and Family Futures, the National Center for Substance Abuse and Child Welfare. This service is supported by Casey Family Programs.
- Supporting Evidence Based Practices.
- Contracting for Residential services for mothers and young children
- Contracting for Transitional Housing programs
- Expanding the Sobriety Treatment and Recovery Teams (START) model

In 2014, the Indiana legislature, in Senate Enrolled Act 408, brought Neonatal Abstinence Syndrome to the forefront. SEA 408 established a clinical definition of Neonatal Abstinence Syndrome and directed the Indiana State Department of Health to meet with medical and pediatric stakeholders to develop recommendations

regarding diagnosis, screening, and reporting of NAS. The Task Force made the following recommendations for a uniform process for both pregnant women and newborns for the purpose of correctly identifying pregnant women at risk for delivering a baby with NAS.

The Obstetric Protocol focuses on two points in time:

- The first prenatal visit; and
- Presentation at the hospital/birthing center for delivery.

First Prenatal Visit

At the initial prenatal visit, as part of routine prenatal screening, the primary care provider will conduct a standardized and validated verbal screening process and a urine toxicology screen. The toxicology screen is voluntary and the pregnant woman can opt out of the toxicology screen. At the discretion of the primary care provider, INSPECT and/or repeat verbal and toxicology screenings may be performed at any visit. The toxicology screen is always voluntary on the part of the pregnant woman.

Presentation at the hospital/birthing center for delivery.

When the pregnant woman arrives at the hospital for delivery, hospital personnel will conduct a standardized and validated verbal screening on all women. Medical staff will request that the woman consent to a urine toxicology screening for anyone with a positive screening result at any point during her pregnancy including presentation for delivery. Babies whose mothers had a positive verbal screen or positive toxicology screening results or babies whose mothers did not consent to the toxicology screen will be screened using urine, cord or meconium.

The Neonatal Protocol focuses on three cohorts of babies:

- Newborns with **no identifiable risk**;
- Newborns **at risk** for NAS; and
- Newborns with **unknown risk**.

Mother's Status	Level of Risk for Infant	Suggested Action
Negative verbal and toxicology screens	Newborn with no identifiable risk	No testing recommended at birth
Positive verbal screen and/or positive toxicology screen at any time	Newborn at risk for NAS	<ul style="list-style-type: none"> • Perform urine and meconium or cord toxicology screening at birth

		<ul style="list-style-type: none"> • Perform Modified Finnegan scoring • Evaluate maternal support resources
<ul style="list-style-type: none"> • No known verbal or toxicology screen during pregnancy • Negative verbal screen but no known toxicology screen 	Newborns with unknown risk	<ul style="list-style-type: none"> • Perform urine and meconium or cord toxicology screening at birth. • Perform Modified Finnegan scoring

After submission of the NAS Report, the Task Force reformed as a subcommittee of the Indiana Prenatal Quality Improvement Collaborative (IPQIC). Jane Bisbee, DCS Deputy Director of field Operations represents DCS on the NAS Subcommittee. DCS Executive and Field Staff are continuing to examine the issue and work with fellow state stakeholders to develop a comprehensive plan to combat this epidemic. Sam Criss, DCS Deputy Director of Services and Outcomes, Gil Smith, DCS Asst Deputy Director of Field Operations, and Kelly Moore, DCS Fatality Team, serve on the Infant Mortality and Child Health Subcommittee which identifies and addresses issues involving the multi-factorial issue of infant mortality including NAS, SIDS and suffocation, and improved newborn screening.

The Governor’s Assurance Statement relating to substance-exposed infants and plans of safe care is attached hereto as **Attachment 5**.

G. AMENDMENTS TO CAPTA MADE BY P.L. 114-22, THE JUSTICE FOR VICTIMS OF TRAFFICKING ACT OF 2015

I. Provisions and Procedures for Identifying and Assessing All Reports of Known or Suspected Child Sex Trafficking Victims

During the 4th quarter 2017, a new featured was added to MaGIK for an allegation of “Human/Sexual Trafficking” that can be used to track any reports of human and/or sexual trafficking. For substantiated allegations, there are Maltreatment Subtypes of: (1) forced labor; (2) involuntary servitude; (3) prostitution; (4) child exploitation, as defined in IC 35-42-4-4(b); (5) marriage, unless authorized by a court under IC 31-11-1-6; or (6) trafficking for the purpose of prostitution or participation in sexual conduct as defined in IC 35-42-4-4(a)(4). If any of these are checked, there is an additional question of “yes” if a CHINS 3.5 was filed, or “no” a CHINS 3.5 was not filed with validation that one of the two were selected.

Additionally, a screening tool was completed and has begun to rollout for each youth returning from a run

episode (Probation and DCS) that will then instruct how to proceed. If there are risk factors present, the full assessment tool will be required. For DCS the FCM continues with the full tool, for Probation, Probation officers are prompted to make a report of “Human/Sexual Trafficking” to the Hotline so that the full tool can be completed by an FCM.

In summary, as of October 1st, 2016, DCS began to have the ability to track the following:

- Reported Allegations of Human/Sexual Trafficking
- Substantiated Allegations of Human/Sexual Trafficking and their Subtypes
- Youth screened for Human/Sexual Trafficking
- Risk level for Human/Sexual Trafficking for those that have an indicator of risk during screening (this is not yet completed and still in development)

II. Training of CPS workers, Efforts to Coordinate with Stakeholders, and Future Plans

DCS is currently working on an Indiana Profile for Child Victims of Human Trafficking and developed a mandatory computer assisted training for all DCS employees that was required to be completed by employees before December 31, 2015. This mandatory training was completed by all FCMs and 3FCMs. As policy updates continue to be made, the human trafficking training will be updated to reflect any changes. An updated human trafficking training was rolled out in the fall of 2016 and included the screening tool, assessment tool, and when to call the hotline for a new report. A copy of the DCS human trafficking screening and assessment tool is attached hereto as **Attachment 10**.

In October 2016, the updated Human Trafficking CAT rolled out and is continuously available to DCS staff to enable them to take this required training on an annual basis. It is one of the TOL requirements for completion by new FCMs prior to graduation. The CAT is housed on the Training Partnership website with a link to the CAT for CASA/GAL staff and for all service providers who are contracted through DCS. In addition, a Human Trafficking workshop is offered at the annual Resource and Adoptive Parent Conference in order to make information on this topic available to foster parents.

The Indiana Supreme Court established a Commercially Sexually Exploited Children (“CSEC”) Task Force in early 2016 in order to establish a state wide uniformed assessment tool and process for identifying and working with youth who are victims of human trafficking. Upon the CSEC Task Force completing its work, a newly formed steering committee whose members will oversee and implement the process of training personnel to use the tools in the initial five counties (Allen, Clark, Delaware, Marion and Tippecanoe). This steering committee reports to the Juvenile Justice and Cross System Youth Task Force of the Commission on Improving the Status of Children in Indiana.

DCS Placement Support and Compliance, in conjunction with the DCS Clinical Support Group, is working on implementation of a residential program service category and are coordinating with current providers involved in the community to develop an appropriate standard of care for this population. A new workgroup was recently established during Q2 of 2017 to bring providers to the table on this initiative. June Artis, DCS Program Director of Residential Licensing, will lead the monthly workgroup that will examine best practices for the CSEC population to ensure placement and service providers create appropriate placements and a continuum of care.

Also related to this effort, DCS is in discussions with the Indiana Youth Services Association (IYSA) to partner on human trafficking initiatives state wide. IYSA has 32 youth service bureaus and in October 2015, received a grant from the Indiana Criminal Justice Institute for the Indiana Trafficking Victims Assistance Program (ITVAP) to raise awareness of human trafficking and increase recognition and identification of victims and to develop a state wide network of service providers for minor trafficked youth. The ITVAP will identify and provide comprehensive services to 150 youth who have been trafficked or sexually exploited by creating five regional coalitions and engaging community partners across the state.

Lastly, DCS continues to participate on the Indiana Protection for Abuse and Trafficked Humans Task Force (IPATH) on coordinating human trafficking efforts that take place across the state.

III. Definition of Child Abuse and Neglect

Indiana Law IC 31-34-1-3 (eff. July 1, 2016) was amended to provide a child in need of services designation for a child who: (1) lives in the same household as an adult who committed or is charged with human or sexual trafficking; and (2) needs care, treatment, or rehabilitation that the child is not receiving or is unlikely to be provided without intervention.

IC 31-34-1-3.5 (eff. July 1, 2016) was added to Indiana law to provide a child in need of services designation for a child who is the victim of human or sexual trafficking as defined in Indiana or under the law of another jurisdiction, including federal law; and (2) needs care, treatment, or rehabilitation that the child is not receiving or is unlikely to be provided without intervention. A child is considered a victim of human or sexual trafficking regardless of whether the child consented.

IC 31-9-2-133.1 (eff. July 1, 2016) was added to Indiana law and states that a “victim of human or sexual trafficking”, for the purpose of IC 31-34-1-3.5, refers to a child who is recruited, harbored, transported, or engaged in: (1) forced labor; (2) involuntary servitude; (3) prostitution; (4) child exploitation; (5) marriage, unless authorized by a court; or (5) trafficking for the purpose of prostitution or participation in sexual conduct.

At this time, DCS is not planning to apply the sex trafficking portion of the definition of “child abuse and neglect” and “sexual abuse” to persons who are over age 18 but have not yet attained age 24. Indiana will be able to submit the new CAPTA assurances related to sex trafficking by the May 29, 2017 deadline and does not anticipate requesting technical assistance to implement the amendments to CAPTA made by the Justice for

Victims of Trafficking Act of 2015.

XII. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM (CFCIP)

A. AGENCY ADMINISTERING CFCIP (SECTION 477(B)(2) OF THE ACT)

DCS administers and supervises contracted providers who deliver CFCIP, including the Federal Education and Training Voucher program, directly to eligible youth. Services are available in all 92 counties across the state. DCS utilized a fair bid Request for Proposal (RFP) process to award contracts for CFCIP services. The DCS Central Office Older Youth Initiatives (OYI) Team provides direct oversight of program, service array and service provision of contracted providers or Older Youth Services (OYS) providers. The DCS OYI Team is made up of key personnel from the Child Welfare Services Division and works cross divisionally with the Collaborative Care Program Management team which is made up of key personnel from Field Operations Divisions.

DCS provides program oversight to the six (6) Older Youth Services (OYS) Providers that provide CFCIP services through multiple methods. Bi-monthly meetings are held with OYS Providers, DCS OYI program and Collaborative Care (CC) leadership staff. Program success, challenges, potential improvements and best practices are discussed. DCS Collaborative Care Case Managers (3CM), Collaborative Care Supervisors, Independent Living Specialist, OYS provider direct staff and Supervisors come together at the local level (per Service Area, which is comprised of two DCS Regions) to discuss individual cases, local resources and CC practices. DCS Independent Living Specialists are in consistent communication with the OYS Providers to provide technical assistance for program and contract questions. DCS also gathers feedback on service delivery, gaps and quality from youth participating in services provided under the OYS service array. Contract compliance is monitored by the DCS Fiscal Audit Group.

The DCS OYI team has completed phase one (1) of implementing continuous quality improvement (CQI). The Independent Living Specialist, the Collaborative Care Division Manager and the Older Youth Services service providers have received CQI training on the Plan-Do-Study-Act (PDSA) model. This model for quality improvement provides an interactive four-stage problem-solving technique for continuous improvement of processes or carrying out change. To ensure our providers are following the fidelity of the model and to provide support to the CQI process, the DCS Older Youth Initiatives team has added a data analyst. DCS OYI team has moved into phase 2 of implementing CQI. Each provider is responsible for implementing a CQI project within their agency. The OYS providers have formed CQI teams that consist of community stakeholders, DCS staff, and youth. Each CQI team has developed a team charter, identified an aim statement and began the PDSA cycle.

B. DESCRIPTION OF PROGRAM DESIGN AND DELIVERY

1. Current Practice

DCS' OYS service delivery method utilizes the broker of resources model, which is designed to: 1) ensure youth

have or establish ongoing connections with caring adults; and 2) promote youth to develop as productive individuals within their community, by the acquisition and maintenance of gainful employment, the achievement of educational/vocational goals, and the receipt of financial skills training. This model shall also aid in future program development and design for other resources to facilitate the successful transition to adulthood for foster youth.

This model places the provider in the role of connecting youth with services provided in the youth's community or through a natural, unpaid connection to the youth rather than by the contracted provider. Over time, the youth should be able to depend on their social network and individual knowledge in order to accomplish tasks related to living independently.

In addition, the service delivery method is practiced in conjunction with the overall DCS practice model which can be found in Section I.

2. Service Delivery

In 2009, DCS held focus groups with key stakeholders, including youth, to assist in restructuring the service delivery of Independent Living Services. Services for youth were designed to assist youth who will age out of foster care with the skills and abilities necessary or desirable to be self-reliant in accordance with State law. This service is known as Older Youth Services (OYS). The OYS program is comprised of Chafee Independent Living Services, Collaborative Care Program and Chafee Voluntary Independent Living Services. The focal points of OYS are to increase youth voice, offer the opportunity to practice interdependence as well as gaining the skills to build the youth's own social capital.

OYS consist of a series of developmental activities that provide opportunities for youth and young adults to gain the skills required to live healthy, productive and responsible lives as self-sufficient adults. Services are provided according to the developmental needs and independent skill level of the youth based on the Casey Life Skills Assessment (CLSA). Youth receiving OYS, participate directly in designing their program activities, accept personal responsibility for achieving interdependence and have opportunities to learn from both positive and negative experiences. OYS providers assist youth by advocating, teaching, training, demonstrating, monitoring and/or role modelling new appropriate skills to enhance self-sufficiency. Services allow youth to develop skills based on experiential learning and may include outcomes based on the youth's needs as identified through the CLSA.

Indiana DCS opted to extend IV-E foster care. Collaborative Care (CC) was implemented as Indiana's extended foster care program to provide youth the option of voluntarily remaining in foster care up to their 20th birthday.

The state moved to a Broker of Resources model prior to implementation of Collaborative Care (CC). CC program and practice model for case managing older youth in foster care was built upon five foundational pillars: Youth Voice; Social Capital; Relational Permanency; Authentic Youth-Adult Partnerships; Teachable Moments and Adolescent Brain Research. Youth transition to a 3CM at age 17 ½ (for all youth who will not

achieve permanency within 3-6 months after obtaining age 17 ½). The goal of the CC program is to help youth practice living interdependently to gain the skills and knowledge to transition successfully out of the foster care system. Identified youth will move into independent living settings (that are developmentally appropriate) that the youth can continue to live in once DCS closes the case. The focal points of this programming are to increase youth voice, offer youth opportunities to practice interdependence, and provide a foundation for gaining the skills needed to build the youth's own social capital. This program also allows youth to voluntarily return to foster care on or after the age of 18. In efforts to increase service delivery, youth who have a case plan of Another Planned Permanent Living Arrangement (APPLA) at age 16 may transition to the CC team to initiate services.

In addition, DCS has implemented programs focused on assisting youth in transition out of foster care by undergoing changes to meet the requirements of federal regulations; H. R. 4980 "The Preventing Sex Trafficking and Strengthening Families Act. DCS has revised policies and practices to meet the need of youth beginning at age 14. This includes revising and changing the name of the transition plan and policy to the Transition Plan for Successful Adulthood. DCS policy was revised to begin planning at the age of 14 and to provide youth an opportunity to select two (2) child representatives, one acting as the youth advisor or advocate as a part of their team. In addition, other policies have been revised to beginning services and planning at the age of 14 as well as revising language to successful adulthood.

Implementing the new policy revision has empowered youth in foster care because by starting at age 14; youth will also have a strong voice in choosing who is a part of their team including the selection of two (2) child representatives. One child representative will act as the youth adviser and advocate. This team should meet every 6 months or more often if a critical case juncture occurs. There are outlined topics to discuss at each meeting, such as youth's housing, employment and educational goals. Steps to reach each goal are identified as well as which member of the youth's team is responsible for assisting this youth in achieving the goal.

In order to support positive youth development during adolescence, services are adjusted to account for the unique needs of youth who are aging out of foster care. Services are designed in such a way to: 1) provide support; and, 2) foster interdependence (different from independence by the inclusion of/emphasis on social capital) to each youth. This is accomplished by designing services that allow for youth to learn from experiences and mistakes. These experiences and mistakes promote positive brain development at a time when adolescents' brains are in a state of plasticity, allowing youth to gain self-confidence, coping skills, self-regulation and resiliency skills. Indiana's "broker of services" model for Chafee Independent Living Services support older youth in this manner by being structured to allow for youth-adult partnerships in the planning process.

Additionally, the standards are structured in a way that allow for a myriad of individuals to role-model, teach, train, monitor, etc. particular IL skills. Youth should have the opportunity to experience situations that build social relationships and networks (i.e. strengthen their social capital). The contracted Older Youth Service provider is not solely responsible for the growth and development of the young person participating in services. All youth should be supported by a team of people including formal and informal connections. Finally, DCS' OYS

service standards are designed to give differing levels of support to the youth depending on the youth's skill developmental and comfort level. Youth with less experience may require more guidance and face to face instruction time, while other youth may only need assistance occasionally with less guidance.

The expectation of OYS providers is to serve in the role of community resource broker for youth receiving OYS services (CFCIP). This role focuses on increasing the youth's skills in accessing services within their community and building support networks that will exist after DCS services end. OYS providers need to first seek community resource providers to provide the direct services associated with the outcome areas outlined within the OYS Service Standards. Providers must maintain documentation in the file if no community resource exist thus direct service was provided by the OYS provider. If the OYS provider can document a service gap in a region/county for an outcome area, approval may be granted for that specific region/county, thus documentation would not be needed for each youth seeking services in that region/county. Group services with a pre-approved curriculum by the ILS will not need to seek this additional approval.

3. Specific Accomplishments

Help youth transition to self-sufficiency

DCS has fully incorporated the new program design and service delivery within older youth services practice model for transition youth to self-sufficiency. In accordance with H.R. 4980 "The Preventing Sex Trafficking and Strengthening Families Act" DCS has restructured transition planning to begin at age fourteen (14). By continued utilization of the teaming approach youth may select two (2) persons of their choosing with approval of DCS to assist in the development of the youths plan. DCS has also incorporated the term successful adulthood to mean services for youth under the age of eighteen (18). DCS extended foster care program Collaborative Care improved services for older youth transitioning out of foster care. Specialized Collaborative Care Case Managers (3CM) continue to manage all youth at age 17.5. 3CM's case load only comprise of youth 17.5 and older. There is specialized ongoing training for 3CM's that target best practice specifically working with older youth in and transitioning out of foster care. 3CM training focuses on positive youth engagement, which is the foundational pillar of Collaborative Care as well as essential practice and program guidance. To enhance services to youth who have a case plan of Another Planned Permanent Living Arrangement (APPLA) at age 16, youth transition to the CC team to initiate services.

To support the well-being of youth, in accordance with H.R. 4980, DCS has implemented the "Indiana Youth Bill of Rights". This is a document that describes the rights of a child with respect to education, health, visitation, court participation, the right to be provided various documents specified in the law, and the right to stay safe and avoid exploitation. DCS Family Case Managers (FCM) engage youth of their rights at the age of 14 when they enter into care. DCS has also adjusted its procedure to ensure when all youth age out of care, they are provided a copy of their vital records which includes birth certificate, state identification, medical records etc. In addition, the process of transitioning youth to a Collaborative Care Case Managers (3CM) at age 16 was developed to provide authentic youth engagement for those youth who have been in care 15 out of 22 months

with a case plan goal of APPLA. Older youth in out of home placement should have an opportunity for permanency through reunification or with a forever family as a result of adoption or guardianship. DCS continues to pursue case plan goal options of reunification, adoption or guardianship for older youth in care (age 16 and older) through child and family teaming, regional permanency teams and permanency round tables prior to changing a youths plan to Alternative Planned Permanent Living Arrangement (APPLA). These efforts are put in place to ensure plans are being appropriately developed.

In the Older Youth Services Protocol, Indiana specifically address LGBTQ under cultural and religious competence with a link to the Indiana Guidebook for Best Practices with LGBTQ Youth. The guidebook provides information of knowledge and appropriate skill sets of social services needed to effectively meet the needs of LGBTQ youth and their families. It is Indiana's practice to work one on one with youth as they explore their sexual orientation and gender identities by utilizing positive youth engagement. By listening to the youth voice, individuals working directly with youth are able to determine the needs of the youth and assist the youth with appropriate placements, resources, and building their social capital.

Help Youth Receive the Education, Training, and Services Necessary to Obtain Employment

DCS focused on education and employment preparation for older youth in foster care. Through transition and case planning academic youth develop a plan for education and employment. OYS providers and case managers assist youth in achieving their educational and employment goals through supportive services and training such as: tutoring, career & academic exploration, employment search and employment skills training.

Service providers and case managers ensure that youth are referred to WorkOne, through the Indiana Department of Workforce Development (DWD) for employment related services, TASC classes, and testing.

Older youth who are receiving older youth services and have an Individualized Education Plan (IEP) continue to be referred to Vocational Rehabilitation when appropriate and to DCS Educational Liaisons, if additional education support and advocacy is needed. The partnership between DCS and DWD will continue.

In addition, The Older Youth Initiatives team has cross trained with the DCS Educational Liaison to ensure current information on services is being received according to the Every Student Succeeds Act (ESSA). The Independent Living Specialist has also trained case managers and OYS providers on various educational and vocational programs.

Help Youth Prepare for and enter post-secondary training and educational institutions

DCS assists youth in identifying and achieving their educational goals through transition and case planning. DCS ensures that youth have received information regarding their post-secondary educational options by providing educational information and having the youth sign the Acknowledgement of Receipt of information about Various Educational Programs.

All 3CMs have received training on financial aid and other steps needed for youth to access post-secondary

education as well as associated funding. In efforts to increase educational resources for foster youth DCS and DWD is specifically identifying youth for recruitment for the JAG program. As explained in the ETV section, DCS contracts with a vendor to provide Education and Training Vouchers (ETV) to eligible youth. This service will continue in 2017 and 2018.

DCS' current ETV vendor offers student support to current and former foster youth on campuses by using the student support model. The student support model encompasses the focus of awareness, education and collaboration. The ETV support model is in place at various colleges and universities in Indiana. The model allows the ETV Regional Specialists to work in collaboration with campus support services. The campuses listed below offer office space to the ETV Regional Specialists, campus staff assignment in the Financial Aid and Student Accounts/Bursar offices to work with ETV students, and a streamline enrolment process for student support services. The model is actively in place at Vincennes University, Purdue Calumet University, Ivy Tech Community College (Indianapolis, Fort Wayne, and Gary), Indiana State University, IPFW, and IU Northwest. Key components of this model include:

- Implement a TRiO & Student Support meet 'n' greet day
- Secure office space for ETV specialists on campus
- Encourage open enrollment into the TRiO program for ETV student
- Develop a two-way referral format with Admissions, Financial Aid, and Student Support Services wherein the university identifies foster youth and sends information to the ETV specialist
- 21st Century Scholar campus offices receives a list of all ETV 21st Scholars on their campus
- TRiO director shares the INCBY25 initiative and the ETV program information with other student support services staff and the faculty leadership

During the 2015-2016 academic year, the ETV Regional Specialists have made over seventy-five (75) student referrals to higher education institutions, support service programs, and community resources. Students were referred to TRiO, 21st Century Scholar, Campus Support, Disability Services, and Tutoring. The community referrals were related to housing, childcare, employment and basic needs. Eighty (80) students received targeted case management services. The ETV program provided the following student support activities during the academic year:

- Northwest Region maintained and strengthened the links with area colleges/universities
- Northwest Region hosted meet 'n' greet with Purdue North Central students'/campus services
- Northwest Region hosted the 3rd Foster Education Summit
- Northwest Region hosted a College Resource fair
- Northeast Region hosted a meet and greet at Ball State University with Guardian Scholars
- Northeast Region developed a collaboration with Pink Leaf to share ETV information
- Northeast Region maintained and strengthened links with area colleges/universities
- South Region maintained and strengthened the links with area colleges/universities
- South Region hosted a College Readiness workshop

- Central Region maintained and strengthened links with area colleges/universities
- Developed a collaborative relationship with Center for Student Success at ISU
- Developed a partnership with Ivy Tech's ASAP and Ivy Tech's Ivy Works program

The ETV vendor also completed statewide college 101, held statewide education conference calls, implemented statewide higher education in-service month, promoted Nina Scholars program to ETV students and attended DCS meetings, provider fairs and conferences.

During the grant period 2015-2016, 270 students received a care package and gift card.

Regarding Student Ambassadors, the ETV program values the student's voice and works closely with various ETV students in several different capacities. ETV Regional Specialists recruit foster youth for the state youth board, the Indiana Youth Advisory Board (IYAB). INCBY25 also developed Student Ambassadors who work in their region to support students by offering a student perspective at presentations and meetings. The number of Student Ambassadors fluctuates from year to year. During the 2015-2016 grant period, seven (7) ETV students served as a Student Ambassador.

In addition, DCS Educational Liaison train and educate FCMs and youth on educational opportunities as well as provide educational support and advocacy.

Provide Personal and Emotional Support to Youth Aging Out of Foster Care Through Mentors and the Promotion of Interactions with Dedicated Adults.

The Collaborative Care program continues to use authentic youth engagement to provide personal and emotional support to youth aging out of foster care. The programmatic foundations is based on authentic youth-adult partnerships, relational permanency, and supporting building positive social network. In efforts to increase the wellbeing of youth DCS has implemented an age requirement. Beginning at age 14, youth actively participate in the development of their case plan and the Transition Plan for successful Adulthood Youth provides for youth to receive and sign and acknowledgment describing their rights with respect to education, health, visitation, court participation, medical documentation and safety. In addition, youth may select two child representatives to represent the child in the case plan and transition plan for successful adulthood development.

DCS also has the Youth Connections Program (YCP). The goal of the YCP is to ensure that all youth aging out of foster care have a permanent family, or a permanent connection with at least one committed, caring adult who provides guidance and support to the youth as they make their way into adulthood. Although the program goal states that each youth have at least one permanent connection the YCP specialists work to find multiple connections for each youth in the program. Once connections have been identified the YCP Specialist works with the connection and youth to define the level of support and certifies the connection with a Certificate of Connection. The YCP currently serves youth ages 14 – 21 who have no identified supports. However, younger children can be referred as needed. There are currently four YCP Specialist who work within their regions in

partnership with the youth, FCM/3CM, supervisors and Independent Living Specialist to identify youth for the program, finding committed adults, and solidify supports. Once a connection is made between the youth and a committed, caring adult, the YCP specialist can provide resources and supports to that relationship for 3 to 6 months, and then works with the FCM to ensure that the relationship is supported beyond that time.

Provide Financial Housing, Counseling, Employment, Education, and other Appropriate Support and Services to Former Foster Care Recipients Between 18-21 Years of Age to Complement Their Own Effort to Achieve Self-Sufficiency and to Assure that Program Participants Recognize and Accept Their Personal Responsibility For Preparing for and Then Making the Transition into Adulthood.

DCS provides Chafee Voluntary Services. Voluntary services are a set of services for eligible youth ages 18-21 who have aged out of foster care. These services include case management, emancipation of good snad services (EG&S) and room and board services. EG&S is a funding source not to exceed \$1000 and are for goods and services youth may need as they become independent of the system while making a safe and successful transition into adulthood. EG&S funds must be approved by the IL Specialist on a dollar for dollar basis. R&B expenses are considered start-up assistance, ongoing assistance and emergency assistance. These funds are contingent upon availability as well as verification of the youth's eligibility for voluntary services by the Independent Living Specialist. The payment includes a maximum lifetime cap of \$3,000 for assistance up to age 21. Youth must have turned 18 years of age while in foster care or a Collaborative Care placement.

The Collaborative Care program continues to have a re-entry component for those youth who turned 18 in foster care, left the care of DCS, and are in need of supportive services. Youth sign a Voluntary collaborative Care Agreement wherein the youth agrees to be under the supervision of the Juvenile court, to maintain the eligibility requirements for the program, to meet with their assigned 3CM at least once per month, and to actively participate with an OYS provider.

Make Available Vouchers for Education and Training, Including Post-Secondary Education to Youth who have aged Out of Foster Care.

DCS continues to provide ETV funds to eligible students in efforts to support youth's post-secondary education training goals. See Education and Training Voucher section for further details.

Provide Services to Youth who, After Attaining 16 years of Age, Have Left Foster Care for Kinship Guardianship or Adoption.

DCS continues to provide services for youth who transition out of foster care into a kinship guardianship program or adoption on or after the age of 16. Youth are eligible to receive voluntary services which include case management and EG&S. The Education and Training Voucher program is also available to young adults who left foster care due to Kinship Guardianship or adoption. Youth who have been adopted are also able to receive

post-adoption services.

To Ensure that Children Who are Likely to Remain in Foster Care until Age 18 have Ongoing Opportunities to Engage in Age or Developmentally-Appropriate Activities.

DCS revised policy and practice to ensure youth who are likely to remain in foster care until age 18 have ongoing opportunities to engage in age or developmentally-appropriate activities. DCS has adopted the reasonable and prudent parent standard which is characterized by careful and sensible parental decisions that maintain the health, safety, and best interest of a child. The reasonable and prudent parent standard promotes normalcy and increases well-being. A licensee shall use the reasonable and prudent parent standard when determining whether to allow a youth in foster care to participate in extracurricular, enrichment, cultural, and social activities.

Youth beginning at age 14 participate in their case planning and transition planning, including the discussion of any age appropriate activities that the child is interested in pursuing. The youth may select two (2) Child Representatives to advise and advocate for the youth with respect to the application of the reasonable and prudent parent standard to the child.

Youth also have an opportunity to participate in other older youth initiatives programming such as specialized youth career training which promotes life skills and career training through experiential learning.

4. National Youth in Transition Database

DCS received the final report summarizing findings from the pilot National Youth in Transition Database (NYTD) Assessment Review (NAR) in March of 2015. The findings include ratings (on a 0-4 scale) and narratives regarding the 8 NYTD general requirements and 58 NYTD data elements. Findings were based upon information that was gathered throughout the pre-onsite, onsite and post-onsite phases of the NAR. The report includes the NYTD Quality Improvement Plan (N-QIP), which the state responded to in June of 2015. The N-QIP required the state to respond to specific compliance issues, meaning any requirement or element that rated under “4”, that were found during the NAR process. DCS rated “4” on 2 of the 8 general requirements. Of the 6 remaining general requirements, DCS rated a score of “2”. DCS rated “4” on 18 of the 58 data elements, “3” on 19 data elements and “2” on 21 of the data elements. Many of the elements that scored “2” and “3” on the N-QIP could be resolved through code updates, applying skip logic to the survey/updating survey instructions, front end information system modifications and improving the methods of collecting service information from providers. Priority in implementing the needed rectifications relating to compliance issues were given to those requirements and elements for which DCS rated the lowest. DCS has completed the following requirements per the N-QIP:

- Federally-recognized tribe code has been updated to ensure that any youth with “none” selected are reported as “blank”.

- Indiana has updated the methodology used to identify foster care status for youth in the baseline population.
- The state has modified the extraction methodology for extracting baseline data to no longer use hard coded dates to identify baseline records. Instead, the code identifies baseline records by looking at the youths' dates of birth and the applicable report period.
- The NYTD survey instrument has been modified in the following ways:
 - Updated prompt used with element 37 to ensure the wording does not alter the meaning of the survey question. Indiana used wording as proposed by ACF in the N-QIP.
 - Removed "Not applicable" as a response option for element 55.
- The state has removed the survey questions related to public assistance (elements 42-44) on the baseline youth survey.
- Code has been modified to use report period start and end dates, instead of hard coded dates, as an identifier to conduct QA on a data file.
- Code has been modified to no longer default "no" for all race elements (6-12) when race information for the youth has not yet been collected.
- Code has been updated to correctly identify "trial home visit" as not in foster care.
- Upon implementation of the NYTD Service Logs a new guidance document and recorded webinar was distributed to providers giving updated instruction to report element 17 to reference whether a youth reports ever being adjudicated rather than if the youth is currently adjudicated.
- Development of a "mismatch" report to determine if the demographic information being reported for NYTD matches the information that is recorded in MaGIK. If a youth shows on the list as having a discrepancy in information the FCM, probation officer and service provider will be contacted to rectify the discrepancy and ensure accurate reporting of demographic information. Ex: A service provider reports the youth's last grade completed is 11th grade, but MaGIK shows the youth's last grade completed is 6th grade. The FCM and service provider will be contacted to see which information is most up to date and will be asked to update information that is not accurate
- Implementation of NYTD service logs as demonstrated during the pilot NYTD Assessment Review (NAR). Updated service logs eliminate the need for users who enter service information to identify services by federal definition. Instead, they choose the service as defined by DCS' OYS standards and such services are mapped on the back end to the federal definition for data submissions.
- The methodology used to report youth who turn age 17 in one report period and are surveyed timely in the next report period has been updated as specified in Q&A #2.55. The updated methodology will be submitted to ACF for review. If any problems with the updated methodology are identified, DCS will work with ACF to refine the methodology to ensure accurate reporting.
- Front end system update adding the selections "Tribe not on list", "Information not available" and "Tribal membership pending verification" to the federally-recognized tribe dropdown list regarding Federally-recognized tribes.

DCS continues to focus on the following requirements per the N-QIP:

- Service log mapping for data elements 24 and 29-33 has been submitted to ACF for review.

- An administrative page has been developed and is currently in production. The administrative page allows for the NYTD administrators to update completion dates to the date the survey was completed/declined rather than the date that the survey was entered electronically, if those two dates differ. Documentation of this change has been submitted to ACF for review.
- A contract has been awarded for a service provider to perform engagement and incentive disbursement activities for youth in the baseline population as well as surveying, engagement and incentive distribution activities for youth in the follow-up population. Documentation of the posted Request for Proposal (RFP) has been submitted to ACF for review.
- An Informed consent page has been developed Indiana has submitted documentation to ACF for approval.
- The state's system must allow this element to be selected in combination with other race data for a multiracial youth. Indiana has submitted documentation that Indiana's child welfare information system allows for this combination to occur.
- The values "declined", "unknown" and "unable to determine" remain stored in the same field in the database. Indiana continues to work toward ensuring this Finding to Address is rectified.

Indiana is working on enhancing its NYTD data system to make improvements on how data is collected and validated for several NYTD data elements. Indiana is also making improvements with how informed consents are provided to youth at age 17 during the initial NYTD survey. Indiana also corrected how youth are identified at age 17 to be included in the population. Indiana issued an RFP and selected a vendor to provide services for the administration of NYTD follow up survey's for 19 and 21 year old's in the follow up population, actively engage youth 17 through 21 years of age whom are in baseline and follow up population through outreach services.

The N-QIP identified that Indiana had no business process or policy for keeping in contact with youth between survey waves and that having a regular or periodic contact plan for follow-up youth may assist in improving its performance surveying youth who have left foster care and who are not receiving services. The N-QIP recommended that "the state is strongly encouraged to develop and implement a plan to stay in touch with and to collect updated contact information from youth who leave foster care between survey waves." In response, Indiana is opting to work with a contractor, Howe, LLC, to engage youth between survey periods and conduct surveys at ages 19 and 21. Indiana will notify ACF once the contract has been awarded. Miguel Vieyra is the CB representative that is monitoring Indiana's N-QIP and giving final approval regarding whether Indiana has completed action items on the plan. In addition to the N-QIP, Indiana has been in contact with Mr. Vieyra for technical assistance in relation to what procedures successful states have in place for surveying the follow-up population. Mr. Vieyra routed Indiana to such states for technical assistance and Indiana has subsequently reached out to Texas and Oregon for assistance. Locally, Indiana has worked with an OYS provider, Connected by 25, to provide incentives to youth in the follow-up population who participate in taking the survey. Indiana has also worked with Connected by 25 to generate ideas surrounding improving the participation rate.

Furthermore, to improve participate rates, Indiana is identifying recommendations surrounding gleaning good participation rates in longitudinal studies (sources include: Office of Management and Budget (OMB) Standards and Guidelines for Statistical Surveys, “Practical Strategies for Tracking and Locating Youth” publication developed and released by Children’s Bureau, NYTD Technical Assistance Document 13: Summary of Guidance, Tips and Recommendations Related to Surveying the Age 21 Follow-up Population, Chapin Hall NYTD Guidebook, NYTD Final Rule Commentary and Q&A, Study Design for the Midwest Study and University of Wisconsin Survey Center (UWSC)) and which suggest many strategies for engaging participants in such studies. Indiana is following procedures outlined in such guidance with the exception of providing a monetary incentive to each participant in the study AND keeping in contact with participants between surveys. The proposed RFP and resulting contract mentioned above includes provisions for both of these activities.

DCS is using NYTD data with the initiation of the CQI process with the OYS providers. Each provider will develop a CQI project specific to the needs of the area and youth they serve. Phase 1 of the CQI process for OYS providers is designating a CQI champion for their agency and becoming trained in the CQI process (Plan, Do, Study, Act). The OYS providers have completed phase 1 and have entered into phase 2. In phase 2, each OYS provider will develop their CQI team and develop a team charter. DCS has also used data to plan a financial capability initiative using Your Money Your Goals toolkit.

Indiana voluntarily participated in the pilot and are almost done with our N-QIP. Because of our participation in the pilot we will be exempt from the first round of reviews.

5. Future Planning

DCS will continue to build upon the foundations laid to create the Collaborative Care practice model, improve individualized services to the various special needs populations, continue active collaboration with the whole Older Youth Services community (includes DCS program, youth, DCS CC case management, OYS providers and other key stakeholders) and explore strategies to build public awareness regarding the needs of older youth in care and those transitioning out of foster care.

DCS will continue to focus on older youth in care and those transitioning out of care. More specifically, the Older Youth Initiatives Team will enhance youth post-secondary attainment by offering a summer bridge program in collaboration with the ETV vender (Connected by 25) and Purdue University Northwest (a Indiana State university). This program allows ETV eligible first time college students to participate in an 8 week program to help youth reach success by impacting the barriers to success. Summer bridge programs help high school seniors prepare to enter post-secondary education. Summer bridge participants are more academically prepared. Foster youth often lack necessary skills to be successful in college. DCS will continue to utilize the IYAB for feedback on program implementation and service development and delivery. As DCS continues to develop

the OYS evaluation, DCS will explore ways of institutionalizing feedback from youth. Some possible methods DCS may explore are adding relevant program questions to the NYTD survey, seeking external funding to host CC focus groups or annual surveys.

DCS is in the process of evaluating all the various sources of data on older youth, the quality of this data and the best way to present this data to internal and external stakeholders. DCS will begin sharing data with the OYS providers and the IYAB. These stakeholders will assist DCS in identifying and prioritizing data elements and analysis that should be shared with stakeholders. DCS will work with the Child Welfare Improvement Committee of the Court Improvement Program at the Judicial Center to identify relevant data points and strategize and develop a communication plan to start a state wide dialogue about current service delivery, service gaps and possible service improvements.

C. SERVING YOUTH OF VARIOUS AGES AND STATES OF ACHIEVING INDEPENDENCE

DCS offers Successful Adulthood Services: services for youth that are designed to assist youth who will age out of foster care with the skills and abilities necessary or desirable to be self-reliant in accordance with State law. This service is known as Older Youth Services (OYS). The Older Youth Services program is comprised of Chafee Independent Living Services, Collaborative Care Services, and Chafee Voluntary Independent Living Services. The focal points of Older Youth (OY) services are to increase youth voice, offer the opportunity to practice interdependence as well as gaining the skills to build the youth's own social capital. The goals are to prepare youth to emerge into adulthood and move identified youth into a permanent housing setting that the youth can continue to live in once DCS closes the case. This program also includes allowing youth to voluntarily return to foster care on or after the youths 18th birthday.

The OYS array (including CFCIP) provides Successful Adulthood services that consist of a series of developmental activities that provide opportunities for young people to gain the skills required to live healthy, productive, and responsible lives as self-sufficient adults. Successful Adulthood services should be seen as a service to young people that will help them transition to adulthood, regardless of whether they end up on their own, are adopted, enter a guardianship or are reunified. OYS should be based on the Casey Life Skills Assessment (CLSA) following the youth's referral for services. Youth receiving OYS must participate directly in designing their program activities, accept personal responsibility for achieving independence, and have opportunities to learn from both positive and negative experiences.

Services are provided according to the developmental needs and differing stages of interdependence of the youth, but should not be seen as a single event, or as being provided in a substitute care setting, but rather as a series of activities designed over time to support the youth in attaining a level of self-sufficiency that allows for a productive adult life. Services should address all of the preparatory requirements for interdependent adulthood and recognize the evolving and changing developmental needs of the youth/young adult.

OYS follows the broker of resources model and are designed to assist young people by advocating, teaching,

training, demonstrating, monitoring and/or role modeling new, appropriate skills in order to enhance self-sufficiency. Services must allow the youth to develop skills based on experiential learning and may include the below outcomes based on the youth's needs as identified through the Independent Living assessment.

DCS is serving the following age groups in the following ways:

Youth under the age of 16

CFCIP are not offered to youth under the age of 16. However, DCS does focus on transition planning for youth at age 14. DCS Policy 11.6 Transition Plan for Successful Adulthood states all youth who enter foster care will transition out and all youth need skills, knowledge and abilities to ensure a successful transition home, to a new home, or to their own home. DCS has been improving youth engagement and wellbeing by empowering youth to participate in their transition plan as well as case plan beginning at age 14. Youth now have the ability to select two (2) child representatives to be a part of their team. One representative will represent the youth as an advisor and advocate. In addition, at age 14, youth will receive a list of their rights while in foster care regarding education, health, visitation, court participation, and safety.

Youth ages 16 to 18

All youth in out of home care receive Successful Adulthood (SA) services at the age of 16. Who provides the service depends upon where the youth is placed. If a youth is placed in a residential facility, group home or a Licensed Child Placing Agency home, the facility or agency is responsible for providing the direct SA skills education. If a youth is placed in a DCS licensed foster home, a relative home, or another court appointed placement, a referral may be made to the OYS provider (if services are appropriate for the youth). At age 17.5 all youth should be referred to an OYS provider (if services are appropriate for the youth). Youth in Collaborative Care Host Homes and College Dorms, may or may not be referred to an OYS provider. This decision is made with the youth and the youth's team and based upon what resources are being offered by the Host Home adult or college campus. Youth who have a case plan of APPLA may have their case transferred to a 3CM to begin intensive OYS.

All services are delivered based upon the broker of resources model and should be based upon the individual youth's abilities and needs.

Youth ages 18-20 in foster care

All OYS are based upon the youth's abilities and needs. To better equip youth, DCS ensures that all youth 18 and older who have spent six months or more in care are provided the following documentation prior to leaving care: birth certificate, Social Security card, health insurance information, medical records, and a driver's license or State Identification. The OYS array does not change with age. The method by which services are delivered varies based upon youth's skill level, needs and abilities.

Former foster youth ages 18 through 20

Youth who turned 18 in a foster care placement and are not yet 21 years of age are eligible for Voluntary IL

Services. The OYS array is available for youth participating in Voluntary IL Services. Services are to be administered using the broker of resource model and should be individualized based upon the youth needs and abilities.

Room & Board funds are offered to youth who are participating in Voluntary IL Services only.

Youth, who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption

Youth who transition out of foster care on or after their 16th birthday due to an adoption or guardianship are eligible for OYS array.

DCS utilizes the Casey Life Skills Assessment as a starting point to evaluate what skills, knowledge and abilities a youth needs to focus on while preparing to practice living interdependently. The Independent Living Plan is developed by the youth and OYS provider. The goals should be individualized and based upon the youth's abilities, skill level and needs.

In addition, prior to a youth transferring from a Family Case Manager to a 3CM, a team meeting is held to talk with the youth about their plan for after foster care and what skills and education they need to move forward with their plan. These transition meetings between case managers, the youth and the youth's team should also include discussion about the youth's stage of development, current services being utilized and future service needs.

D. SERVING YOUTH ACROSS THE STATE

1. State's Definition of "room and board"

Below is an excerpt from the OYS Service Standards regarding Room & Board funding:

Room and Board (R&B) expenses are considered start-up assistance, ongoing assistance and emergency assistance. These funds are contingent upon availability as well as verification of the youth's eligibility for voluntary services by the Independent Living Specialist.

Room and Board payments include a maximum lifetime cap of \$3,000 for assistance up to age 21. Youth may access this assistance as long as they continue to participate in case management services and receive SSI (Supplement Security Income through Social Security) or participate in a full or part time schedule of work (or are actively seeking employment) until the \$3,000 limit is exhausted.

Start-Up Assistance: Start-up cost are expected to be a one-time payment and are made available when youth move into their first apartment. Start-up cost covers application fees, security deposit, first month's rent and utility installation fees. Utilities are limited to electric, gas, water and sewage.

Ongoing Assistance: Ongoing cost are identified as ongoing monthly rental assistance. This assistance will be will be tailored to the need to the youth. Youth who need the maximum assistance may access these funds using the payment guide below. While receiving Room and Board funds, youth are expected to make incremental

payments toward their own housing and utility expenses beginning in the third month of assistance and should be prepared to accept full responsibility by the sixth month unless there are extenuating circumstances. Requests for an extension of this capped amount will be considered on a case-by-case basis by DCS Older Youth Initiatives Manager or designee, based on availability of funds. Room and Board payments will only be made through a contracted service provider who is providing older youth case management services to the youth.

Emergency Assistance: Emergency cost is a one-time payment to youth who present in an emergency or crisis situation. These situations are temporary or extenuating. Youth receiving emergency assistance will need to develop a crisis plan and agree to be placed in an alternative setting as available. Emergency Assistance must be approved by the Older Youth Initiative Manager or designee.

Youth receiving room and board assistance and planning to attend a post-secondary institution may access room and board funds to obtain off-campus housing prior to beginning their post-secondary program. Deposits for housing on campus may be made through Emancipation Goods and Services funding. Education and Training Voucher (ETV) funds are available for housing for youth attending post-secondary institutions. Those attending school full time or part time may access the ETV Program at www.indiananetv.org. If eligible for ETV funds, housing assistance must be accessed through this program and not Room and Board.

2. Housing Options

Potential housing options for youth accessing Voluntary IL services may include host homes with foster families, relatives other than biological or adoptive parents, or other adults willing to allow the youth to reside in their home with or without compensation. This setting does not require the same responsibilities provided by the host home adult as the Host Home placement type in Collaborative Care. Other housing options may include youth shelters, shared housing, single room occupancy, boarding houses, semi-supervised apartments, their own apartments, subsidized housing, scattered site apartments, and transitional group homes.

Youth aged 18-20 who are eligible may remain in or return to foster care through participation in the Collaborative Care program. For youth whom are in the Collaborative Care program, available placement and housing options include all traditional foster care placements, such as foster home and congregate care, as well as Supervised Independent Living options such as Host Home, College Dorm, and own or shared housing. Youth in Collaborative Care are wards, thus all placements and housing is paid for by DCS. During 2016-2017, DCS is planning to implement staff supported housing as a collaborative care placement option for youth for whom DCS has placement and care. Staff supported housing will provide an intensive level of older youth services that will prepare youth for successful adulthood, living interdependently and apartment living by serving as a broker of services to connect youth to community service providers as defined in the older youth services standards.

Youth who wish to leave care at or after the age of 18 and are eligible can access voluntary independent services. The service array is described above. Room & Board funds are reserved for only those youth accessing Voluntary IL Services.

Room and Board funds are not used for youth who enter Collaborative Care. Room and Board funds are reserved for youth who access Voluntary Independent Services.

At this time, DCS does not systemically track program participation per eligibility condition. This information is available through paper records only. However, as of June 2016, there are currently 249 youth in care age 18 or older.

Through a team process, placement opportunities are determined giving consideration to the youth’s developmental needs. Below is a comparison of placement types in March 2014, April 2015, and April 2016.

Placement Locations	April 2015	April 2016	April 2017
Relative Home	8.2%	8.6%	22.8%
Non Relative Foster Home	36.9%	39.1%	34.21%
Residential Setting	18.4%	20.9%	25.98%
Own Apartment	14.1%	11.3%	6.3%
Shared Housing	1.1%	0.9%	.05%
Host Home	11.3%	12.6%	4.73%
College Dorm	5.1%	4.0%	1.53%
Other Placement	4.6%	2.6%	4.37%

3. Education and Employment

Education and employment preparation for older youth in foster care continues to be a focus. Service providers and case managers continue to ensure that youth are referred to Work One, through the Indiana Department of Workforce Development (DWD) for employment related coaching, TASC (Test Assessing Secondary Completion) classes, and testing. Specifically, DCS Collaborative Care team partners with the Department of Workforce Development (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 Work One initiatives.

DCS contracts with a provider to provide Specialized Youth Career Training (YCT). The program provides life skills and career development services to at-risk youth by combining hands-on experiential learning and community

resources. Youth are provided with tools and opportunities to use skills needed to build a successful and sustainable future. YCT services consist of boot camp style services with intensive experiential learning and hands-on lessons in the following service components: culinary arts, serve safe, building trades, car maintenance, life skills, and other identified camps that meet the needs of youth.

Older youth who are receiving OYS services and have an Individualized Education Plan (IEP) continue to be referred to Vocational Rehabilitation, when appropriate and to DCS Educational Liaisons if they are in need of additional education support or advocacy.

Youth goals are supported in several ways; this includes youth's educational goals. Youth must address education at each transition planning meeting that starts at age 14. This includes current educational status and future educational goals. Education is an outcome area addressed in the OYS Service Standards and outlines youth outcomes and provider responsibilities that will assist youth achieve the identified core competencies. Education may also be an area that is addressed in the IL Plan developed by the youth and the OYS provider. 3CMs may reach out to the DCS Education Liaisons for assistance with educational issues or barriers. The Education Services team has partnered with the Collaborative Care and Older Youth Services teams to provide trainings and attend joint meetings to assist in ensuring the educational needs of the other youth in care are being effectively met. 3CMs receive training in assisting youth who apply for post-secondary training or education. Youth who are enrolled in post-secondary training or education and are receiving ETVs can also utilize the regionally based ETV Specialists for assistance.

4. Young adults who are pregnant and parenting

Within the Collaborative Care program, DCS implemented a pilot program that designed a case management system where one case manager managed both the older youth's open DCS case, as well as the open DCS case for the child of the older youth.

DCS ensured that all services were managed with a family centered approach as outlined below.

1. All services are coordinated with one team,
2. Both cases are reviewed by the same Judge virtually simultaneous to one another, and
3. Case planning is used as a means to support the family unit.

Before leaving care, the youth and their team will make sure parenting youth have established sustainable resources, including: established paternity and a child support order entered for their child; developmental needs addressed for their child, including medical and dental health; and supportive, sustainable services are in place and planned around the family unit, through referrals to the Indiana Healthy Families program, First Steps/Head Start and other social services.

DCS will continue to evaluate the effectiveness of this pilot by comparing outcomes of youth in the pilot with a control group of youth in similar situations who had a different case worker than their child. Depending upon the results of the evaluation, DCS may expand this program to other areas across the state.

DCS hosted a parenting conference during Q4 of 2016 to provide support through education and resources to pregnant and parenting young adults. The parenting conference hosted 19 young ladies and their significant other. During the conference the youth received information on safe sleep, parenting tools and relationship building, a resource fair was provided to the youth and the youth received a gift package for their participation.

5. Young adults with histories of substance abuse

This is an identified area of need within the Older Youth population. DCS is currently and will continue to explore transitional housing and programming options for older youth and young adults who suffer from Substance Use/Abuse with existing Substance Abuse Treatment providers within Indiana (see Objective 1.4 Under Plan for Improvement (IV-A)). DCS will explore how to develop and implement individualized services to meet the needs of this group of Older Youth and existing services within local communities across the state. DCS will research if the START program could be effective for youth/young adults. All 3CMs and OYS providers have received training in working with youth who are suffering from Substance Use/Abuse. DCS will explore training materials and opportunities via SAMSHA as well as the Indiana Department of Mental Health and Addictions.

6. Young adults with mental health and/or trafficking histories

These are identified areas of need within the Older Youth Population. DCS is partnering with a small group of Community Mental Health Centers to explore the idea of transition services for youth engaged in mental health services. The identified problem is that at risk youth struggle with continuing to engage in mental health services when they are transitioned from children's services to adult services. Barriers identified are:

- While active in children's mental health services, the provider is responsible for seeking out the client for engagement, whereas, in adult mental health services, the client must seek out services. At risk youth, including foster youth struggle with making this transition.
- Many services provided by the Community Mental Health Center are not well known to youth aging out of care.

Strategies identified thus far to remove barriers include:

- Ensuring key stakeholders and decision makers are invited to this group to ensure an action plan can be developed, and
- Engaging Medicaid regarding what services/reimbursements will be offered as part of MA15. DCS has started meeting with Managed Care Entities to improve service access for youth.
- DCS has partnered with CB25 to bring in the Managed Care Entities to provide training to current and former foster youth, 3CM's, and OYS provider staff.

DCS continues to explore and assess the impact of human trafficking on youth in foster care. DCS has an

identified agency lead who works closely with the Attorney General’s Human Trafficking initiative. See below for more details on this initiative. The DCS OYI Team is researching best practices for intervention services, service coordination/management, placement, and aftercare services for this group of older youth. DCS has been working with residential service providers to develop programming appropriate to meet the needs of this population. Residential programs are required to offer Trauma Focused Cognitive Behavioral Therapy as a core program, which should begin to address the youth’s trauma history. DCS has also expanded TF-CBT in the Community Based service array and has trained more than 300 clinicians statewide. DCS will continue to work to gain an understanding of the true need of youth who have experienced trafficking, identify best practices, and develop a more expansive service array to meet the needs of this special group and develop an evaluation of services. As previously mentioned, DCS will be implementing a revised mandatory human trafficking training in the fall of 2016 for all FCMs and 3FCMs and will be rolling out a new human trafficking intake tool to help the agency more effectively identify and serve youth who have been trafficked.

7. Youth with Criminal Histories

The OYS array does not differ for youth who have criminal histories. All youth in foster care experience circumstances that warrant individualized service delivery. Youth Voice and Authentic Youth-Adult Partnerships are foundational pillars for the Collaborative Care model. 3CMs have received training on youth engagement and use these skills to work alongside youth to overcome their pasts and look toward the future. 3CM’s have been trained on how to assist youth with expungement of their criminal records. Youth criminal history can be a barrier to education, housing, and employment. 3CM’s assist the youth with the expungement process which help them overcome these barriers.

8. Young adults with disabilities

Young adults who have a disability and / or developmental needs receive additional services and information that meet their specific needs. Services include, but are not limited to reviewing eligibility for continued SSI benefits based on disability rules for adults, help youth apply for SSI and other special needs adult benefits a youth may be eligible for. 3CM’s help youth develop and increase support and build social capital. OYS providers link youth to other supportive agencies such as the Bureau of Developmental Disabilities, local mental health agencies, vocational rehabilitation, and other local providers.

3CMs continue to receive on-going training on the process to help youth apply for the Bureau of Developmental Disability Services (BDDS). In addition, on-going training consist of available resources in each DCS Region/County including BDDS, Vocational Rehabilitation, Community Mental Health Centers, Children’s Mental Health Wraparound Services, and Housing for youth who struggle with mental health issues.

In some areas designated 3CMs carry a full case load of youth who will transition to adult services through the BDDS. DCS and BDDS have a formalized partnership that allows DCS youth to automatically enter the BDDS system at age 21, if not before.

Youth who have developmental and/or intellectual disabilities, but do not qualify for BDDS receive a higher level of case management from 3CM's and the OYS provider. The 3CM meets with the DCS placement committee to review placement options and seek recommendations. During the transition and case planning meetings the 3CM, youth and the youths' team identify the needs of the youth and focus on connecting youth to appropriate services.

After examining data, DCS has found that youth are leaving the program prior to turning age 20 for many reasons. Many youth are reuniting with biological family and requesting case closure. Some youth are entering adult services so the DCS case is closed. Other youth are struggling to maintain eligibility. Collaborative Care practice is to assist the youth in becoming eligible for services for up to 60 days. If youth have not obtained eligibility by the 60th day, the case needs to move towards case closure.

When a youth is leaving care prior to obtaining 20 years of age, re-entry procedures and procedures to access Voluntary IL Services are explained and given to the youth in writing. All youth continue to receive the full service array with goals focusing on transitioning out of care once it has been decided that the case will move towards case closure. All eligible youth can access Voluntary IL Services, once the case is closed. In most cases, the youth's OYS provider worker will not change if a youth moves from Collaborative Care to Voluntary IL Services. The full OYS array is offered in Voluntary IL Services. In addition Room & Board, funds are available for eligible youth to access.

E. COLLABORATION WITH OTHER PRIVATE AND PUBLIC AGENCIES

DCS' OYI Team identifies public and private entities that might be able to assist youth achieve interdependence. Some examples of partnerships are the Department of Workforce Development, Indiana Connected By 25, One Simple Wish, Indiana Housing and Community Development Authority, Twenty-First Century Scholars, and the Bureau of Developmental Disabilities.

More specifically, the Department of Workforce Development and DCS have created a partnership to work more closely in identifying youth that both agencies serve. Foster youth are prioritized for local Work One initiatives. DCS works closely with Department of Workforce Development (DWD) JAG (Jobs for American Graduates) program to identify foster youth in their junior and senior year of high school. Partnering with JAG to specifically recruit foster youth for their program will build better resources for and increase foster youth preparedness for post-secondary education and/or employment.

DCS has partnered with Indiana Connected by 25 (CB25) to further the states work with older youth in foster care. CB25 is a strategy developed by a group of national funders, the Youth Transition Funders Group, which focuses on young people ages 14 to 25 either living in foster care, detained in the juvenile justice system, or who have dropped out, or had to leave school due to the school system not meeting their needs. This organization targets youth currently in foster care and youth who have aged-out of foster care (alumni). CB25 focuses efforts in 5 areas: Housing, Financial Literacy, Health, Education and Employment. CB25 has been able

to leverage funding from DCS with private foundational funds to serve Indiana's Older Youth. Currently, DCS is working in collaboration with CB25 to implement two (2) new financial capability initiatives.

1. **SuperVitamin Building Financial Capability:** DCS has piloted a financial capability initiative by implementing an enhanced version of the Opportunity Passport called SuperVitamin in collaboration with Connected by 25. This initiative provides financial coaching to youth through remote coaching, mobile account security and one on one interactions. Youth receive financial coaching from professionals through Apprisen. Youth receive budgeting, saving, banking and credit information to assist with goal setting and the development of a financial plan. The financial coaches meet with the youth to review and assess their achievement of goals set by the youth.

There were two cohorts and each cohort was served for six months. 22 youth participated in the cohorts: 14 in Cohort 1 and 8 in cohort 2. The program success was measured by the change in the financial stability score, change in savings, and the ability to withstand a financial emergency.

2. **Your Money Your Goals (Building Financial Capability):** DCS was selected as a Your Money Your Goals site. This is a 1yr. initiative designed to support sites by integrating financial capability into the service delivery framework. A train the trainer model with a tool kit that supports staff. The training curriculum builds the capacity of frontline staff to help youth build financial capability and gain access to community resources.

YMYG is a financial toolkit created by the Consumer Financial Protection Bureau (CFPB). DCS in collaboration with Connected by 25 was trained on YMYG financial toolkit. The training was provided by ChildFocus, Inc. and Annie E. Casey Foundation. YMYG financial capability initiative served as a state-wide training curriculum provided to each DCS contracted older youth service provider and the Collaborative Care Case Managers to provide a continuity of financial management services to foster youth with a focus on youth aging out of foster care. The training provided a more supportive authentic youth engagement approach in assisting youth in developing and increasing their financial capability through teachable moments and healthy risk taking by learning the following:

- Financial values and setting financial smart goals
- Developing a simple plan to budget / save money and pay down debt
- Learning credit management and reviewing credit reports
- Financial decision making
- Accessing community resources.

Following the Initiative's train-the-trainer event in Atlanta in August 2016, participants developed a group listserv to learn and support one another as they executed future trainings. To deepen trainer skills and build confidence, technical assistance provider offered multiple supplemental webinars on credit and debt, cash flow budgeting, and identity theft, as well as strategies for planning the training. These webinars also

provided an opportunity for participants to share their experiences with training and strategies that were successful in engaging the community.

Over 100 DCS and service provider case management staff have been trained on the YMYG toolkit and are now implementing it in their services and case management with youth. 60 Healthy Family prevention worker were trained. These workers cover the entire state of Indiana. In addition to the YMYG Toolkit training, additional training on the supplemental tool “Behind on Bills” was conducted in March 2017 for approximately 75 DCS and provider staff, many of whom had received the initial YMYG toolkit training.

DCS has partnered with One Simple Wish (OSW), a not for profit organization based out of New Jersey, created in 2008 by a foster/adoptive parent. OSW takes advantage of the internet to bring an awareness to foster youth. OSW is a wish granting program that allows private citizens or organizations to grant wishes posted by youth in foster care. Examples of what youth could wish for include sports equipment/uniforms, name brand clothing/money for a shopping trip, computers, prom dresses, limo for prom, tickets to a theme park or concert, furniture...basically, a wide range of items from practical to fun.

DCS continues to support supportive housing programs throughout the State to ensure current and former foster youth have supportive and affordable housing.

DCS has strengthened its partnership with the Twenty-First Century Scholars program, which is a program supervised by the Indiana Commission for Higher Education (ICHE). ICHE vision is to provide every Hoosier with clearer and more direct paths to timely college completion, quality competency-based credentials that deliver the learning outcomes students need and employers expect, and purposeful career preparation that equips graduates for fulfilling employment and lifelong learning. ICHE promotes awareness of Indiana financial assistance programs through its website, guidance counselor workshops, financial aid nights, college fairs, community forums and other statewide events such as College Goal Sunday.

In addition, ICHE provides student success initiatives such as Twenty First Century Scholars. Through the partnership with ICHE – Twenty First Century Scholars program, DCS has increased the number of foster youth eligible for the program by ensuring youth are applying and completing the scholar success program requirement. ICHE has trained staff on the program and has identified foster youth as a special population by providing all DCS staff with access to the website for foster youth enrolment and verifying enrolment status. DCS works closely with Twenty First Century Scholars program staff as a direct contact for approving foster youth eligibility status. To move the collaboration forward DCS and ICHE is developing a memorandum of understanding to share outcome data.

DCS continues partnering with Connected by 25 and Cargo Services in the Youth Adult Connections Program (YAC) to focus on providing resources to young adults in foster care graduating from High School that may not be available or possible. YAC changed the selection process for youth to ensure the program is youth friendly. Youth selected to participate in YAC exemplified excellence in their schools and community or have overcome

challenges and barriers while obtaining their high school diploma. YAC recognizes the accomplishments of foster youth by providing an opportunity for foster youth to share their success with friends and family. During the 2015 – 2016 graduation year there were 10 youth who participated in the YAC graduation open house. The open house took place at the Indianapolis Colts facility where the youth received a buffet meal of their choice, graduation gifts, and formal recognition of their accomplishment in front of their invited guest of family, friends and supports. Prior to the open house each youth received a photo shoot for senior pictures, specialized invitations, and participated in the Opportunity Passport financial literacy program.

DCS has partnered with The Villages and Stop Child Abuse and Neglect (SCAN) to share information and focus on the housing needs of youth aging out of foster care. Through the partnership of The Villages, SCAN and Brigs, they developed the Courtyard apartment complex which accommodates current and former foster youth 18 – 25 years of age. The Courtyard provides affordable housing, support, and resources as youth emerge into adulthood. Services include: case management, job/life skills training, parenting education, and access to GED/high school diploma and post-secondary education.

During the 2016-2017 year DCS partnered with the Indiana State Department of Health (ISDH) in an Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (CoINN) project. As part of the collaboration a member of the IYAB was selected to be a part of the CoINN team. The CoINN project focused on adolescent and young adult health by emphasizing well-being and evidence-informed strategy measures to increase the quality of preventive services for adolescents and young adults within the State of Indiana. As part of the CoINN team the IYAB member participated in the Adolescent and Young Adult Health CoINN summit in Washington D.C. The project will last up to 6 months.

The OYS Team has also partnered with other agencies that may have services that youth can access concurrently or in replacement of CFCIP services. Independent Living Specialists, data analyst, and the Older Youth Initiatives Manager will make themselves available to give presentations to agencies, departments, and companies that interact with youth on a regular basis. In this way information about available services can be disseminated to the stakeholders in order to better reach youth.

At this time, DCS does not have any campaigns to raise awareness on the needs of youth/young adults in foster care. DCS has consulted with key members of the Older Youth Community on this topic. Both Youth and OYS providers believe pursuing a public awareness campaign may be beneficial for the state. Some suggestions from stakeholders include: utilizing providers to form grassroots campaigns in each community; targeted outreach for Host/Foster Homes for Older Youth; an RFP for Older Youth Community Outreach and/or Training; utilizing social media for cost effectiveness and widespread availability; and work with the IYAB. The Indiana Connected By 25 program communicated that they are already working with national partners on similar marketing projects aimed at raising public awareness about older youth in foster care and offered to bring DCS to the table.

DCS will continue to explore the idea of campaigns to raise awareness of the needs of older youth in foster care.

DCS will also continue to consult with Older Youth Community as well as the Indiana Governor's Office on such an effort.

1. Federally funded Transitional Living Programs

There are two federally funded transitional living programs in Indiana. When DCS learns of a youth who is homeless that young person is brought into care under a CHINS. Thus that youth is eligible to access CFCIP services. DCS has meet with local youth shelters to inform and educate about extended foster care services for former foster youth who aged out of foster care at age 18.

2. Abstinence Programs

The DCS older youth service providers continue to work one on one and provide groups to address building health life skills and relationships. The providers also provide resources and support to youth to develop healthy social skills, including but not limited to: boundaries and strategic sharing.

DCS continues to partner with the Indiana Health Department to ensure youth are included in and encouraged to attend programs to prevent unplanned pregnancies and to attend abstinence programs throughout the state. At this time, DCS does not have a direct partnership with any FYSB grantees. However, service providers work with local agencies in their service area/community to ensure youth are able to connect with programs in their area.

3. Local Housing Programs

At the state level, DCS has a partnership with the Indiana Housing & Community Development Authority (IHCDA) to coordinate and identify housing options for youth. At the local level, both 3CMs and OYS provider direct staff provide education to youth on local housing programs, if appropriate. Specifically, 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. In order to help prevent homelessness, DCS has partnered with the local Lafayette, Indiana Housing Authority to ensure current and former foster care status is included as a preference in applying for subsidize housing. DCS has partnered with the Fort Wayne, IN Housing Authority to ensure current and former foster youth are made aware of the ready to rent program and are being referred.

3CMs and OYS providers have received training on various housing options throughout the state.

4. Programs for disabled Youth

At the state level, DCS has a partnership with FSSA - BDDS, as described in the collaborations/partnering sections.

5. School to Work Programs

At the State level, DCS has a partnership with the Department for Workforce Development, as described in the collaborations/partnering sections. At the local level 3CMs and OYS providers work with youth to ensure they know why and how to access local Work One offices. 3CMs also encourage youth to join the Jobs for America's Graduates (JAG, a DWD program) when available and appropriate. 3CMs have also been trained on alternative certification programs that support school to work. DCS supports youth attending accredited vocational programs through ETV to further their education and employment opportunities.

6. Plan to coordinate services with local youth shelters and other programs serving young adults at risk of homelessness

DCS will explore expanding the state partnership with IHCD to the local level. DCS will be visiting local youth shelters to distribute Medicaid information (see below). DCS will use this time to talk with local shelters about foster youth and learn how frequently shelters are serving current and former foster youth. DCS will also provide education material on how youth may re-enter care and access voluntary services if eligible. DCS will need to develop a plan to effectively carry out this process working with the capacity of the OYI Team. DCS will also revisit the idea of administering a homeless risk assessment prior to youth turning 18 and then again prior to turning 20. DCS will partner with IHCD and local youth shelters to explore a stronger partnership between these entities to better serve youth who may face homelessness.

As mentioned above, DCS has partnered with The Courtyard in Fort Wayne, Indiana, a 36-unit development that targets youth leaving foster care. The Courtyard received funding through the Fort Wayne Housing Authority which participates in HUD's Family Self-Sufficiency Program and provides housing vouchers.

DCS is working with the Office of Medicaid Programs and Policy on creating a flyer to be distributed to all 3CMs, OYS providers and ETV Specialists. Flyers will be distributed at local homeless shelters, youth shelters, food pantries, federal transitional housing programs and other identified places where young adults may visit.

A member from the child welfare agency serves on the Core Group for the Indiana Protection for Abused and Trafficked Humans (IPATH). The Core Group of IPATH discusses current cases of human trafficking in the State of Indiana. This group also provides education and training opportunities for constituents in Indiana. Members of IPATH include, but are not limited to, the Indiana Attorney General's Office, Assistant United States Attorney for the Southern District of Indiana, FBI, DCS, law enforcement officers from Indianapolis and the State Police Department, the Marion County Prosecutor's Office, juvenile probation, and victim service providers.

The child welfare agency is developing policies and procedures, which include training opportunities for child welfare agency staff, to address the ongoing need of young people and children who are involved in the child welfare system.

F. DETERMINING ELIGIBILITY FOR BENEFITS AND SERVICES (SECTION 477(B)(2)(E) OF THE ACT)

Services to be provided are the same and are based upon the Broker of Matrix section of the OYS Service

Standard.

1. CFCIP Services

Eligibility for CFCIP Services starts at age 16. Placement drives who provides services. When youth are placed in a DCS licensed foster home, a relative home or another court appointed placement, a referral is made to an OYS provider. When youth are placed in residential facilities, group homes or a Licensed Child Placing Agency foster home, the facility/agency is responsible for providing the CFCIP Services, according to the OYS Service Standards.

The following youth meet the eligibility requirements for voluntary case management services:

- Youth ages 18 to age 21 who were formerly in foster care after the age of 16 for a period of six (6) months while a CHINS or probation youth or a “ward or in the custody of another state” or
- Youth ages 16 to age 21 who were formerly in foster care for a minimum of six (6) months as a CHINS or probation youth between the ages of 16-18 who have been adopted or placed in a guardianship from foster care and were receiving OYS services prior to the dismissal of their case.

DCS has determined the following former foster youth meet the eligibility requirements for room and board (R&B) services:

- A youth who turns 18 years of age while placed in foster care; or
- A youth who turned 18 years of age in foster care, who was a “ward or in the custody of another state”; or
- A youth age 18 to 21 who was on a trial home visit on his or her 18th birthday or in runaway status with an open CHINS or probation youth case.

DCS will assure that all youth receiving R&B services also receive case management.

2. Collaborative Care

DCS opted into all eligibility criteria outlined in the Fostering Connections Act for extending Title IV-E Foster Care. In addition, DCS decided that youth who are not IV-E eligible are included in the population. Eligibility is determined the same way for all youth in the following categories.

- CHINS: youth who have an open CHINS case are presumed to remain in care until age 20. Under a CHINS case, you can remain in care to the age of 21. Youth receive all the same service and placement options. When it is in the youth’s best interest, the CHINS case will be dismissed and a Collaborative Care court case will open.
- Re-Entry: youth who have aged out of foster care (turned 18 in a foster care placement) either with an open CHINS or Juvenile Probation case, youth who are 18 years of age, but not yet 20 years of age and meet Collaborative Care eligibility may re-enter foster care. Youth sign the Voluntary

Collaborative Care Agreement, agreeing to come back into foster, meet at least monthly with a 3CM and be under the supervisor of the Juvenile Court. Youth who re-enter care can remain in an open Collaborative Care case until their 20th birthday. Youth receive all the same service and placement options.

G. COOPERATION IN NATIONAL EVALUATIONS

DCS will cooperate in any national evaluations of the effects of the programs in achieving the purposes of CFCIP.

DCS participated in the Pilot National Youth in Transition Database (NYTD) Assessment Review (NAR). The NAR is an onsite review that focused on two major areas: the eight general requirements for NYTD data collection and reporting and the 58 NYTD data elements. The NAR consist of findings based on onsite demonstration, case record review and stakeholder interviews. Progress in implementing the N-QIP is described in the NYTD section. See NAR section for more information.

H. CONSULTATION WITH TRIBES (SECTION 477(B)(3)G))

The Pokagon Band of Potawatomi Indians is Indiana's only federally-recognized tribe. When the Pokagon Band intervenes in an Indiana DCS case and assumes jurisdiction, they request that all IV-E benefits be terminated. The Pokagon Band provides income and services for the family and youth as part of their tribal benefits and has indicated that they do not want to participate in Title IV-E. If the child remains under Indiana DCS jurisdiction, the child is eligible for all benefits and programs available to foster children and youth. The Pokagon Band is aware that DCS will assist them if this changes in the future and DCS continues to inform them of new benefits and programs during meetings.

Additionally, although they do not currently operate education and training voucher and independent living program, the Pokagon Band is aware that should they request it, DCS would work with them to arrange for CFCIP funds to be made available for youth in the tribe's care.

I. CFCIP PROGRAM IMPROVEMENT EFFORTS & INVOLVEMENT

DCS will continue its efforts to gather youth feedback and ideas for program improvements. DCS will continue to consult with youth on the Indiana Youth Advisory Board on older youth related agency initiatives. DCS will explore avenues to partner with outside stakeholders to fund and facilitate focus groups to gather feedback from youth involved with the full OYS array as well as others who are involved with the program, such as providers, foster parents, host home adults, etc. DCS will revisit the practice of gathering youth input on new policies and procedures. As DCS develops the OYS evaluation plan, youth feedback, ideas and input have been included. Currently, DCS has begun to initiate the CQI process within OYS providers and conducted site visits using the data from the NYTD survey to explore needs of the service area. Youth Advisory Board members and stakeholders have been included as part of the OYS CQI teams.

Members of the Youth Advisory Board met with the DCS executive team to provide valuable insight on foster youth experiences in foster care and system improvement feedback.

J. CFCIP TRAINING

The OYI team is facilitating quarterly trainings for internal DCS staff in the local offices on CFCIP and OYS. The OYI Team has developed a state-wide plan for training internal DCS staff on CFCIP and OYS. The OYI Team also facilitates a bi-monthly training for 3CM and trains the OYS provider staff twice a year. The OYI Team will explore the option of requesting OYS be a reoccurring training topic for the annual Local Office Director and Local Office Supervisor workshops. The OYI team continues to provide training to external stakeholders and Licensed Child Care Placement Agency's on older youth services and authentic youth engagement.

While reviewing and gathering feedback on the CFSP from the OYS providers, a shared training goal was developed. The OYI Team will partner with the OYS providers to identify shared training that will focus on best practices in working with Older Youth.

Based upon feedback from youth, the OYI Team will work with the IYAB on creating a workgroup of youth to assist DCS in developing trainings for Case Managers (both DCS and provider) on working with Older Youth in foster care, assisting in transition planning from a youth's perspective and additional topics. The OYI Team will work with the team of youth on developing the trainings; explore methods of training the youth as professional trainers and support youth as trainers.

Foster parents also receive training on fostering older youth and preparing them for independence. Training includes identifying the different phases of independent living development (Phase I: Informal learning, Phase 2: Formal Learning, Phase III: Practice, and Phase IV: Self-sufficiency), the challenges foster youth face in the transition to independence, and practices foster parents can put in place to help in the transition, including outside resources that are available, as well as the availability of ETV funds to help with different phases of development.

Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ): DCS designates a certain number of trainings that are required to be a part of the annual training hour requirement for ongoing case workers. For 2015-2016, DCS required all workers to take the LGBTQ Youth training. Furthermore, foster and adoptive parents also receive training on LGBTQ. The Foster and Adoptive Parent Training – Fostering Older Youth curriculum includes training on speaking and working with foster youth who might be LGBTQ. The training includes approaches to take in working with youth, examples of challenges these youth face, and outside resources that are available for assistance. One such resource is the Indiana Youth Group (IYG), which provides a safe place and confidential environment where self-identified LGBTQ youth are empowered through programs, support services, and leadership opportunities.

K. EDUCATION AND TRAINING VOUCHER PROGRAM

The ETV program is a federally funded-administered program designed to provide financial and academic support to youth who have aged out of the foster care system and who are enrolled in an accredited college, university or vocational training program. Current and former foster youth must have been in foster care on or foster care will end on their 18th birthday and youth who was adopted or placed in a kinship guardianship from foster care on or after their 16th birthday are eligible for ETV. Students may receive up to \$5000 per academic year based on the cost of attendance. Youth must enroll between the ages of 18 up to their 21st birthday. Students may continue to receive ETV support until age 23. ETV Foster youth who graduate high school at age 17 and will be attending post-secondary institution can apply for ETV. Currently DCS makes ETV funds available through a contracted provider.

DCS has a contract with one vendor to administer the ETV program. This vendor is required to create and maintain a web-based application system, funding methodology that ensures ETV award does not exceed the cost of attendance, administer funds directly to students, monitor student grads and offer academic support. The current program model includes student ambassadors and ETV Specialists. The student ambassador role offers peer support to other students and provides education on ETV to new and incoming students. The ETV Specialist role offers support, guidance and advocacy to ETV students and helps student navigate the campus process.

Cost of attendance is determined by each participant's choice of school based on factors such as tuition, fees, books, housing, transportation and other school-related costs unique to the participants' needs at their institution of choice. All ETV participants are required to submit a Cashier statement and Financial Aid statement to their higher education institution. Once cost of attendance is calculated by the school, verification is provided in accordance to the Higher Education Act of 1995, typically either by fax or mail, to the main ETV office with the appropriate staff signatures from the institutions. The ETV Program Manager reviews documents to ensure the ETV funds awarded do not exceed the total costs of attendance.

All financial aid directors at educational institutions that ETV recipients attend are informed each academic year, about the ETV program and ETV aid is reported to the higher education institutions via sharing of documentation. In addition ETV program staff are aware of each student's total financial aid package to ensure that ETV funds are used to fill the funding gaps up to but not exceeding the cost of attendance.

ETV staff work closely with The Commissioner of Higher Education (CHE) to insure all parties are updated on all financial aid rules, regulations, changes and supports. The ETV vendor monitors and participates in a listserv sponsored by Department of Education and CHE for higher education Financial Aid directors. ETV staff are also connected to the American Bar Association Center on Children and the Law Foster Care Education group. Higher education institutions are updated each academic year and the ETV vendor encourages and has leveraged the institutions to designate a key person to work with ETV students and required documentation.

The ETV staff also works closely with all Financial Aid directors and staff where ETV students are enrolled. The higher education institutions report student grants and additional aid on the financial aid form. The ETV vendor tracks all student aid dollars by category and student demographic. To stay ahead of developing issues, ETV staff hosted informational sessions for Financial Aid directors in 2015 -2016 and will continue to do so moving forward. ETV Specialist continue to work with colleges financial aid departments on a local level.

The ETV recipients apply each semester (fall, spring, summer), which allows the ETV vendor to track the student’s enrolment, progress and pull quantitative data on retention and persistence each academic year. A comparative analysis is completed to extract new applicants in each academic year.

The ETV vendor tracks retention and persistence of its ETV students. Retention is an institutional measure and persistence is a student measure. During the 2015 – 2016 the following data was collected for ETV students who received funding:

- 62.96% -170 students were returning form pervious academic years.
- 51.64% -47 of the 91 freshman who completed AY 2014-2015 returned in AY 2015-2016
- 37%- 37 of the 100 freshman of AY 2015-2016 completed the full semester
- 50% - 6 of the 12 seniors of AY 2015-2016 graduated

Demographics include the following information, parenting, marital status, age, gender, ethnicity and employment. ETV applicants are requested to report on their parenting and marital status on the application.

2015 – 2016 Gender Comparative		
	Number	Percentage
Male	155	35.07%
Female	287	64.93%
Total	442	

2015 -2016 Age Comparative		
	Number	Percentage
Total	442	
17		1%
18		18%
19		25%
20		21%
21		15%
22		11%
23		9%

2015 -2016 RACE COMPARATIVE		
	NUMBER	PRCENTAGE
TOTAL	442	
AFRICAN AMERICAN	159	35.97%
ALASKAN NATIVE	0	0.00%
ASIAN / PACIFIC ISLANDER	2	0.45%
BIRACIAL/MULTIRACIAL	40	9.05%
CAUCASIAN	208	47.06%
LATIN AMERICAN	10	2.26%
NATIVE AMERICAN	2	0.23%
OTHER/NO ANSWER/UNDISCLOSED	22	4.98%

DCS works closely with the ETV vendor to improve and strengthen Indiana’s postsecondary educational assistance program. The ETV has increased its service component to meet the needs of youth attending postsecondary institutions. The ETV Support model is in place at eight of the state colleges/universities. The model allows the ETV Regional Specialist to work in collaboration with the campus support services. The campuses listed below offer office space to the ETV Regional Specialist, campus staff assigned in the Financial Aid and Student Accounts/Bursar office to work with ETV students, and a streamlined enrollment process for student support services. The ETV Regional Specialists referred students to numerous college student support service programs and community resources. Students were referred to TRiO, 21st Century Scholar Campus Support Disability Services, Tutoring and basic need resources. ETV Specialists were trained on the education case management, Foster Success model developed by Western Michigan University. ETV Specialist were able to support students in learning how to reach a decision after looking at all options. The model helps the student develop a voice and learn about advocacy. The students were able to utilize these effective tools to foster

informed decision making.

Finally, Indiana offers the Nina Scholars program / scholarship for residents who face barriers to obtaining higher education INCBY25 ETV program manager works closely with the Nina Scholars program board and submits student names for program and scholarship application.

XIII. TARGETED PLANS WITHIN THE CFSP

A. FOSTER AND ADOPTIVE PARENT DILIGENT RECRUITMENT PLAN

There are no changes necessary in the Foster and Adoptive Parent Diligent Recruitment Plan at this time. In response to the recent CFSR and current PIP development, DCS anticipates making significant updates to the Foster and Adoptive Parent Diligent Recruitment Plan which will be reflected in future APSRs. For example, DCS is currently in discussions with a vendor on a project for the dedicated recruitment of potential foster and adoptive family homes throughout the State of Indiana to respond to the dramatic increase in the number of children in need of out of home care. The vendor would be responsible for the management of all elements of the recruitment until the referral information is obtained. DCS will be responsible for referring the potential foster family information to a licensed child placing agency to work with the foster parents for specialized training, review, and recommendation regarding licensure. Additionally, diligent recruitment plans that were previously developed by each DCS Region will be reexamined at an upcoming Regional Foster Care Supervisors Meeting in July 2017.

As mentioned previously, DCS has implemented the efforts described in the Foster and Adoptive Parent Diligent Recruitment Plan, and has developed reports indicating the ethnic and racial diversity of children in need of out of home placement. DCS has begun sharing this data with its licensing workers and LCPA licensing workers in order to ensure that targeted recruitment can occur.

DCS does not have any policies limiting the array of available foster homes in terms of cultural diversity. DCS does not limit the ability of lesbian, gay, bisexual or transgender (LGBT) applicants from being licensed foster family homes. DCS encourages cultural competency in its staff, contracted providers, and foster family homes through specific training offerings.

B. HEALTH CARE OVERSIGHT AND COORDINATION PLAN

There are no substantive changes necessary to the Health Care Oversight and Coordination Plan at this time.

Since the inception of the DCS Psychotropic Consultation Program, IU Psychiatry has completed a total of 578 cases. In all, 252 peer-to-peer medication reviews have been completed with prescribing physicians.

During the current project period, between March and May 2017, a total of 112 cases have been completed. The case reviews completed and submitted during the current project period (N=30) reveal inappropriate prescribing

practices, but the review process continues to have promising outcomes. The most prevalent concern cited by reviewing clinicians is medication quantity, and specifically 4 or more psychotropic medications being prescribed simultaneously (67%). Indication is also a common problem, with 30% of children in the review group being prescribed medications with insufficient evidence of effectiveness, and 57% being prescribed medications that are inappropriate for their diagnosis and symptoms, or without any diagnosis at all. Another common reason for concern is inadequate documentation and monitoring, with failure to appropriately monitor laboratory values and vital signs in 17% of cases, and failure to adequately document physical exams, vital signs, or side effects in 47% of cases. Prescribing procedures are also problematic. In 30% of cases, multiple medication changes were made simultaneously. With respect to provider response, in all cases reviewed the prescribing physician agreed with the recommendations discussed. Thus, among cases with concerns, there was total agreement between IU Psychiatry consultants and prescribing physicians about next steps toward bringing the medication regimen in line with PMAC criteria. Additionally, following the peer-to-peer review, there were remaining concerns expressed by the IU child psychiatrist conducting the review in only nine cases (30%), and these concerns were never reported to be significant ones.

C. DISASTER PLAN

The DCS Disaster Plan was updated in June 2014 and there have been no additional updates in the past year and there are no changes needed at this time. DCS was not affected by any disaster in the past year.

D. TRAINING PLAN

Over the past year, the focus was not on developing new trainings, but rather enhancing those currently in place. While no new trainings are included in the updated DCS 2017 Training Plan (attached as **Attachment 6**), as in year's past, a brief summary of the trainings for the 2016-2017 period are provided to demonstrate progress in implementing the plan. During the past twelve months, the Cohort training was realigned to allow new workers to stay at their base county during the first week of employment, instead of going straight to training. This is an effort to build relationships with their local co-workers from the start of their employment to assist with retention efforts. Also during the past year the Supervisor Core curricula was enhanced, updated and rolled out to new supervisors. There have been a number of requests from other states for copies of Indiana's supervisor training products. Next year, Staff Development will turn its attention to local office director training curriculum updates and enhancements to specific topical trainings.

Of note, Indiana's Round 3 CFSR found that probation officers that serve youth in the delinquency setting and receive IV-E funded services lack sufficient child welfare training. DCS will be collaborating with counterparts in the Indiana judiciary to finalize curriculum updates for probation officers as part of the continued PIP development process and those changes will be reflected in future DCS Training Plan updates.

XIV. STATISTICAL AND SUPPORTING INFORMATION

A. INFORMATION ON CHILD PROTECTIVE SERVICE WORKFORCE:

FCM Preferred Experience:

- Bachelor's degree from an accredited college/university required.
- At least 15 semester hours or 21 quarter hours in child development; criminology; criminal justice; education; healthcare; home economics; psychology; guidance and counseling; social work; or sociology required (copy of transcript must accompany the application or must be submitted at the time of interview if granted).

FCM Supervisor Preferred Experience:

- Bachelor's degree from an accredited college/university in Child Development, Criminology, Criminal Justice, Education, Healthcare, Home Economics, Psychology, Guidance and Counseling, Social Work, or Sociology or a related field.
- Two (2) years experience in the provision of education or social services to children and/or families. One (1) year of the experience in an administrative, managerial, or supervisory capacity is preferred or accredited graduate training in Social Work.

County Child Welfare Director E4-E7 (Local Office Director) Preferred Experience – Varies

E7: Experience:

- Four (4) years of experience in public welfare, education, public administration, business administration, or social services; plus
- An additional three (3) years of supervisory experience in these areas.
- Education: Bachelor's degree from an accredited four-year college. (Concentration in Business Administration, Child Development, Counseling and Guidance, Economics, Education, Health Care, Home Economics, Law, Psychology, Public Administration, Social Sciences, Social Work, or Sociology preferred.)
- A combination of experience and accredited graduate training in any of the above areas may be considered.

E6: Experience:

- Four (4) years of experience in public welfare, education, public administration, business administration, or social services; plus
- An additional four (4) years of supervisory experience in these areas.
- Education: Bachelor's degree from an accredited four-year college. (Concentration in Business Administration, Child Development, Counseling and Guidance, Economics, Education, Health Care, Home Economics, Law, Psychology, Public Administration, Social Sciences, Social Work, or Sociology preferred.)
- A combination of experience and accredited graduate training in any of the above areas may be considered.

E5: Experience:

- Four (4) years of experience in public welfare, education, public administration, business

- administration, or social services; plus
- An additional five (5) years of supervisory experience in these areas.
- Education: Bachelor’s degree from an accredited four-year college. (Concentration in Business Administration, Child Development, Counseling and Guidance, Economics, Education, Health Care, Home Economics, Law, Psychology, Public Administration, Social Sciences, Social Work, or Sociology preferred.)
- A combination of experience and accredited graduate training in any of the above areas may be considered

E4 : Experience Considered as Regional Managers (Marion & Lake):

- Four (4) years full time professional experience in public welfare; education; public administration or social services; plus
- Six (6) years full time experience in an administration or supervisor capacity in the above areas or as a state-level public welfare consultant.
- Graduation from an accredited four year college.
- Fifteen (15) semester hours in public administration; business administration; or social science; economic; law; child development; education; counseling and guidance; social work; home economics; sociology; psychology; or health care required.
- Substitutions: accredited graduate training in any of the above areas may be substituted for the required experience with a maximum substitution of two (2) years, except for the administration, supervisor, or consultative experience.
- Full time experience in state social services as a state pat 1, sam pat 4 or higher may sub for the required experience and specialized education on a year for year basis.

Data on the education, qualifications, and training of such personnel

DCS does not track the number of child welfare workers with a Bachelor (BSW) and/or Masters (MSW) of Social Work degree; however, DCS does keep track of the number of staff with Title IV-E Supported Bachelor and Masters of Social work degrees. DCS in partnership with IU continues to offer the IV-E BSW and MSW programs. Participation in these programs are as follows:

In 2014,

- 46 students were selected for the BSW program.
- 23 students were selected for the MSW program.
- 42 BSW students began employment as family case managers in May through August, 2014.

In 2015,

- 50 students were selected for the BSW program.
- 18 students were chosen for the MSW program.

- 34 BSW students will begin employment as family case managers in May and June of 2015.
- In 2016,
- 52 students were selected for the BSW program (50 will be funded and 2 will not receive funding but will still matriculate with the other BSW students)
 - Interviews and selection of students for the MSW program will be completed in July 2016. However, DCS expects close to 20 students being selected.
 - 43 BSW students will begin employment as family case managers in May and June of 2016.

In 2017,

- 58 BSW students were selected for the BSW program (50 funded and 8 were unfunded but matriculated with other BSW students)
- The MSW Scholars program is under development for enhancement and will recommence in 2018.
- 58 BSW students began employment as family case managers in May and June of 2017.

DCS does not have information available related to the number of years of child welfare experience or other related experience working with children and families.

Child Protective Services Demographics – Age - As of 6/22/17

Family Case Managers and Family Case Manager Trainees

<22	22-25	26-30	31-40	41-50	51+	Total
8	468	646	771	393	228	2514
0%	19%	26%	31%	16%	9%	100%

FCM Supervisors

22-25	26-30	31-40	41-50	51+	Total
2	59	159	88	57	365
0%	16%	44%	24%	16%	100%

County Welfare Directors

26-30	31-40	41-50	51+	Total
1	28	31	22	82
1%	34%	38%	27%	100%

Executives

31-40	41-50	51+	Total
13	19	27	59
22%	32%	46%	100%

Information on caseload or workload requirements for such personnel, including requirements for average number and maximum number of cases per child protective service worker and supervisor (section 106(d)(10) of CAPTA).

Pursuant to IC 31-25-2-5, enacted in the spring of 2007, DCS is required to ensure that Family Case Manager staffing levels are maintained so that each county has enough FCMs to allow caseloads to be at not more than: (1) twelve active cases relating to initial assessments, including investigations of an allegation of child abuse or neglect; or (2) seventeen children monitored and supervised in active cases relating to ongoing services. The 12/17 caseload standard is consistent with the Child Welfare League of America’s standards of excellence for services for abused and neglected children and their families.

The issue of caseload data must include the current national discussion regarding caseload definitions. As currently set out in statute, DCS must comply with standards that include 12 new investigations or 17 ongoing children being supervised by a case manager. These definitions are clear in large to medium counties, where the large scale of operations allows FCMs to specialize in either investigations or on-going cases. In smaller counties, however, the issue of mixed caseloads is more difficult to determine, in large part because ongoing caseloads of 17 are fairly static while new investigation caseloads are fluid, changing day to day and week to week. DCS continues to work with national leaders and organizations as these discussions bring more mathematical certainty to those designations.

Using existing monthly data reports, Regional Managers monitor caseloads regionally and locally to allocate staff as needed in individual counties.

Reports are generated monthly to monitor the timely completion of new assessments within 30 days as well as periodic detailed reports which help managers track the length of time various case types remain open. This allows managers to further analyze how to more consistently provide permanency for those children and thereby close the case. All Regions have formed Permanency Review Teams (PRTs) to review and provide recommendations to local offices for those cases where traditional measures have failed to achieve permanency. Each region reports monthly on the status of all PRT cases to the Permanency and Practice Support Division.

In addition, Regional Managers also monitor the number of overdue assessments or assessments that are not completed within the required thirty day timeframe. Two overdue assessment reports are run on a weekly basis. The first identifies all cases that have been open for 20 to 30 days. This report enables managers to identify assessments that are at risk of becoming overdue (i.e., open for more than 30 days). A second report captures all assessments that have been open for more than 30 days. There is also a supervisory report that tracks assessments that have been sent to a supervisor for approval. This report shows the total number of days an investigation has been open for quick reference.

B. JUVENILE JUSTICE TRANSFERS

This information is available as a part of the Indiana Probation Report prepared by the Indiana Supreme Court Division of State Court Administration at <http://www.in.gov/judiciary/admin/files/rpts-ajs-2015-probation-v1-summary.pdf>.

Listed below are the page numbers within the 2015 report where data can be found for juvenile justice transfers. The 2016 juvenile justice transfer data will not be available until September, 2017.

Juvenile Probation	16
Juvenile Probation Referrals 2006-2015	16
Juvenile Probation Supervisions 2006-2015	18
Juvenile Probation Supervisions Method of Disposition	20
Juvenile Supervision Levels	22
Juvenile Supervision as Result of Substance Abuse Convictions 2005-2014	22
Juvenile Supervisions as Result of Sex Offenses 2010-2015	23
Juvenile Supervision Completed Predisposition and Progress Reports	23
Juvenile Law Services Report	24
Juvenile Law Services Financial Report	28

C. SOURCES OF DATA ON CHILD MALTREATMENT DEATHS:

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:

DCS uses the following information in child maltreatment deaths as applicable on a case by case basis:

- Information gathered by filling out the Sudden Unexpected Infant Death Investigation forms (only applicable in certain types of deaths)
- Prior DCS history
- Autopsy Report (final report)
- Death Certificate (state issued)
- Law Enforcement Agency records
- Emergency Medical Service records
- Medical records
- Mental Health records for child and/or caregiver (if applicable)
- Drug screens
- Pictures
- Interviews with all appropriate parties (as we do for any assessment, caregivers, witnesses, other children, professionals, etc.)
- Scene investigation
- Scene reenactment
- Any information gained from professional consult (i.e. Pediatric Evaluation and Diagnosis (PEDS) referral)

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 Manager 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. DCS 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 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.

D. EDUCATION AND TRAINING VOUCHERS

Education and Training Vouchers:

The number of ETV applicants including all semesters: fall, spring and summer received via the ETV website: During the 2015-2016 academic year 75.41% of applicants received ETV funding.

	Application 2015 – 2016 Snapshot				
	# of Applicants	Eligible Applications	Total Funded	Unduplicated	New Awards
Total	442	358	270	190	100
Fall	232		150	150	
Spring	158		82	35	
Summer	52		38	5	

A similar chart for 2016-2017 school year will be available in September, 2017.

E. INTER-COUNTRY ADOPTIONS:

During FY 2016, records indicate one (1) child adopted from another country entered into DCS custody as a result of a disruption. The youth was adopted in the Ukraine on May 23, 2016 and the disruption was a result of a sexual relationship with the adoptive mother. Indications are that a boarding school for orphans, District State Administration in the Odessa Region, and a city council were involved. The tentative plan for the youth was to transition him to collaborative care.

XV. ATTACHMENTS (SEPARATE DOCUMENT)

1. 2016 Citizen Review Panel Report– Hendricks County.....Page 1
2. 2016 Citizen Review Panel Response – Hendricks County.....Page 16
3. 2016 Citizen Review Panel Report– Switzerland County.....Page 18
4. 2016 Citizen Review Pane Response – Switzerland County.....Page 20
5. CAPTA Governor’s Assurance – Comprehensive Addition and Recovery Act of 2016.....Page 23

6. 2017 DCS Training Plan.....Page 24
7. CFS-101, Part I, II, and III (signed PDF).....Page 60
8. Attachment E – Educational and Training Voucher Chart.....Page 63
9. Section H – Financial Information.....Page 64
10. Human Trafficking Screening & Assessment Tool.....Page 66



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2016 Indiana Foster Care Citizen's Review Panel Annual Report

The current Indiana Foster Care Citizen Review Panel began serving its term in 2014. Heritage Foster Adoption Support Inc., (a regional parent support group for foster, adoptive and kinship caregivers), was asked to form a Foster Care Citizens' Review Panel from among its members for the three year term beginning in January 2014. The following representatives were chosen for the panel:

- Stephanie Kerner, BA: President and founder of Heritage Foster Adoption Support Inc. (HFASI). Former foster parent and adoptive mother of four. Has worked with at risk children and families in various capacities since 1989. Chairperson of the Indiana Foster Care Citizen Review Panel.
- Bridgett Morales-Kilgore, BA: Active foster parent licensed through the Indiana Department of Child Services and adoptive mother of three; Regional Program Specialist at Insource. Training manager of the Hendricks County Heritage Foster Adoption Support Group.
- Jenifer Alexander: Former foster parent and adoptive mother of four; leader of the Morgan County Heritage Foster Adoption Support Group (inactive).
- Donna Redmond, BA: Former foster parent and adoptive parent of two. Global Practice Manager of Process and Standards at Salesforce.
- Mike Klindt, BS: Active foster parent licensed through the Indiana Department of Child Services. Controller at Marketing Informatics LLC.
- Wendy Crouch, M.A.: Active foster parent licensed through the Villages (LCPA) and adoptive mother of three. Certified Medical Assistant.

In 2014, the panel opted to investigate how initial assessments of families completed by caseworkers at the Indiana Department of Child Services impact the outcomes of services in foster care, with the goal of assessing the thoroughness of the process, identification and application of appropriate services, and offer feedback to the Department of Child Services on the quality and efficacy of the initial assessment process. The panel focused on the consistency of assessment within the CANS (Child and Adolescent Needs and Strengths) assessment and then specifically assessed the domains assessing substance use by caregiver and children, as this is a prevalent issue at this time.

2016/2017 CRP meetings occurred as follows (meetings consisted of at least three panel members attending):

January 16, 2016

May 21, 2016

September 17, 2016

February 18, 2017

Activity 1: Completion of surveys of DCS caseworkers and foster parents.

2014 update: Development and finalization of specific survey questions for Indiana Department of Child Services caseworkers occurred over several months in 2014. The survey is intended to ascertain caseworkers' opinions on the effectiveness of current assessment tools and recommendations on possible improvements to the process in order to improve outcomes for families and children. It was determined by the panel that a brief survey would be appropriate, consisting of twenty questions that caseworkers would be able to complete in minimal time over the Internet. Fluid Surveys was chosen as the framework for this survey. At this time, the survey is completed and is in the process of being transferred to Fluid Surveys for implementation.

2015 update: The survey has not been implemented at this time. The plan is to have the survey open to DCS caseworkers beginning August 1, 2016, with completion and data analysis to being August 31. A copy of the intended survey questions has been included with this report.

2016 update: Due to unforeseen complications, the panel was unable to conduct a state-wide survey of Family Case Managers. However, the Department provided answers to the significant questions posed by the panel in the intended survey. The following is a list of survey questions with answers provided by the Department of Child Services (DCS):

- ***Do CPS/CS workers complete bio/psycho/social assessments?*** Family Case Managers (FCM) do not complete bio-psychosocial assessments.
- ***If not, do you refer families for bio/psycho/social assessments?*** Yes, FCMs complete a referral for a Clinical Interview and Assessment which includes the bio-psychosocial assessment.
- ***To whom do you refer for bio/psycho/social assessments?*** There are contracted providers across the state. We currently have several providers contracted (sp) for Diagnostic and Evaluation Services. Within the service standard for this service, providers are required to first complete a Clinical Interview and Assessment which includes a Biopsychosocial. In addition, DCS partners with 27 Community Mental Health providers located throughout the state. For many clients these means the completion of an MRO assessment, which includes the completion of the CANS and a biopsychosocial.
- ***Are these assessments completed within the first thirty days?*** The report should be completed with a summary to DCS within 14 calendar days of referral.
- ***What does CPS assess and what tools do they use?*** FCMs assess child safety and well-being. Tools include the Initial Safety Assessment, the Initial Family Risk Assessment, and the Child and Adolescent Needs and Strengths (CANS) Assessment.

- **What does CS assess and what tools do they use?** FCMs assess child safety and well-being. Tools include the Safety and Risk Reassessment (In-Home), the Reunification Reassessment (Out-of-Home), and the Child and Adolescent Needs and Strengths (CANS) Assessment.
- **Is there any state-wide standard for bio/psycho/social assessments?** Yes, there are Service Standards for Diagnostic and Evaluation Services. DCS is not aware of a current, standard reporting tool for bio/psycho/social assessments across the state. However, DCS requires providers who are contracted for Clinical Interview and Assessments to utilize a standard reporting format which is comparable to a bio/psycho/social assessments. In addition, The CANS is utilized by both DCS and Community Mental Health Centers (CMHC) for the assessment of services, which is also utilized for the collection of information pertinent to the bio/psycho/social assessments
- **How often do you reassess with CANS?** CANS is completed every 180 days and at critical case junctures (i.e. change in the child or family needs, or when new information is obtained indicating a need exists that was not previously identified). CANS is also completed within 30 days of case closure
- **Who is completing the CANS?** Most often it is the FCM who completes the CANS; on vary rare occasions would it be a Family Case Manager Supervisor (FCMS) or LOD.
- **To which version of the completed CANS are foster parents to refer? On which version does the state base their service referrals?** FCM's should be in communication with foster parents regarding the most recent CANS that was completed as that should have the most up to date information. The state bases their service referrals again on the most recent CANS, which would mean it is the Comprehensive Version as that is the one that is required to be completed prior to the development of IA's Case Plans, or Service Referrals
- **What is the average number of CANS completed on an IA (informal adjustment)? On a CHINS case?** It would depend, meaning it is all contingent on the "Life of the Case" as CANS must be completed prior to developing an Informal Adjustment (IA), and prior to the development of Case Plan, within 5 days of removal, and every 180 days and at critical case junctures.
- **Are foster parents being appropriately trained on how to complete/participate in a CANS assessment?** The Permanency and Practice Group does not provide training on this to the foster parents.
- **On average, how timely is the referral process for assessment with service providers?** DCS has a documented service standard for all contracted services, which includes timelines for initiation of services and contact with clients. The service standards also include a timeline around the completion of assessments and the reporting back to the referral source. Timelines may differ based on the service referred.

- ***Are services available for appropriate assessment in all counties/region?*** Services are widely available, however we continue address service gaps for specialized target populations. DCS contracts for multitude of differing assessment. Gaps in assessments available are very much dependent upon the area of the state, and the specialty/qualifications required to complete the assessment.

Based on the answers provided by the Department, as well as review of the select cases provided, the process of initial assessment of children and families appears to be a thorough, albeit somewhat inconsistent process. Issues of inconsistencies within the CANS assessment will be addressed later in this report. The Department indicates that bio/psycho/social assessments are contracted out to services providers under a Department service standard. However, there does not appear to be a consistent biological/psychological/social assessment used statewide. The panel would recommend the Department consider implementing a standard format from service providers in order to improve continuity across regions.

Activity 2: Review selected DCS cases and identify where further assessment would be beneficial to families.

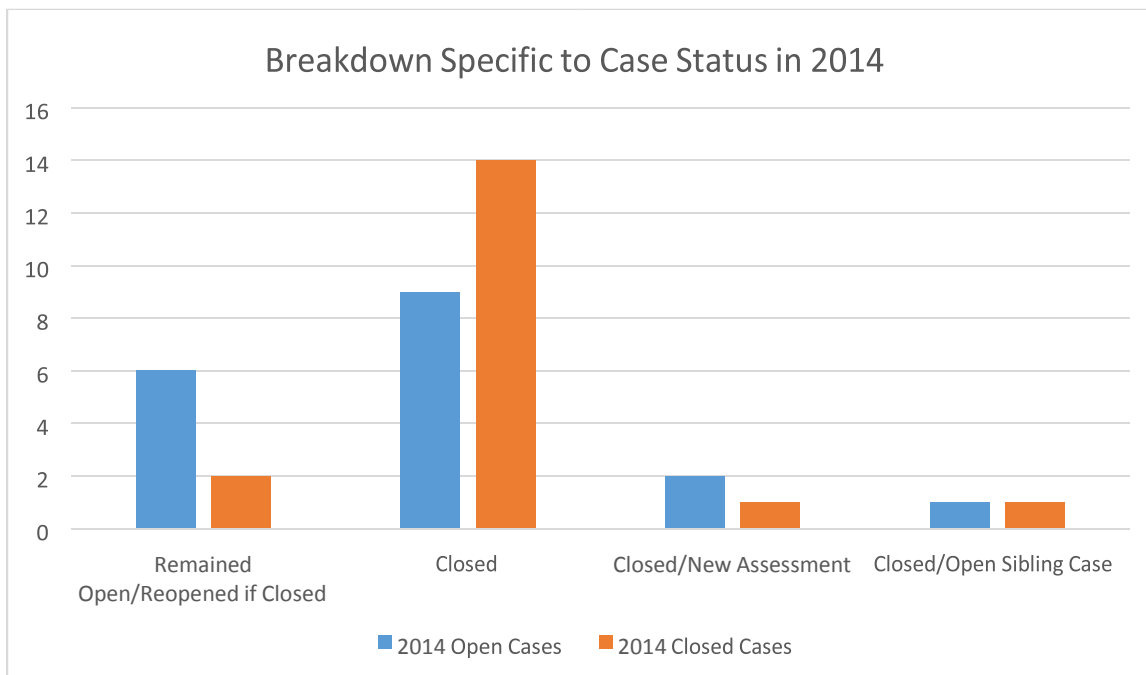
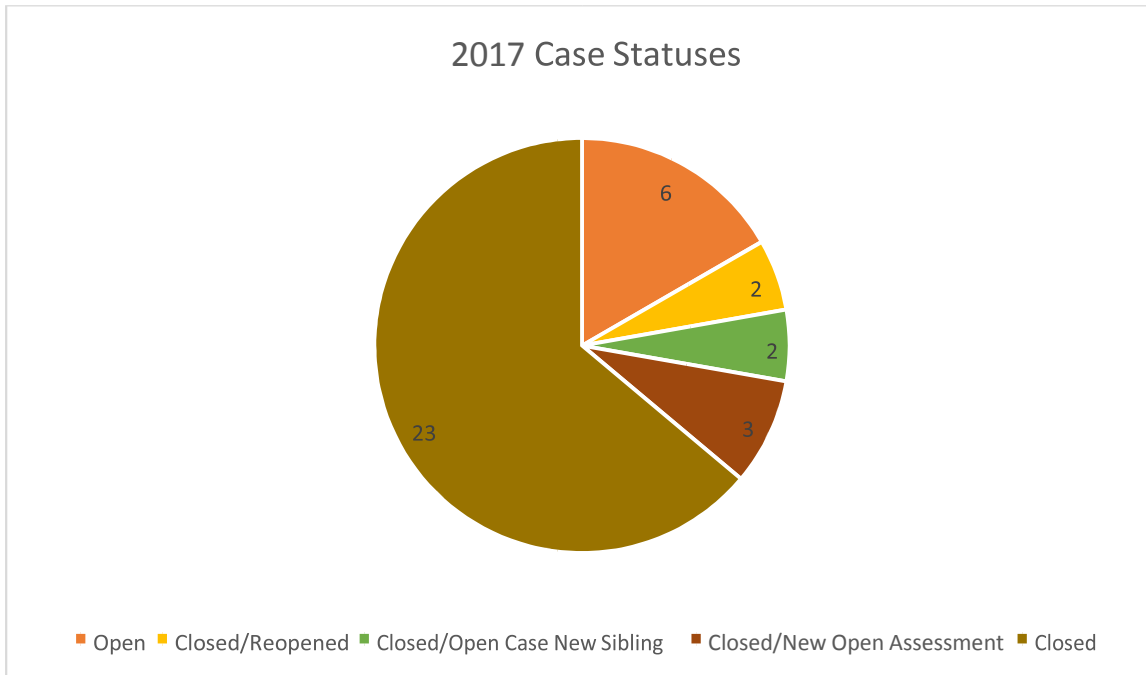
2014 update: In March, the panel sent a general list to the Department of Child Services liaison requesting to review three cases from each DCS region in Indiana. The purpose of the panel was to review each case for initial evaluations conducted by the case manager for services and/or needs, as well as the outcomes in each case. The Department responded with specific questions regarding the type of cases requested and information regarding assessment tools used. From this point, the panel was able to narrow the specific cases to certain parameters. A total of 36 cases would be reviewed from across the state. Only substantiated cases of abuse would be reviewed, and only those that resulted in CHINS findings where a child was placed in foster care or relative care.

2015 update: Cases are in the final stages of review by panel members. The panel will be requesting updates on the cases prior to August 1, 2016 in order to have current information, which will be coordinated with the DCS liaison. Panel members are focusing on initial assessments, service referrals, outcomes of referrals and overall outcomes of cases.

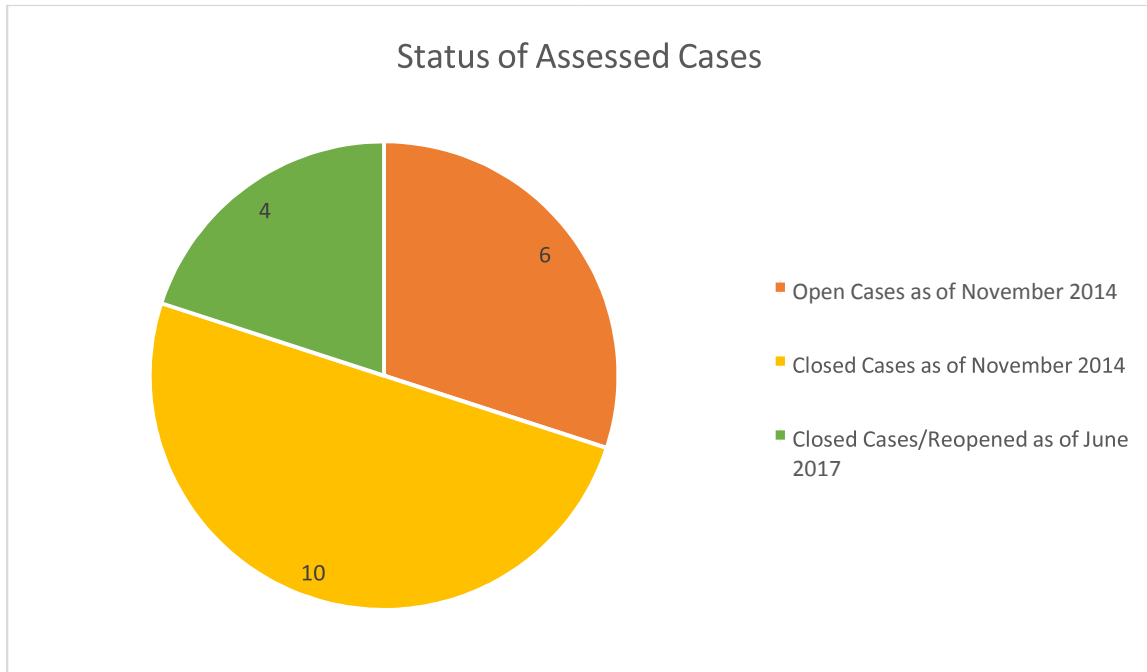
2016 update:

In 2014, a total of 36 cases from around the state were selected for review. As of November 2014, eighteen (18) of the cases were considered “open” with the Department, while the remaining 18 were considered “closed”. The panel requested CANS assessments, as well as reports of service referrals, outcome of referrals and overall outcomes of cases. Information from those cases was reviewed throughout 2016. Prior to completion of this report, the CRP requested status updates on the original 36 cases.

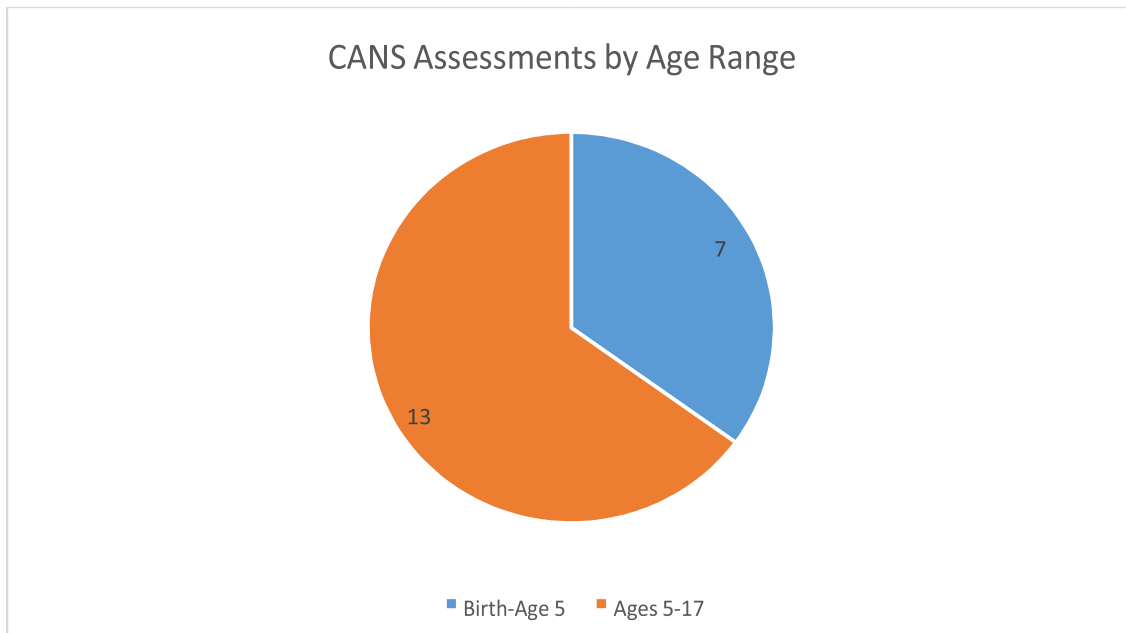
The following chart details the current status of the original 36 cases as of May 2017. As the chart shows, sixty-four (64) percent of the total cases initially reviewed were closed and have not reopened within the studied time frame. Further analysis shows the status of the cases in 2014, as compared to the current status of the case. Seventy-eight (78) percent of the cases which were closed in 2014 remain closed at the current time.



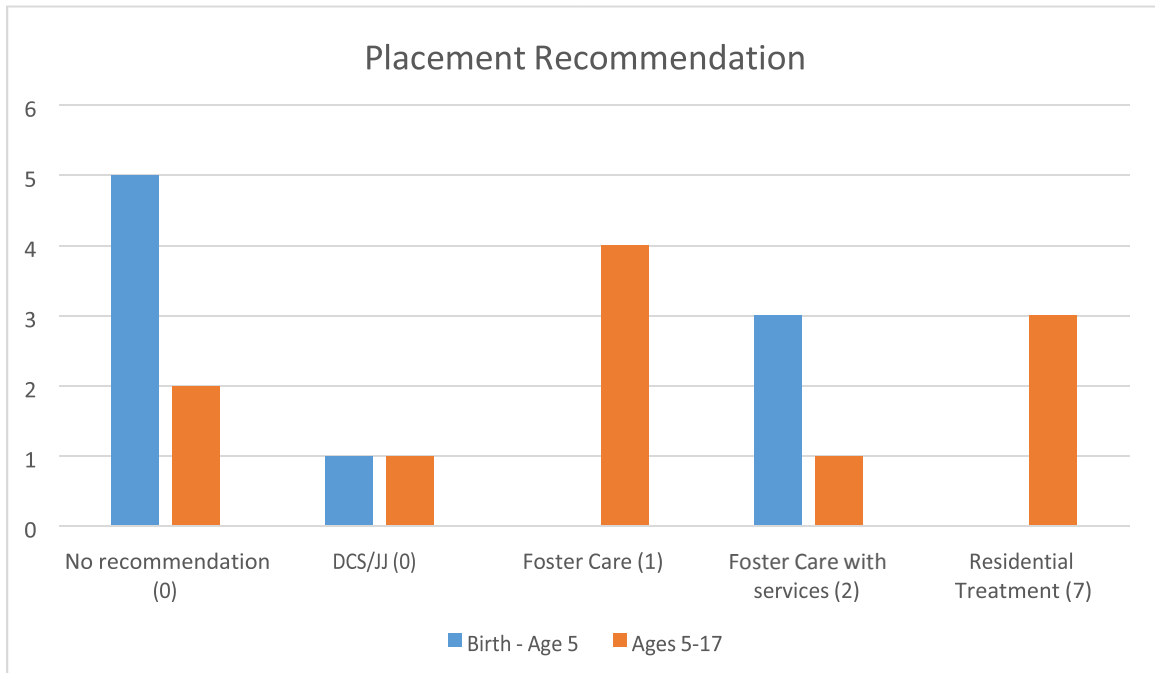
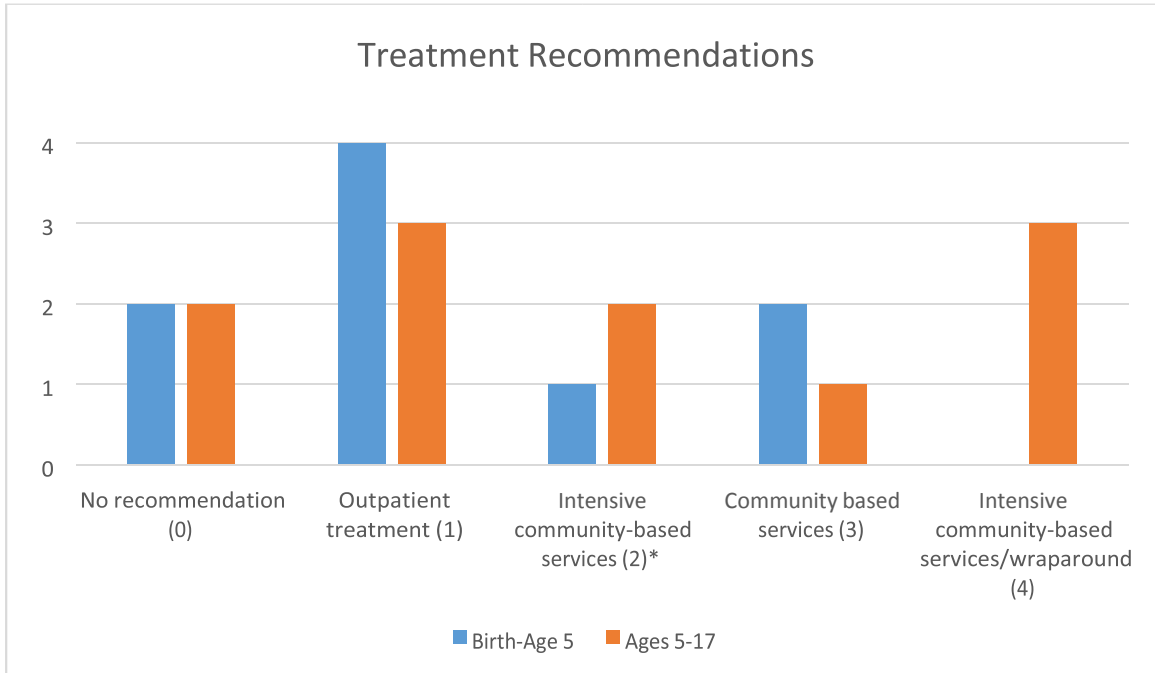
The panel then selected 14 of the 2014 “Closed” cases and 6 “Open” cases which had remained open, or closed then reopened for the purpose of reviewing specific CANS data. A total of 20 CANS assessments were reviewed.



The panel reviewed two versions of CANS assessments: Birth to age 5, and Ages 5 to 17. The chart below details the distribution of CANS assessments by age.



The charts below detail treatment and placement recommendations determined by each CANS assessment.

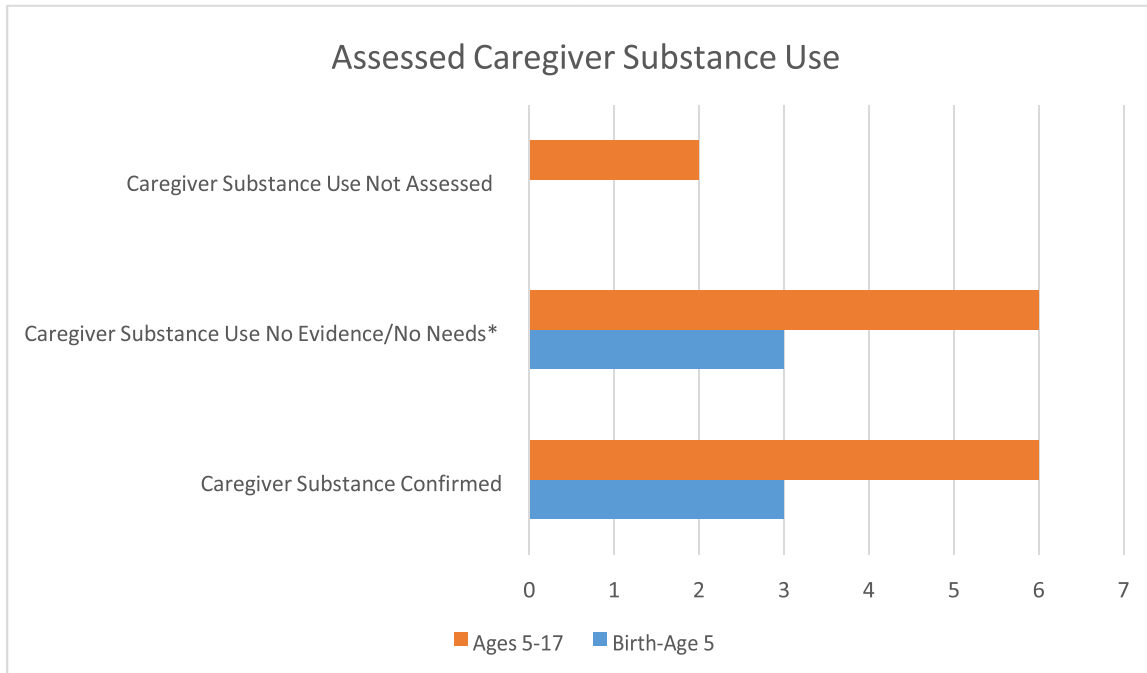


The panel had the opportunity to review one case, identified by the designation Closed Case 5 (CC5), which contained an initial CANS assessment and closing CANS assessment. The panel reviewed both assessments to assess continuity between assessments and outcomes of services referred in the case by the Department. The assessment contained a consistent history of the caregiver's substance use history, as well as accurate assessment of the behavioral and emotional needs of the child. However, in many areas which the panel considered to be "historical" information related to the case, there were discrepancies between assessments. These included:

- Prenatal care: in the initial CANS, the child was noted as having significant exposure to alcohol/drugs in utero. In the second CANS, the child was identified as having no exposure.
- Medical: The child was identified as having a history of asthma in the first assessment, but no medical problems were indicated in the second CANS.
- Witness to community violence: the child was rated as having witnessed significant community violence in the initial assessment; the second assessment indicated no exposure.
- Witness to criminal activity: the child was rated as having witnessed significant criminal activity in the initial assessment; the second assessment indicated no exposure.
- Witness to family violence: the child was assessed as having witnessed "repeated episodes of family violence" in the initial CANS. The second assessment states "there is no evidence the child witnessed family violence."

This case is notable in that while the case was successfully closed (child reunified with primary caregiver), the child was noted to have increased behavioral and emotional issues from the initial CANS to the final CANS. Specifically, the child was noted to have increasing difficulty with self-regulatory behavior. This could be related to either the documented prenatal alcohol/drug exposure or the documented trauma; however, neither of these issues were documented in the final CANS assessment. The Department made appropriate and successful services referral to the family for the purposes of reunification; however it does not appear based on information provided by the Department that the caregiver received education in regards to managing the child's behavior, pursuing diagnosis, or counseling to address the child's escalating behavioral issues likely related to the identified prenatal and trauma issues.

After review of this case, the panel opted to review continuity within the CANS provided, but focus specifically on consistent identification of substance use within each CANS reviewed. The cases distributed as follows:

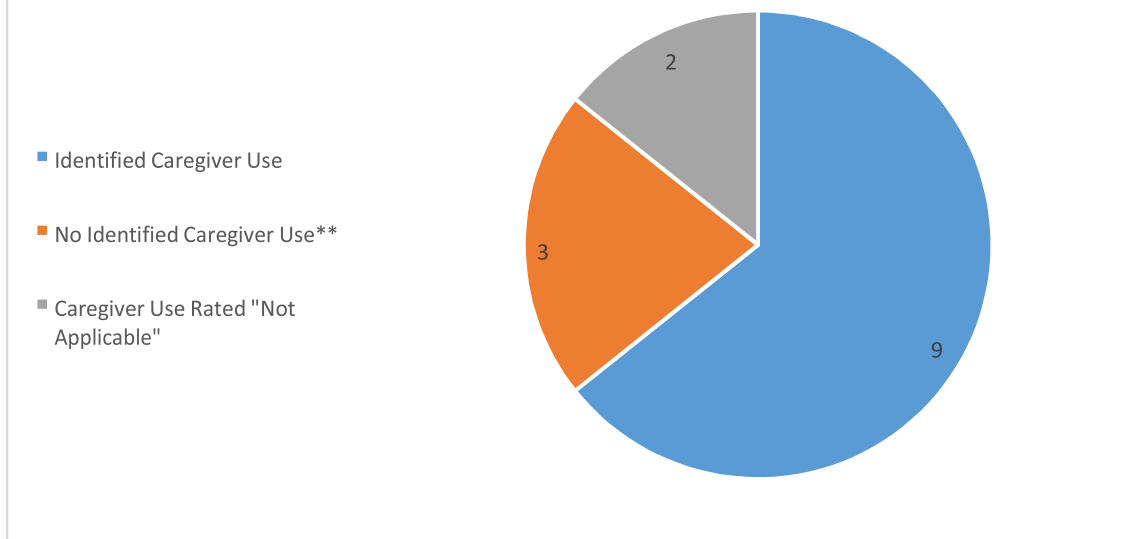


*In one CANS assessment, the caregiver was rated as having no substance use issues; however, the child was rated as having significant prenatal exposure to alcohol/drugs.

Fourteen (14) cases were identified out of the 20 to involve substance use in some form. Of those, four (4) involved some level of substance use by the child. However, in each of those cases, the child was identified as having “no substance use” in the “Child Behavioral/Emotional Needs” domain in the assessment, yet in the additional “Substance Use” domain addressing this area specifically, the child is identified as having a history of substance use.

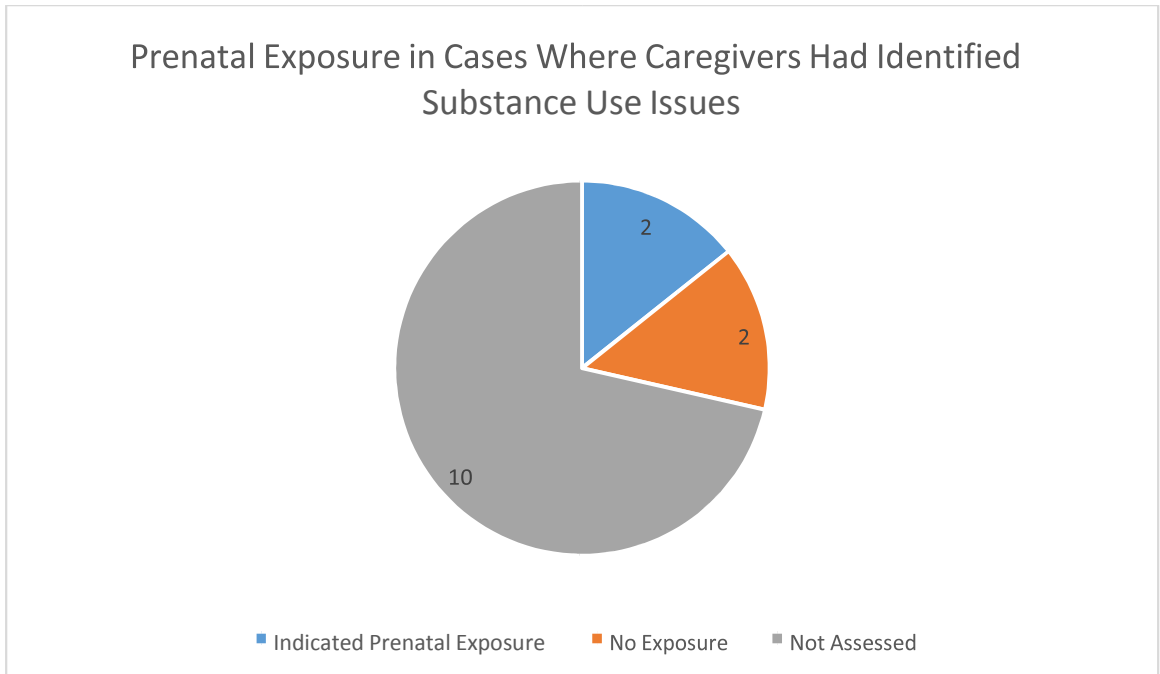
A further issue in interpreting the CANS assessment is the lack of identification of the caregiver being assessed. In at least two assessments, the caregiver was not assessed in the domain of “Caregiver Strengths and Needs” with no indication as to the reason other than “Not Applicable.” The panel feels some identification of the caregiver would be beneficial to the Department for statistical purposes in determining successful outcomes for biological parent caregivers as opposed to other caregivers.

Cases Involving Identified Substance Use



**In one case, caregiver was rated as having no identified substance use needs, yet the child was identified as having significant prenatal exposure to alcohol/drugs.

At this point a significant difference was identified between the CANS Birth-5 and the CANS Ages 5-17. CANS Birth-5 assesses for prenatal and birth information in the category "Child Risk Factors" domain, which includes assessment for prenatal substance exposure. This domain is not included in the CANS 5-17 assessment. As evidence by the chart below, in cases where this domain was assessed, half of the cases indicated the child had prenatal alcohol/drug exposure, which has been identified as a significant causal factor for behavioral and emotional problems in later life.



National statistics indicated seventy (70) percent of children entering into foster care have had some level of prenatal alcohol exposure. Further research indicates that “only eleven (11) percent of children with (a) Fetal Alcohol Spectrum Disorder have symptoms that will warrant a diagnosis by age 6” (Streissguth, 1996). As Fetal Alcohol Spectrum Disorders often parallel other common diagnoses seen in foster children, such as Attention Deficit Disorders and Attachment Disorders, it would appear to benefit the Department to assess for prenatal issues in older children in order to make more appropriate and successful service referrals. A chart detailing the overlapping characteristics in FASD and related mental health diagnoses has been included at the conclusion of this report for reference purposes.

The Indiana Department of Child Services has previously implements the best practices of family engagement, routine substance screening and assessment and permanency planning in their commitment to the families they serve. It would appear from the service referrals made in the reviewed cases that DCS is making successful service referrals based on the CANS assessment in many cases. The panel would suggest the FASCETS neurobehavioral screening tool, utilized by either FCMs or by service providers, to assess children who have identified prenatal exposure to alcohol/drugs, as this exposure may lead to organic brain damage, which is usually not successfully addressed in common treatment models.

Activity 3: Review Indiana statutory requirements for initial DCS assessment and make recommendations if necessary.

2014 update: Panel members have each been provided with a complete copy of the Indiana statutes regarding the initial assessments required to be completed by the Department of Child Services and are reviewing them at this time.

2015 update: The panel will be reviewing the current instrument used for initial assessment, the Child and Adolescent Needs and Strengths (CANS) tool.

Panel members will also be requesting statistical information from the Department of Child Services regarding statewide Child in Need of Services (CHINS) cases where alcohol and illicit drugs are significant factors.

2016 update: Following a review of the State of Indiana statutory requirements regarding initial assessments by the Department of Child Services, the panel did not have any recommendations for legislative change. Further, due to the documented epidemic proportions of the opioid crisis within the state at the current time, the panel did not feel the need to determine a percentage of cases where alcohol and/or illicit drugs are a contributing factor, as it was felt the sample number of cases reviewed accurately reflected current overall statistical trends.

PANEL RECOMMENDATIONS

- **The panel recommends that the CANS assessment identify the caregiver on the assessment form as either the biological parent or non-biological caregiver for clarity.**
- **The panel recommends that the Child Risk Factors Domain from the CANS Birth-5 be incorporated into the CANS Ages 5-17 assessment if the assessment is being completed with a biological caregiver or caregiver with knowledge of the child's birth history.**
- **The panel recommends the Department review the CANS and identify domains where information should remain consistent between assessments. Further, it is recommended that such information should be electronically carried over between assessments, or that the electronic system notifies the assessor when there is a discrepancy in such information.**
- **The panel recommends the Department identify and require a standard biological/psychological/social assessment for use by service providers throughout the state, in order to improve consistency in collecting relevant information needed to determine services for families. The panel recommends the Department of Child Services consider implementing the FASCETS assessment, available through www.fascets.org, with children and families where the child has been identified as having prenatal alcohol/drug exposure, in order to determine if specialized services are indicated.**
- **The panel recommends no legislative statutory changes at this time.**

Respectfully submitted,

Stephanie Kerner

Chairperson, Indiana Foster Care Citizens' Review Panel

June 27, 2017

Survey Questions for Indiana Department of Child Services Caseworkers (June 2016)

Are you a designated CS or CPS caseworker?

Do you use CANS on regular basis?

Do you complete bio/psycho/social assessments?

If not, do you refer families for bio/psycho/social assessments?

To whom do you refer for bio/psycho/social assessments?

Are these assessments completed within the first thirty days?

Do you have suggestions on what additional assessments are needed?

What does CPS assess and what tools do they use?

What does CS assess and what tools do they use?

Is there a gap between information being passed between CPS and CS? Comments?

Do you have ready access to previous files, referrals and relevant information regarding families?

What information is not readily accessible to you?

Is information relayed verbally being documented appropriately? Comments?

Is there any state-wide standard for bio/psycho/social assessments?

In which county do you work?

How often do you reassess with CANS?

Who is completing the CANS?

To which version of the completed CANS are foster parents to refer? On which version does the state base their service referrals?

Does CANS assess thoroughly for medical issues?

What is the average number of CANS completed on an IA (informal adjustment)? On a CHINS case?

Are foster parents being appropriately trained on how to complete/participate in a CANS assessment?

How subjective is the CANS assessment? (scale of 1-5)

How effective is communication between Child and Family Team members regarding information necessary to effectively assess families' needs?

On average, how timely is the referral process for assessment with service providers?

Are services available for appropriate assessment in your county/region?

Is law enforcement being involved in the communication/assessment process?

Overlapping Behavioral Characteristics & Related Mental Health Diagnoses in Children

Overlapping Characteristics & Mental Health Diagnoses	FASD	ADD/ADHD	Sensory Int. Dys	Autism	Bi-Polar	RAD	Depression	ODD	Trauma	Poverty
	Organic	Organic	Organic	Organic	Mood	Mbod	Mbod	Mbod	Environ	Environ
Easily distracted by extraneous stimuli	X	X								
Developmental Dysmaturity	X			X						
Feel Different from other people	X				X					
Often does not follow through on instructions	X	X					X	X	X	X
Often interrupts/intrudes	X	X	X	X	X		X			X
Often engages in activities without considering possible consequences	X	X	X	X	X					X
Often has difficulty organizing tasks & activities	X	X		X	X		X			X
Difficulty with transitions	X		X	X	X					
No impulse controls, acts hyperactive	X	X	X		X	X				
Sleep Disturbance	X				X		X		X	
Indiscriminately affectionate with strangers	X		X		X	X				
Lack of eye contact	X		X	X		X	X			
Not cuddly	X			X		X	X			
Lying about the obvious	X				X	X				
Learning lags: "Won't learn, some can't learn"	X		X			X			X	X
Incessant chatter, or abnormal speech patterns	X		X	X	X	X				
Increased startle response	X		X						X	
Emotionally volatile, often exhibit wide mood swings	X	X	X	X	X	X	X	X	X	
Depression develops, often in teen years	X	X				X			X	
Problems with social interactions	X			X	X		X			
Defect in speech and language, delays	X			X						
Over/under-responsive to stimuli	X	X	X	X						
Perseveration, inflexibility	X			X	X					
Escalation in response to stress	X		X	X	X		X		X	
Poor problem solving	X			X	X		X			
Difficulty seeing cause & effect	X			X						
Exceptional abilities in one area	X			X						
Guess at what "normal" is	X			X						
Lie when it would be easy to tell the truth	X				X	X				
Difficulty initiating following through	X	X			X		X			
Difficulty with relationships	X		X	X	X	X	X			
Manage time poorly/lack of comprehension of time	X	X			X		X			X
Information processing difficulties speech/language: receptive vs. expressive	X			X						
Often loses temper	X		X		X		X	X	X	
Often argues with adults	X				X			X		
Often actively defies or refuses to comply	X				X			X		
Often blames others for his or her mistakes	X	X			X		X	X		
Is often touchy or easily annoyed by others	X				X		X	X		
Is often angry and resentful	X						X	X		



Eric J. Holcomb, Governor
Mary Beth Bonaventura, Director

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Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

June 28, 2017

Dear Hendricks County Foster Care Citizen's Review Panel ("Panel") Members:

DCS is in receipt of your 2016 Foster Care Citizen's Review Panel Annual Report and would like to thank the Panel for volunteering its expertise in examining the agency's assessment practices. As you know, quality assessments are critical to ensuring that children and families receive timely and effective services. While significant effort has been devoted to creating and implementing a thorough assessment process, DCS recognizes that there is still room for improvement, especially in ensuring the quality and consistency of those assessments in a time of increasing cases. The Panel's review of assessments is especially timely in that the recent Child and Family Services Review (CFSR) performed by the federal Children's Bureau agency made similar observations as those offered in the Panel's report. As such, a number of items in the program improvement plan the agency develops will be devoted to improving assessments and the Panel's work will help inform those plans.

Responses to each of your recommendations are listed below:

Recommendation #1: The Panel recommends that the CANS assessment identify the caregiver on the assessment form as either the biological parent or non-biological caregiver for clarity.

As part of the CFSR mentioned above, a file review was completed and discrepancies were found similar to those mentioned in the Panel's report. While those discrepancies were often clarified when participants were interviewed, the assessments and case files nevertheless must be clear about who is being assessed. This is especially important as a renewed focus will be made on making sure the entire family (not just the target child) is being assessed. Improving consistency of case files and identification will be part of the CFSR program improvement plan.

Recommendation #2: The Panel recommends that the Child Risk Factors Domain from the CANS Birth-5 be incorporated into the CANS Ages 5-17 assessment if the assessment is being completed with a biological caregiver or caregiver with knowledge of the child's birth history.

Recommendation #3: The Panel recommends the Department review the CANS and identify domains where information should remain consistent between assessments. Further, it is recommended that such information should be electronically carried over between assessments, or that the electronic system notifies the assessor when there is a discrepancy in such information.



Protecting our children, families and future

Recommendations #2 & #3 are similar in that they focus on ensuring complete and consistent information is provided to ensure a proper assessment is taking place, both at the time of assessment and during a quality review. DCS has dedicated staff that focus on the CANS assessment tool and how it can be improved, especially as it relates to the tool producing consistent information. Furthermore, DCS continues to develop and refine its case management system known as the Management Gateway for Indiana's Kids (MaGIK) to make its use easier and more intuitive for case managers. The recommendations for incorporation of the Child Risk Factors Domain, auto populating certain fields, and implementing information validation points to avoid discrepancies will be forwarded to the CANS and MaGIK development teams for review.

Recommendation #4: The panel recommends the Department identify and require a standard biological/psychological/social assessment for use by service providers throughout the state, in order to improve consistency in collecting relevant information needed to determine services for families. The panel recommends the Department of Child Services consider implementing the FASCETS assessment, available through www.fascets.org, with children and families where the child has been identified as having prenatal alcohol/drug exposure, in order to determine if specialized services are indicated.

The FASCETS assessment information will be shared with the agency's Clinical Services Manager along with other Department leadership. Any changes in implementing a standard biological/psychological/social assessment would be done after working closely with the service provider community.

Recommendation #5: The panel recommends no legislative statutory changes at this time.

As mentioned in the Panel's report, the opioid crisis in Indiana is having a significant impact on children and families in Indiana. DCS recently supported legislation that was passed into law that added infants born with Neonatal Abstinence Syndrome (NAS) or controlled substances in their bodies can be considered children in need of services (CHINS). As the opioid crisis is driving an increase in DCS cases, the agency is continuing to investigate services and interventions for helping families dealing with opioid addiction. Also noteworthy, federal partners are assisting states in making sure policies and procedures are in place to help substance exposed newborns and parents get the care and support they need.

I want to express my sincere appreciation to the Panel for volunteering its time and expertise over the past three years to complete the term as a citizen review panel all while continuing to play an important role in Indiana's foster parent community. The work of a citizen review panel is important in educating local citizens about what is happening with child abuse and neglect, providing vital information to the state on how improvements can be made, and ultimately helping Indiana create a community based approach to child welfare.

Sincerely,



Mary Beth Bonaventura
Director, Indiana Department of Child Services



The Switzerland County CRP, once again, considered several topics and believe that the issue of caseworker turnover was something that continues to be problematic not only in Indiana, but across the country. For this reason, we chose to research and discuss the issue and submit our recommendations for our last topic.

High Family Case Manger turnover in the State of Indiana has been an ongoing problem for the past several years. Constant turnover and short worker tenure lead to remaining workers having to absorb the cases of those who left. This, in turn, leads to increased stress and low morale. When stress levels are high and morale is low, the quality of casework suffers. Not only do Family Case Managers have to assume responsibility for more cases, they are often given the responsibility of training the new workers which results in these workers having less and less time to keep up with their own caseload. Before becoming a member of the Switzerland County Child Protection Team, one of the members, Cindi Wagner, spent several years as a Family Case Manager before retiring in March 2014. She saw these and other frustrations during her time with the Department of Child Services. Some of her concerns were as follows:

1. The DCS publicly talked of incentives including Pay for Performance as an attempt to retain staff. The first year the Pay for Performance became effective, Ms. Wagner got the maximum 10% raise for exceeding expectations. The following year, her Director and Supervisor felt she, again, deserved the maximum raise of 10% and subsequently submitted the proper paperwork for this pay increase to happen, however, the maximum raise was denied. Ms. Wagner was advised that she couldn't get the maximum raise for exceeding expectations two years in a row. She did not understand this reasoning behind this if she did, indeed, exceed expectations. What incentive does one have to do more than the bare minimum if this is what happens?
2. Management decided to have an Employee Appreciation Day where each county would come up with an idea where their staff could spend time outside the office for an afternoon to have fun and forget the stresses of the job. With the caseload demands as they are, many FCMs didn't feel they had the time to go to the local park for a picnic and that they really needed to be in the office working. The staff were told they had to go unless they had to be in court or had a valid excuse such as a doctor's appointment. Most staff she spoke with felt they were made to feel they "were going to go and were going to have a good time." It's not easy to have a good time when your desk is piled high. Another failed attempt to boost morale in the minds of many.
3. More often than not, FCMs had more than the 12 assessments recommended each month. It was not unusual to have 18-20 or even more. Even though assessment caseloads were much more than the recommended 12 assessments, management was not forgiving when it came to having all assessments completed within the 30-day time frame. The expectations were the same whether they had 12 or 22 assessments. The stress level was off the charts in an attempt to meet deadlines.
4. In her current position as a Child & Family Advocate with the regional Children's Advocacy Center, Ms. Wagner sees FCM's who have only been on the job six months providing "training"

to new workers. Six months is not enough time to learn the complex details of the Child Protective Services program, let alone training others to do the job.

Options for remedying the problem of Family Case Manager turnover are limited, but our group came up with some possible solutions:

1. Increase pay significantly for Family Case Managers. Perhaps a pay matrix like the state police would be beneficial. Indiana probation officers are also on a mandated pay schedule. Most probation officers who came from the DCS will tell you that there is no comparison in stress levels indicating they don't have near the stress as probation officers as they did as Family Case Managers. Pay increases should take effect as soon as possible. The salary increase should be given to all Family Case Managers, Supervisors, and Directors. Even if these employees are currently earning above the minimum salary, they should be given a pay increase.
2. Increase staff so that regions are slightly overstaffed. This should include supervisors as well as Family Case Managers. Then, as a worker leaves, it's not as hard on the remaining workers.
3. Consider part-time positions or job sharing positions. They would not receive health insurance which would be an added savings to the state.
4. The DCS needs to diligently lobby our legislature for the funds to increase staff and to provide for a significant salary increase. Perhaps have current or retired seasoned employees speak to our representatives to give them an idea of what it's like to be on the front line and the stress that goes with the job.
5. Increase the time allotted to complete an assessment from 30 days to a minimum of 45 days to reduce stress on the Family Case Managers.
6. Consider hiring FCMs to work afternoon and night shifts or have FCM's take an afternoon or night shift once a week or two.

Turnover has been and continues to be a major problem. Management needs to look at the situation and come up with better ways of approaching the situation, perhaps incorporating some of the above mentioned recommendations. We can't keep doing the same thing and expect a different result. "Nothing's gonna change, if nothing's gonna change..."



Eric J. Holcomb, Governor
Mary Beth Bonaventura, Director

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June 27, 2017

Dear Switzerland County Child Protection Team Citizen's Review Panel ("Panel") Members:

DCS is in receipt of your 2016 Child Protection Team Citizen's Review Panel Annual Report and is grateful for the time and consideration put into examining the topic of workforce retention and recruitment. As you know, local DCS field staff are the backbone of Indiana's child welfare system. Unfortunately, similar to child protection agencies across the country, DCS continues to experience higher than desirable employee turnover and recruitment challenges. Reflecting this nationwide trend, more national research is being dedicated to examining the potential negative impact these challenges can have on the children and families that are served.

In Indiana, DCS began tracking turnover data for the family case manager position in March 2007 and has allocated a number of resources to implement strategies to reverse the negative trend of worker turnover. For example, DCS has continued to build upon its partnership with the National Child Welfare Workforce Institute (NCWWI). Details of other strategies and how DCS is working to improve worker recruitment and retention can be found in the responses to each of your recommendations listed below.

Recommendations #1 & #4:

Increase pay significantly for Family Case Managers. Perhaps a pay matrix like the state police would be beneficial. Indiana probation officers are also on a mandated pay schedule. Most probation officers who came from the DCS will tell you that there is no comparison in stress levels indicating they don't have near the stress as probation officers as they did as Family Case Managers. Pay increases should take effect as soon as possible. The salary increase should be given to all Family Case Managers, Supervisors, and Directors. Even if these employees are currently earning above the minimum salary, they should be given a pay increase.

The DCS needs to diligently lobby our legislature for the funds to increase staff and to provide for a significant salary increase. Perhaps have current or retired seasoned employees speak to our representatives to give them an idea of what it's like to be on the front line and the stress that goes with the job. Consider part-time positions or job sharing positions. They would not receive health insurance which would be an added savings to the state.

DCS continues to request additional funding to maintain previous raises for DCS staff in proposed budgets submitted to the legislature. Furthermore, DCS outlines in its annual presentation to the State Budget Committee the worker hiring and retention challenges it faces, making sure those making



budget decisions understand the importance of having adequate staffing levels and the potential consequences (increased stay in care, delay in assessments and permanency, etc.). For example, based on February 2015 staffing and caseload data, Governor Pence requested \$7.5 million per year in additional funding for DCS to hire additional workers that were needed to meet continued increasing caseload demands. Undoubtedly, DCS and the legislature must continue to work together to find funding solutions to challenges facing Indiana's child protection system, including whether those solutions could be in the form of staff pay raises.

Recommendation #2:

Increase staff so that regions are slightly overstaffed. This should include supervisors as well as Family Case Managers. Then, as a worker leaves, it's not as hard on the remaining workers.

DCS has shifted the focus of its FCM hiring from a county-based effort to regional. With fluctuations and spikes in caseloads, along with FCM vacancies, this process allows Regional Managers the flexibility to redeploy FCMs to another county within a region, either temporarily or on a permanent basis. Additionally, a group of DCS Central Office employees made up of Field leadership and HR representatives meet weekly to track workforce hiring and cohort numbers. To more quickly train incoming FCMs, the Department increased the capacity for new worker training cohorts in SFY 2015. DCS begins a new training cohort every two weeks, and beginning in March 2015, it increased the class size from 25 to 30-35 new workers. However, a continued increase in cases along with challenges in retention result in the hiring of additional workers having the effect of primarily maintaining staffing levels and not increasing them.

DCS also recognizes that there is a limited number of potential employees and the need to ensure a sufficient pool of social workers to support the entire continuum of services. As a result, DCS collaborates with service providers and other state agencies to promote the social work field in order to increase the pool of viable candidates with a social work background.

Recommendations #3 & #6:

Consider part-time positions or job sharing positions. They would not receive health insurance which would be an added savings to the state.
Consider hiring FCMs to work afternoon and night shifts or have FCM's take an afternoon or night shift once a week or two.

DCS Field leadership works closely with HR staff and the State Personnel Department to examine ways for strategic staffing of offices and where available, identifying methods for creating flexibility of employee hours without impacting the safety of children and families. These staffing ideas will be shared with DCS Field and HR leadership to identify whether opportunities exist for strategic staffing that work within the parameters of state and federal employee law and policy.

Recommendation #5:

Increase the time allotted to complete an assessment from 30 days to a minimum of 45 days to reduce stress on the Family Case Managers.

Following Indiana's Child and Family Service Review in 2016, DCS is taking a focused look at assessments, ensuring they are both timely and of sufficient quality to address the underlying needs of children and families. As you know, the goal is to implement services as soon as possible in order to



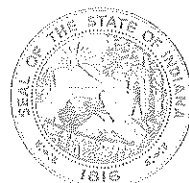
limit DCS involvement without sacrificing the safety, permanency, and well-being of the youth being served. With that goal in mind, DCS has been focused on creating efficiencies so that instead of pushing the timeframe back, a realignment of FCM duties can take place that shifts some responsibilities off of their plate. For example, a recommendation of the Deloitte Workforce Study (a comprehensive review and report that examined DCS field workload in order to make recommendations to meet caseload demands), DCS began implementing additional training of clerical and administrative staff to take on additional tasks that otherwise consume 30% of an FCM's time. In the climate of increased cases and worker retention challenges, DCS will continue to identify ways in which FCMs can work more efficiently and provide timely services to Indiana children and families.

I want to recognize the Panel for completing the three-year term as a citizen review panel. The important work your Panel did in reviewing and submitting recommendations on Neonatal Abstinence Syndrome, treatment strategies for juvenile sex offenders, and workforce recruitment and retention are critically important issues that are facing children, families, and child protection systems in Indiana and across the country. As a citizen review panel, your work in your local community and the input the Panel has provided has helped contribute valuable information and guidance to DCS and furthers the goal of creating a community based approach to child protection in Indiana.

Sincerely,



Mary Beth Bonaventura
Director, Indiana Department of Child Services



**Child Abuse Prevention and Treatment Act (CAPTA)
Grant to States for Child Abuse or Neglect Prevention and Treatment Programs
State Plan Assurances amended by Public Law 114-198, the Comprehensive
Addiction and Recovery Act of 2016**

(These amendments to CAPTA were effective July 22, 2016)

**Governor's Assurance Statement for
The Child Abuse and Neglect State Plan**

As **Governor** of the State of *Indiana*, I certify that the State has in effect and is enforcing a State law, or has in effect and is operating a Statewide program, relating to child abuse and neglect which includes:

- (ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to –
 - (I) establish a definition under Federal law of what constitutes child abuse or neglect; or
 - (II) require prosecution for any illegal action;
- (iii) the development of a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –
 - (I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and
 - (II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

Signature of Governor:



Eric Holcomb

Date:

Reviewed by:

Date:

(CB Regional Child Welfare Program Manager)



Eric J. Holcomb, Governor

Mary Beth Bonaventura, Director

Indiana Department of Child Services

302 West Washington Street, E306

Indianapolis, IN 46204

DCS TRAINING PLAN

2017

1. New Family Case Manager Training

a. Pre Service Training and Ongoing Staff Development Training

The Indiana Partnership for Child Welfare Education and Training (a Partnership between the Department of Social Services and the Indiana University School of Social Work) is designed to provide high quality, competency-based in-service training for staff in the Department of Child Services throughout Indiana. Program activities include assessment of training needs, development of curricula, development of trainers and other resources, training of trainers, delivery of training, evaluation of training programs and consultation to local offices as well as external stakeholders. In addition, a comprehensive Training Records Tracking System called Enterprise Learning Management (ELM) has been developed which allows staff to register on-line for identified trainings, and upon completion of the training as verified by trainers, the establishment of a permanent training record which can be used to track/verify all training of any staff member throughout their employment history. This Records Management System is embedded within the PeopleSoft State Personnel System so that official Personnel Records also include this training history. Full-time trainers, supervisors, a curriculum manager, curriculum writers, evaluators, production personnel, fiscal staff and records management personnel comprise the positions devoted to this area. Very minimal use is made of any contract trainers for the Department of Child Services at this time.

The Institute for newly hired Family Case Managers is 12 weeks in length including 26 classroom days, 32 transfer of learning days. A summary of this program is:

New Worker Cohort Training Schedule

Effective July 2017
58 total training days
(25 classroom / 37 local office)
8:00 AM to 4:30 PM daily

Unit 1

- 1 Day – Human Resources Orientation
- 5 Days – On the Job Training
- 1 Day – Getting to Know DCS
- 1 Day – Laptop & Introduction to MaGIK
- 1 ½ Days – Worker Safety
- ½ Day – Job Skill Building - DCS Hotline

- 5 Days – Transfer of Learning in County

Unit 2

- 1 Day – Culture & Diversity I
- 2 Days – Engagement & Interviewing
- 2 Days – Facilitation Training Session I

- 1 Day – Overview of Legal Concepts
- 1 Day – Legal Roles and Responsibilities

2 ½ Days – Transfer of Learning in County
½ Day -- Facilitation Training Debrief

Unit 3

1 Day- Culture & Diversity II
2 Days – The Effects of Abuse & Neglect on Children and Families 2
Days – Transfer of Learning in County

Unit 4

1 Day-- MaGIK Training 4 Days – Assessing Child Maltreatment
4 Days-- Case Planning and Intervening for Permanence
1 Day – Cohort Evaluation & Self-Care

17 Days – TOL / On the job skill reinforcement

All training is designed to promote culturally competent child welfare practice. Courses related to the Indiana Practice Model which include Teaming, Engaging, Assessing, Planning and Intervening (TEAPI) have been incorporated into new worker training. New cohorts begin every 2 to 3 weeks and complete the entire cycle above. All curricula have been updated to reflect the Indiana Practice Model and address concerns raised by evaluations from previous cohorts. Continuous feedback from the Qualitative Service Review process, the training evaluation process (described below) and legislative or policy changes are reflected in ongoing curriculum revisions.

Prior to completing pre-service training, all Family Case Managers are assigned a Peer Coach within their region to assist them in becoming trained facilitators. Following a prescribed shadowing, observation and mentoring program, Peer Coaches authorize these Family Case Managers to complete their Child and Family Team Meetings independently. De-Brief feedback forms are completed and Supervisors quarterly complete Observation forms to maintain fidelity to the model. Six Regional Peer Coach Consultants (who are part of Staff Development) monitor progress and provide additional information and support as necessary including fidelity monitoring.

During pre-service, all Family Case Managers are also assigned a Field Mentor. Following a one-day training for field mentors, the Field Mentor and the trainee work side by side during the transfer of learning days and the last two weeks of the on-the-job training period. Required and optional activities have been developed for the Transfer of Learning days that align with the coursework completed in the classroom sessions immediately prior to these field experiences. The Field Mentor also completes skill assessment scales at the time of graduation. These are behaviorally anchored scales designed to assess the strength of the trainees' skills in each of 57 areas. Supervisors receive a copy of this assessment and can use as a basis to strengthen their newly hired staff's skills. Three months after graduation, the new employee's supervisor also completes Skill Assessment Scales to assist Staff Development with analyzing any additional training needs during the pre-service period.

This feedback process provides the necessary link between classroom training and transfer of learning to job performance and provides specific knowledge about the strengths and challenges of training provided. When challenges are noted, training can be adjusted to better facilitate the transfer of learning from classroom to the actual practice of public child welfare. This project is on the cutting edge of national best practice in the training and supervision of frontline child welfare workers and has been presented at the annual National Staff Training

and Development Association's workshop. Feedback from this process is also used to provide necessary modifications to new worker curriculum.

This feedback was used by Staff Development to redesign the pre-services training for newly hired FCM's during 2014, and was used in with a pilot/inaugural class which began in January 2015. The new design is comprised of 26 classroom days, 28 Computer Assisted Trainings (CATs), 32 transfer of learning (TOL) days back in each participant's base county, and graduation from the Institute. The redesign changed the model from that of primarily instructor led lecture to that of learner based facilitation. The redesign focus is on the development of critical thinking skills that are needed to effectively do the job of family case manager. They are enhanced by small and large group discussion using real-life examples.

The transfer of learning days (TOL) consist of working with both the assigned supervisor, the assigned mentor, and the peer coach, doing activities such as reviewing CATs, observation and shadowing activities in the office, court and field visits, as well as interviews with families and service providers.

Prior to graduation from the pre-service training new cohort members are certified as facilitators for Child and Family Team Meetings (CFTM) for the families on their caseloads. Oversight for this facilitation is provided by 9 Peer Coach Consultants located throughout the state who monitor the Regional Peer Coaches as they train new cohort members.

All new staff must complete pre-service training, including pre-tests and post-tests prior to being assigned a caseload. This requirement is monitored through the statewide database (MaGIK) since all cases are assigned through the system. The Training Evaluation Yearend Report of 2014 indicates that Participants in the New Worker Pre-Service Training improved 18.6% on average, from their scoring on the pre-test prior to completing the New Worker Pre-Service, to scores on the post-test after completing New Worker Pre-Service. Supervisors rated their new employees' skill sets upon graduation from a low of 4.7 to a high of 5.3 out of 6 in knowledge needed to perform their jobs. Mentors rated their new employees skill sets from a low of 5.0 to a high of 5.6 out of 6 in having the knowledge to do their job. The Evaluation Team is working on data that will correlate knowledge to outcomes for children. It is important to note that the 2014 Training Evaluation does not reflect results from the New Worker Pre-service redesign which was not initiated until January, 2015.

Effective in July 2017 new cohort members will spend 5 days in their local offices completing on-the-job training activities subsequent to one day of Human Resources Orientation. This initial week in the county was piloted, and it was determined that providing an opportunity to establish relationships with the local office staff, getting to know the community in which they will work, and providing opportunities for shadowing prior to classroom training afforded many advantages in increasing job readiness, expectations and understanding the context of the curricula.

A listing of the new cohort training, including the initial 5 days at the local office, is as follows:

Unit 1

- 1 Day—Human Resources Orientation
- 5 Days—On the Job Training
- 1 Day—Getting to Know DCS
- 1 Day Laptop & Introduction to MaGIK

- 1 ½ Days—Worker Safety
- ½ Day—Job Skill Building—DCS Hotline

Unit 2

- 1 Day--Culture and Diversity I
- 2 Days--Engagement and Interviewing
- 2 Days--Facilitation Training Session 1
- 1 Day—Overview of Legal Concepts
- 1 Day—Legal Roles and Responsibilities
- 2 1/2 Days—Transfer of Learning in County
- ½ Day—Facilitation Training Debrief

Unit 3

- 1 Day—Culture and Diversity
- 2 Days—The Effects of Abuse and Neglect on Children and Families
- 2Days—Transfer of Learning in County

Unity 4

- 1 Day—MaGIK Training
- 4 Days—Assessing Child Maltreatment
- 3 Days—Case Planning and Intervening for Permanence
- 1 Day Cohort Evaluation and Self-Care
- 17 Days—TOL/On the Job Skill Reinforcement

2. Ongoing Training for Family Case Managers

In January of 2010, Indiana established required yearly required training hours for Family Case Managers, Supervisors and Field Management Staff. This consisted of 24 annual hours (12 of which could be on-line) for Family Case Managers and 32 hours (16 of which could be on-line) for Supervisors and other Field Management Staff. DCS staff have been extremely responsive to this directive and has clearly sought out training opportunities to fulfil this requirement.

This policy was updated on January 1, 2012 (see http://www.in.gov/dcs/files/Internal_Training.pdf) to establish required training hours for all DCS personnel in all divisions. Staff Development worked with these divisions to establish a process to assist with providing and/or facilitating trainings that would meet each division’s needs. Many divisions, such as finance and child support, have developed their own methods of training staff to meet this requirement and enhance their professional development. In addition, DCS Staff Development developed Practice Model training for non-field staff which includes a Computer Assisted Training as well as webinars that have been occurring throughout this fiscal year and count toward these required annual training hours.

DCS has also implemented a policy that addresses external trainings. The External Training policy outlines the procedures staff must follow to participate in external trainings and details the criteria that the External Training Review Committee will use to approve/deny such requests. The External Training Policy was effective June 1, 2011 (see http://www.in.gov/dcs/files/External_Training.pdf) and was updated April 1, 2015 to include the Child Support Division.

Beginning in August of 2007, Staff Development developed tools to assist with determining ongoing training needs. A comprehensive analysis of these assessments was completed and training needs identified.

During 2014 the work efforts of curricula writers was focused on pre-service training redesign. In 2015, their focus returned to the development of experienced worker training. The list of experienced worker trainings slated for completion/revision during 2015 is included below. This list was based on findings from Quality Service Reviews, ITNAs completed by family case managers, and the Strategic Planning meeting held by the Staff Development Management and Curricula Teams during January, 2015.

- 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

The staff training requirements for non-management staff include a minimum of 24 hours of training per year. Training hours are logged into Peoplesoft (ELM System) for classroom courses and CATs populated into that system for course enrollment and completion. This database is managed through the Training Partnership. If enrollment for a course is not completed through Peoplesoft, a hardcopy enrollment form is used and must be signed by the trainer and maintained in each employee file. Each employee's supervisor documents the training hours as part of the employee's annual performance appraisal.

During the past fiscal year the curriculum team revised experienced worker trainings including the following: Secondary Trauma; Engaging Challenging Clients; Customer Service for Non-FCMs, and Worker Safety. In an effort to increase the capacity of utilizing online training the following new CATs were completed, including PEDS; Hotline Intake; Use of the iPhone; CASA; Safe Haven; Experienced Worker Safety; RPS; and Human Trafficking (update).

3. Enhanced Practice Model Training

Peer coach consultants provide additional coaching/mentoring as needed and also provide mini "information" sessions related to the Indiana practice model utilizing material from the initial practice model training.

The nine Peer Coach Consultants, Practice Model Supervisor and the Practice Model Manager continue to respond to the practice needs that are identified through the Quality Service Review process, Permanency Roundtable process and the Executive Team.

2014 mandatory quarterly workshops for experienced workers and supervisors included:

Collaborative Care and Practice—which trained on the role and voice of the older youth and other team

members in case decision making.

The Role of the Supervisor in the CFTM Process—the training included the use of the CFTM notes recorded from the team as a basis for the case plan development for the child/youth and family.

Practice as a Process—which focused on role and voice, and tracking and adjusting case plans, in response to needs identified through the Quality Service Reviews.

Meaningful Meetings—which provided curricula that focused on improving the quality and productivity of meetings that supervisors lead with their team members. This was in response to the Supervisor’s ITNA.

2015 mandatory quarterly workshops for experienced workers and supervisors included:

Engaging Fathers in the Child and Family Team—which provided training on how to help fathers increase their role in the lives of their children and their role and voice in decision-making for their children. This was in response to findings from the Quality Service Reviews which indicated a need for better engagement of fathers.

Engaging Foster Parents in the Practice Model - which addressed the need to provide further training on working with foster parents to develop their understanding of the rules, regulations and procedures of the DCS Practice.

2016 mandatory quarterly workshops for experienced workers and supervisors include:

Utilizing the Practice in Case Planning - which provided the following training objectives: an understanding of how to maintain case progression toward sustainable case closure by using the Case Plan as a living document. This in-service also presented how to utilize the Child and Family Team in conjunction with intervention tools such as CANS and Service Planning. A focus of tracking and adjusting the Case Plan outcomes as the underlying needs of the family change was the last objective for this training.

The Practice of Intervening – this was provided in 2016 4th quarter.

The Practice of Intervening was delivered and it highlighted ways to utilize services and service mapping within the Case Planning process. Sixty-eight half day sessions were presented by the Peer Coach Consultants around the state.

2017 mandatory quarterly workshops for experienced workers and supervisors include:

Regional Tailored Workshops-Peer Coach Consultants met with each regional management staff to determine what topics were needed in each region, utilizing management input, and QSR and PI findings. The Peer Coach Consultants designed and provided custom training to each region to meet their individual needs. During the 4th quarter of 2017 each region will again be offered a menu of topics from which to choose. These will include Compassionate Confrontation to use with families, and Clinical Supervision, as well as other various topics.

4. Management Gateway for Indiana’s Kids (MaGIK) Training

A new computer information system was activated for the Indiana Department of Child Services on July 5, 2012. In anticipation of this transformation, Staff Development, in close collaboration with the Practice and Permanency Division and the DCS contracted vendor, Case Commons, developed and implemented a statewide training initiative for all relevant employees. A group of field individuals were identified to be “power users” and

were trained in late 2011 and early 2012. An additional group of interested individuals, called “early adopters” were also provided training through a collaborative effort. Numerous “specialized” trainings were developed and offered during the first quarter of 2012 in anticipation of the July implementation date.

Manuals and various other materials have been posted to a common SharePoint for easy access and scenarios were developed to assist individuals with the transfer of learning component from the classroom to their daily tasks. MaGIK Coordinators continued to develop scripts for additional Computer Assisted Trainings that were implemented in 2013 and 2014. Enhancements continue to occur regularly and are communicated through regular newsletters and SharePoint updates.

MaGIK Coordinators continue to provide user support and trainings to both new and experienced staff. During new worker pre-service training they provide a one day Introduction to MaGIK during Unit 1 and more in-depth one day training on MaGIK during Unit 4. In addition, the MaGIK Coordinators provided a total of 32 requested trainings throughout the state on a variety of functionality topics during 2014 and 15 requested trainings throughout the state to date in 2015. Additional trainings will be scheduled based on requested needs.

Development of a new Intake module was underway in early 2015. MaGIK Coordinators began initial testing in Spring of 2015 and the anticipated completion date is Fall of 2015. MaGIK Coordinators will assist with training of statewide users prior to its release.

The newsletter, now referred to as the [MaGIK Times](#), is published periodically and emailed to all MaGIK Users. The newsletter provides helpful hints, current information, and other items to support the use of MaGIK as a tool of DCS Practice.

MaGIK Coordinators continue to provide user support and trainings to both new and experienced staff. MaGIK Consultants provide ad hoc trainings to local offices as requested, as well as facilitate a half-day session for New Supervisor Onboarding. As a team the Consultants provided 34 in-person training sessions in calendar year 2016 and 11 in-person training sessions thus far in 2017. The Consultants also utilize tools such as instant messaging, WebEx, e-mail and telephone support for users across the state.

The new Casebook Hotline Module was released in 2016. Prior to release the Consultants collaborated with Staff Development to develop online tutorials for the new module, specifically focusing on actions related to field supervisors and their role in the intake report review and approval to be assigned as an assessment process. All staff were expected to complete this training prior to the deployment of the new Hotline module.

The MaGIK Times newsletter is published periodically and emailed to all MaGIK users. The newsletter provides helpful hints, current information on recently deployed features, and other items to provide information on the use of MaGIK as a tool to support DCS Practice.

5. Permanency Roundtable Process and Training

In 2011, Indiana adopted a process for specialized staffing called “Permanency Roundtables” based on work completed by Casey Family Programs. These structured internal staffings focus on reviewing youth in extended care without attainable permanency goals. They are designed to identify and address system barriers, improve

case decision-making, strengthen practice, and influence timely permanency for children in out of home care.

Training on this new process includes a one day orientation session which describes the process and reviews values. This training has been broadly provided to DCS staff as well as stakeholders. In addition, a one day training on enhancing facilitation is conducted for those individuals designated to provide facilitation services for the meetings. A professional video production company was engaged to videotape a "mock" permanency roundtable session which is being used in training at this time. The Permanency and Practice Support Division has continued to take the lead in providing this training. Permanency Roundtable Orientations are held six times during the year and include DCS and probation staff. There are monthly trainings for the scribes who record the Roundtables, as well as 2 Roundtable Facilitator trainings per year.

Permanency Roundtables (PRT) continue to provide good outcomes for children. The PRT Outcome Report for the first quarter of 2015 indicates that 69% of PRT cases have improved at least one Permanency Status Level. 65% of PRT cases that have closed achieved the "gold standard" of legal permanency (reunification, adoption or legal guardianship).

Since piloting PRTs in June 2011, DCS has completed 1,020 round tables. Of the 418 (41%) of these PRT cases have closed with 64% of these closed cases achieving the "Gold Standard" of legal permanency through reunification, adoption, or legal guardianship. 66% of PRT's have improved at least one Permanency Status Level.

There have been 408 additional children for whom PRTs have been completed. Seventy-five per cent of these have improved at least one Permanency Level Status. Sixty-two per cent of the cases that have been able to be closed have achieved the "Gold Standard" of legal permanency through reunification, adoption, or legal guardianship. The PRT data is currently being transferred to a new database housed within KidTraks.

6. Supervisory and Management Training

All new supervisors receive a comprehensive training over a 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 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.

Evaluations provided for these supervisor trainings will allow the Staff Development Department an opportunity to enhance and revise these trainings to make them more practical and provide more alignment of our current practice and policies.

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. 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 computer assisted training 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.

Ongoing supervisory training includes a specialized course in "Coaching for Successful Practice" which is available to all supervisors based on need, as well as a yearly two day workshop for all supervisors addressing training needs identified by the Field. Both of these trainings continue to occur and address relevant topics. To further assist with providing supervisors with skills and tools necessary to provide for Staff Retention and Better Outcomes in Child and Family Services, the Department of Child Services worked with the McKenzie Consulting Group in 2009 to provide a workbook series and training plan for all supervisors. A thorough description of this initiative follows:

Indiana DCS, in partnership with Casey Family Programs, acquired the rights to make the Staff Retention for Better Outcomes in Child and Family Services workbook series available for use within the State. This included tailoring the workbook content to align with the State's Practice Model and Practice Indicators. .

Workshops based on this series occur quarterly facilitated by individuals who have completed training provided by John and Judith McKenzie and staff, by those who have completed the DCS sponsored MSW program, or by other identified experts in the topic area. Videoconferencing equipment assists with connecting supervisors from across the state for these sessions which focus on a particular topic.

Locations continue to interact through videoconferencing, but the main presentation is done by a local trainer with an established topic/curriculum.

The steering committee who developed the ongoing training plan reviewed the flexible workbook design, which allows for the workbooks to be used in many ways.

Training of supervisors – Indiana’s trained facilitators/trainers have been able to support and train other leaders and supervisors. Participants who attend a training session have the information and tools at their fingertips to refresh their learning and to use as needed long after they attend the training

Supervisory support groups – Learning activities appear throughout each workbook to encourage supervisors to use the materials during formal staff training, supervisory support networks and/or more informal sessions

Self-study – Individuals can benefit from the program by using the workbooks as self-study tools, if they cannot attend a group training

Web/technology based applications – All of the workbooks have been posted on a Supervisor SharePoint site for easy access to workbook content. All supervisors have received copies of the entire workbooks series for use within their units as well.

An Individual Training Needs Assessment (ITNA) for Supervisors was developed and completed by all Family Case Manager Supervisors in July 2013. The following were identified as 2014/2015/2016 priorities:

1. Organizational Commitment

- a. Adjusts work-related priorities to meet staff needs while maintaining focus on agency goals.
- b. Knows the elements of the practice model and core conditions and the impact they have on all agency and casework practices.
- c. Shows ability to communicate a clear vision, motivation and commitment to the safety and well-being of children.

2. Judgment and Critical Thinking

- a. Appropriately incorporates past experience to guide analysis and practice.
- b. Balances short- and long-term implications when making decisions.
- c. Maintains objectivity in handling difficult issues, events, or decisions.
- d. Models and guides caseworkers in using critical thinking skills when making decisions about risk and safety issues for abused and/or neglected children.
- e. Sets priorities for tasks in order of importance.

3. Casework Supervision

- a. Assesses caseworker's use of child and family team meetings.
- b. Demonstrates ability to effectively manage case assignments, case coverage and service delivery to clients via direct caseworker supervision.
- c. Guides caseworkers in recognizing culturally based parenting practices that can be potentially misconstrued as abuse or neglect.
- d. Helps caseworkers identify family strengths and community resources to address poverty and environmental conditions that place children at risk of future harm.

- e. Models, guides, and monitors caseworkers in promoting client's rights of self-determination to the fullest extent possible.
 - f. Structures supervisory staffings (individual and group) to review and document casework activities and caseworker performance.
 - g. Knows and applies relevant federal and state statutes, rules, policies, procedures and current practice standards related to casework.
 - h. Understands the importance of respecting clients' right to privacy and the agency's obligation to protect the confidentiality of information about the client.
 - i. Knows statutes, rules, best practice standards, policies and procedures that apply to child sexual abuse cases.
 - j. Knows statutes, rules, best practice standards, and agency policies and procedures for managing child abuse and neglect cases.
 - k. Knows policies and procedures related to documenting and protecting the integrity of evidence for presentation in court.
 - l. Uses available data from formal and informal reports (including outcome, practice, and performance data) to manage casework performance.
4. Public/Community Relations
- a. Demonstrates ability to deliver presentations at public/private meetings, conferences and workshops.
 - b. Effectively works with and understands various community partners.
 - c. Knows how to prepare and use annual reports and other printed materials to lead regional services council meetings.
 - d. Knows policies and procedures governing access to family and caregiver case information.
 - e. Presents a professional image to other service providers and the community at large through use of the media, personal contacts and presentations.
 - f. Builds and strengthens working relationships with community partners.

Common themes expressed in the ITNA include:

- a. developing the skills to better manage staff as both individuals and as a group
- b. becoming more familiar with DCS policies and procedures
- c. learn how to plan and conduct team and unit meetings, as well as making these meetings more productive
- d. 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)
- e. 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

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 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) will undergo redesign during the third quarter of 2015 and will gradually roll out to new Supervisors in the 3rd quarter of 2016.

The Supervisory Core Modules were updated and rolled out beginning 2016. In addition to Supervisory Onboarding, Orientation to Supervision, Supervisor as Manager, Supervisor as Coach and Supervisor as Team Leader were reformatted to provide a better flow of information. Information was also updated and amplified. The two overriding themes of utilizing the DISC Behavioral Profiles and Leadership were woven throughout the curriculum. The curricula was designed to include less instructor lecture and more participant facilitation and small group activities. Feedback to date on the new enhancements has been positive.

During the last quarter of 2016 the supervisors completed a subsequent Indiana Training Needs Assessment. The report was released during the first quarter of 2017. The supervisors rated their most important training needs to be Interpersonal Understanding, Program Administration, Personnel Management, and Educational Supervision. Based on this self-assessment supervisory training modules and/or workshops will be developed to train/enhance these topics.

a. Curriculum Content of Supervisor Workbooks

The curriculum is based on extensive literature review on the topics of leadership, staff retention and turnover in child and family services, human services and business. Surveys conducted with supervisors and front-line staff in child and family services served to inform content. Curriculum authors and advisors have extensive firsthand experience in agency management and child and family services. Throughout this program, there is strong emphasis on the day-to-day skills and practices needed by front-line supervisors to build mutually respectful relationships with their staff and meet agency outcomes within the context of family centered practice. Workbook subjects include:

Workbook 1 – The Role of Leaders in Staff Retention: presents a leadership model that introduces self-

mastery and teaches ways of cultivating both hard and soft leadership skills; provides information, tools and methods for leaders to use to support staff in creating and sustaining a positive culture and organizational climate for staff retention.

Workbook 2 – The Practice of Retention-Focused Supervision: promotes supervisory competencies for retaining effective staff, including self-assessment and planning tools; includes methods and tools for setting objectives, structuring the supervisory process, encouraging self-care and managing stress in the workplace. Intentional use of the supervisory relationship to meet individual and organizational goals is stressed.

Workbook 3 – Working with Differences: provides understanding, methods and tools for tailoring supervision to the diverse characteristics, learning and behavioral styles and professional development needs of staff; encourages the development of self-awareness, self-mastery and relationship skills.

Workbook 4 – Communications Skills: provides specific information, tools and activities to model effective communication skills within the supervisory relationship.

Workbook 5 – The First Six Months: provides a structure, methods and tools for orienting, supporting and training new staff during their first six months on the job; promotes particular attention to raising supervisory awareness and skills in helping staff cope with and manage the stressors of the job, as well as the growing workload.

Workbook 6 – Recruiting and Selecting the Right Staff: provides information on promising practices and tools for recruiting and selecting front line staff; includes profiles of desirable qualities needed in front-line supervisors and staff and processes for managing timely hiring and conducting successful interviews, including behavioral interview questions.

Initially these quarterly workshops were conducted using Videoconferencing 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 different days in their region or in a neighboring region to minimize travel. This 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.

Supervisor Workshops are still being completed at regional training sites across the state. Supervisor Workshops for 2016 included “Resiliency” during the first quarter and “Introduction to Leadership Styles” during the last quarter. In 2017 during the first quarter “Building a Servant Leadership Plan” was trained. A workshop on “Culture and Climate” is being developed for supervisory training in the fall of 2017.

b. Leadership Academy for Supervisors (LAS)

Beginning in the Summer of 2009, Indiana has been closely working with the National Child Welfare Workforce Institute to provide “pilot” feedback on the Leadership Academy For Supervisors on-line training initiative, including the learning network sessions conducted through webinars. This core curriculum consists of the Introductory Module and five subsequent modules. Learning activities include some pre-learning in preparation for each of the five modules following the Introductory Module as well as follow up peer-to-peer networking to each of the modules facilitated. The entire process was completed with over a 90% participation rate. Three supervisors from each of Indiana’s 18 regions were selected to participate in this leadership program which includes the development and implementation of a “change initiative” based on locally identified needs. Throughout the process, Indiana’s participation and feedback exceeded the national initiative. Modules include: (1) Introductory Module; (2) Foundations of Leadership; (3) Leading in Context: Partnerships; (4) Leading People: Workforce Development; (5) Leading for Results: Accountability and (6) Leading Systems Change: Goal-Setting.

In January 2014, a new class began which included 21 individuals. A coaching component was added to this group. There are currently 3 coaches who had previously gone through this program who are currently coaching 5 of these participants. We will also add an evaluation component to this group which will be implemented in August 2014. This evaluation process will also include an evaluation of the coaches and the LAS.

In January 2015, there were 17 supervisors participating in LAS. There were 5 Supervisors from this group who were promoted to Local Office Directors.

Currently, there are 33 participants in the LAS. As of this date, 5 participants have already been promoted to Local Office Directors and continue to be engaged in this program.

In addition, 5 designated individuals participated in the classroom based Leadership Academy for Middle Managers (LAMM) also facilitated by the National Child Welfare Workforce Institute. In 2015, there were 26 participants in the LAMM who continue to be actively involved in this program in 2016. That brings a total of 14 DCS leaders who have successfully completed this training program.

During the fall of 2016 twenty-three supervisors began the 2016-2017 Leadership Academy for Supervisors (LAS). Concurrently, thirteen local office directors, regional managers and central office managers were selected for participation in the Leadership Academy for Middle Managers (LAMM). Projects for both leadership groups were selected with the criteria that the project must be related to addressing staff retention needs of DCS.

c. Management Trainings

Staff Development has developed formal curriculum for a leadership series which is completed yearly for all newly hired Local Office Directors. Management staff from other areas have also been identified to complete this training (including the legal division, the hotline division, the programs and services division and staff development). Individuals trained through the “train the trainer” program provided by the Leadership Transformation Group continue to facilitate this training. Each individual also identifies a mentor to assist them through the training process and activities, although a formal mentor program has not been developed.

i. Management Innovations Institute

Following a Request for Proposal Process, DCS selected the Indiana University School of Social Work in collaboration with The University’s School of Public and Environmental Affairs (SPEA) Executive Education Program to develop a world class human services leadership program. Called the “Management Innovations Institute”, this academy was charged with preparing identified individuals with skills to assume enhanced executive positions. Learning opportunities have been developed in the areas of critical thinking, leadership skills development, operational skills development, community partnership/resource development, effective team work and shaping an effective, loyal and retention-focused “service” culture. Twenty-two individuals from every division in DCS were chosen to participate in this 7 month training which culminated in a graduation ceremony in May of 2013. As of June 2016, there have been 53 graduates of this academy. The third class included five participants from Indiana provider agencies which was the first time providers were included in this leadership program.

These individuals also assisted in developing a Child Welfare Leadership Conference in June of 2013 for 200 DCS managers and stakeholders. Speakers included Commissioner Bryan Samuels from the Administration on Children, Youth and Family as well as James Hmurovich, President and CEO of Prevent Child Abuse Indiana. Numerous workshops were also held addressing leadership principles.

The Second Annual Child Welfare Leadership Conference was held in June 12-13, 2014 for 200 DCS managers and stakeholders. There were a variety of speakers including Governor Mike Pence.

The Third Annual Child Welfare Leadership Conference was held on June 11-12, 2015 in Indianapolis. There were 200 participants (Managers from DCS and providers) were in attendance. There were several national speakers including the Mayor of Indianapolis, Greg Ballard.

The Fourth Annual Child Leadership Conference was held on June 23-24, 2016 in Indianapolis. There were over 200 DCS and Provider Agency Leaders in attendance.

The Fifth Annual Child Leadership Conference was held in June 2017. Again, there were over 200 DCS and Provider Agency Leaders in attendance. This conference continues to receive excellent evaluations and attracts outstanding presenters.

7. Other Training Initiatives

Staff Development continues to partner with both internal divisions as well as external partners in various training initiatives. Two one-day legal trainings occur each year addressing relevant legal topics for all DCS Staff Attorneys, and monthly legal trainings occur using videoconferencing equipment. Independent Living Specialists provide Regional informational sessions as described elsewhere in this document. Legal Training related to the Indiana Practice Model is available upon request by Regional Offices. Regular trainings occur to prepare individuals to participate in the Quality Service Review (QSR) process. Numerous other trainings are available and can be facilitated based on results from the Individual Needs Training Assessment, an assessment of organizational needs or if needed based on unique local needs. During 2010, Field Operations Staff developed a “protective factors” training that occurred regionally throughout Indiana, building upon concepts presented during pre-service training. This training was developed into a formal curriculum and is currently available based on regional needs. Staff Development has assisted the Child Support Division in utilizing ELM for their staff trainings as well as facilitating some cultural competence trainings.

During Fiscal Year 2014, DCS continued to provide training to Probation Officers focusing on transitioning the functionality of the MaGIK Probation Application to KidTraks. There are 12 sessions scheduled, allowing Probation Officers multiple opportunities to participate. The training will focus on how Probation Officers access cases, enter and edit data and create referrals. Additionally, education will be provided regarding enhancements to the current functionality that will improve the user experience.

In addition, the Staff Development Division, in cooperation with the Indiana Judicial Center, continued to partner on providing training to Court personnel relative to child welfare practice. Several workshops have been provided during this last year which provided cross training in the permanency area to court personnel, probation officers, Guardian ad Litem/Court Appointed Special Advocate personnel and other stakeholders as identified under P.L. 110-351 amended section 474(a)93)(B). Specifically, DCS partnered with the State Court Appointed Special Advocate (CASA) program to provide training to CASA's/GALS through 4 regionally based trainings which occurred in Lafayette, Warsaw, Evansville and Indianapolis. Topics covered in this training included: Legal Requirements for the Identification of Child Abuse and Neglect, The Role of an Attorney Guardian ad Litem in Juvenile Court,

Developmental Considerations in Working with Abused and Neglected Children and Adolescents, Treatment of Child Abuse and Neglect: Trauma Informed Care and Ethics.

There has been ongoing collaboration on the development/re-design of the DCS and Probation interface and DCS and the Judicial Center hosted a webinar to train Probation staff on the new referral and ICPR process. Indiana's Round 3 CFSR found that probation officers that serve youth in the delinquency setting and receive IV-E funded services lack sufficient child welfare training. DCS will be collaborating with counterparts in the Indiana judiciary to finalize curriculum updates for probation officers as part of the continued PIP development process and those changes will be reflected in future DCS Training Plan updates.

DCS representatives routinely attended meetings with the Juvenile Justice Improvement Committee and the Child Welfare Improvement Committee to discuss permanency and other child welfare issues, including the use of emergency shelter care, statutory timelines in CHINS and TPR cases, the statewide IV-E waiver program and DCS Services and Outcomes.

a. Statewide Conferences

Marion County, Indiana's largest jurisdiction, held a "Trauma Informed Symposium" in May of 2013 highlighting the following topics: How Resilience Trumps ACES, Trauma Informed Care and Domestic Violence and Models of Care To Engage Young Men In Caring For Themselves and Others".

Stakeholders included DCS staff, Juvenile Court Staff, Child Advocates, Prevention Partners, Child Protection Team Members as well as Community Members.

b. Additional Assessment Training

Following an agency initiative in 2009 focusing on better assessment of children's behavioral health needs, a decision was made to adopt the utilization of the Child and Adolescent Needs and Strengths (CANS) tool developed by John Lyons, Ph.D. In Collaboration with the Indiana Division of Mental Health and Addictions (DMHA), all DCS Supervisors receive a two day training to become "Super Users" of the tool so they in turn could assist the Family Case Manager staff to become certified by completing an on-line training and certification process. All Super Users also complete a yearly "booster" session which DCS is coordinating with DMHA. Additional training and support regarding the use of this tool was identified by the Field and an amendment was added to the IU School of Social Work contract to provide a part-time CANS Expert trainer who focuses on providing training, consultation and support at the local level through FY 2013. The use of this tool has provided for better information upon which to base both treatment and placement decisions relating to children and youth.

Building on the Indiana focus of identifying and addressing trauma for child welfare clients, DCS is partnering with DMHA to modify the CANS tool to incorporate questions related to trauma to better identify children who can benefit from trauma informed care. Training will continue to be provided so that appropriate referrals can be made based on the results of the cans assessment. In 2013, a Casey study and assessment was completed on the assessment (front end). An identified need was a revision and training on the safety and risk tools. A committee was put together to brainstorm with Casey on ways to improve our assessment tools. The new and revised tools will be trained to all field staff, supervisors, local office directors, managers.

c. Specialized Medical Training for Indiana Physicians and Other Relevant Parties

In 2012, an amendment was prepared for the Pediatric Evaluation and Diagnosis Program Contract with Indiana

University to provide program development, implementation and training on child abuse and neglect identification and/or reporting and related topic to ER physicians, family physicians, pediatricians and others who see infants and children in a medical setting. The contract provides for a minimum of six regionally based trainings along with on-line modules/webinars with Continuing Medical Education credit that can be provided across the state of Indiana on such topics as: identification, reporting, mechanisms of injury and appropriate medical evaluation. This much needed training will clearly benefit Indiana's children.

The first training occurred in April of 2013 in Fort Wayne, Indiana and 400 individuals attended, including 60 physicians. Elkhart, in northern Indiana is scheduled for Summer of 2013 and then the additional four trainings will be scheduled in other jurisdictions to provide Doctors and other individuals the opportunity to learn more about this important topic.

d. Foster Parent Specialist Training

DCS made the decision following a review of best practice programs concerning foster care, that the development of specialists in this area would best meet the agency vision and mission. Therefore, the position of Foster Parent Specialist was fully developed and approximately 100 individuals were designated to complete these responsibilities along with approximately 20 supervisors. A two day training was developed and is delivered to these individuals yearly covering 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. In addition, plans were made to train all of these specialists, based on the Program Improvement Plan, on the Casey Foster Family Inventory tools. Current staff trainers completed a "train the trainer" program and have become certified on this tool. They continue to provide this training for newly hired specialists on how to effectively work with foster parents using this inventory. Since July 1, 2011, all foster care specialists have been providing the pre-service orientation (RAP T 1) to prospective resource parents. Staff Development provides updates as needed.

In 2016 new Foster Care Specialists received two days of training that focused on their job specific skills. Train-the-trainer for Foster Care Specialists (FCS) on RAP T I continues to be provided by the Resource and Adoptive Training Staff, with the most recent one occurring in the spring of 2017. Bi-monthly meetings for Foster Care Specialist Supervisors were held to provide practice updates and enhance problem solving skills. Three days of licensing training for new FCS plus an additional two days for new FCS supervisors were held in August, September and November 2016.

e. Indiana Child Abuse and Neglect Hotline Training

In 2010, DCS implemented a centralized intake hotline beginning with the largest region (Marion County) and continuing with a roll-out plan until all regions were included in the summer of 2010. A four day training session was developed in collaboration with Hotline staff which included topics such as: The Business Flow Diagram; Legal Aspects of Screening in Indiana, Determining Urgency; Customer Service; Intake Appropriateness and Information Gathering; the Intake Guidance Tool; Training on the Indiana Child Welfare Information System (ICWIS), Culture and Its Impact on the Screening Process; Community Resources and Mental Health; Observation and Mock Calls. Following the initial hiring/training, staff has been added due to turnover, some of who were not previously employed with DCS. An additional training component consisting of attendance at pre-service training sessions as well as specialized training sessions related to legal matters and initial assessment procedures has been added to enhance these external workers' understanding of both the agency and their role in the process. This

two week training is offered and modified as needed. Staff development has also prepared and/or facilitated other training for hotline workers geared to their specific needs.

The Centralized Intake Hotline trainers continue to supplement the new worker training with training specific to the new intake staff that are hired. This process and the supportive training materials were updated with the onset of a newly designed Intake Module in early 2016. Intake Trainers also train all staff who go through cohort for a half day training so that they understand the report process that takes place prior to sending the reports out to the county departments.

Extensive Family Preservation Training

Beginning in January of 2011, DCS developed an overall theme of “Safely Home, Families First”. One component of this initiative was an increased emphasis on maintaining children in their homes if at all possible, making sure all safety needs are identified and met. DCS continues to use the Homebuilder Model and training on this program for DCS staff is sustained as part of a new training developed by DCS on all service standards. -In an effort to strengthen Intensive Family Preservations Programs, DCS has identified several Evidence Based Models that will be supported through training funds.

f. Clinical Resource Team

DCS has developed a unit of “Clinical Consultants” who are available to provide behavioral health expertise to field staff related to underlying needs and effective interventions for children, youth and adults involved in the child welfare system. Training and technical assistance was initially provided by Nationwide Children’s Hospital and Franklin County Children’s Services, and supported by Casey Family Programs. Staff Development has coordinated the planning and implementation portion of this project which includes training. Now that the program is established, training is provided by the project’s Clinical Director who is a licensed psychologist, However, staff development continues to review and approve all training materials. In addition, the Clinical Specialists have provided training at various workshops on related topics such as trauma informed care.

g. Educational Liaisons

DCS has developed a unit of “Educational Liaisons” who are available to provide assistance to field staff regarding children’s educational needs. These regionally based specialists have developed training which they regular provide to foster parents as coordinated by Staff Development. Topics are pre-selected and curriculum is approved through Staff Development and include topics such as: Special Education Alphabet Soup, Life After High School, Talking State Test Talk/What if a Child Doesn’t Pass, let’s Think About the Swimming – Planning for Summer. In addition, these individuals have prepared training related to educational topics for field staff.

h. Cost Allocation Methodology

Cost allocation for the training program continues to be determined by an analysis of the content of each curriculum and by tracking the job responsibilities of each person attending each training session. All ongoing courses are provided from 9 to 12 and 1 to 4 each training day, or 6 hours per training day. The allocation methods for child welfare training are described in Appendix E: Child Welfare Trainings/Allocation Methods.

i. Improving the Quality of Visits

Indiana worked with the Child Welfare Policy and Practice Group from Montgomery, Alabama to develop and pilot a three day workshop entitled Making Visits Matter, Home Visiting to Improve Safety, Well-Being, Stability and

Permanence for Children and Families in 2008. This curriculum was finalized and Partnership Staff were prepared to deliver this training. After the initial roll-out which provided this training to every Field Operations Family Case Manager, Supervisor and Local Office Director, the training continues to be provided regularly for more recently hired staff. Prior to the registration for this training, staff is asked to have completed six months of service so that they will have the background and experience necessary to receive maximum benefit from attending.

In this workshop participants explore “levels of knowing” in the context of their work with children and families. This helps them get to know families and caregivers based on the principles that guide the work (Practice model) in efforts to achieve the four major outcomes in child welfare (safety, permanency, well-being and stability).

Participants also learn to know children within their context by examining ways of connecting or joining with children, families and their informal and formal support network in achieving individualized goals and resources to achieve outcomes.

j. Outcomes for Quality of Visits Training

This curriculum is focused on the critical role of worker visits and the relationship visits have in improving safety to children and supporting effective case plan development, implementation and adaptation. In addition, special considerations related to engagement, interviewing and taking a team approach will be integrated throughout the three-day curriculum. The following resulting practices are discussed and practiced within the training session:

- Identification of purposes and the value of partnership in worker visits with children and families
- Development of strategies toward effective working agreements for visiting
- Identification of and practice in safety assessment during visits, including observation and interviewing information

Individualization of visiting techniques and observations based on developmental considerations, case progress and key decision points in work with children and families.

k. Realistic Job Preview

Building on research regarding worker recruitment and retention and based on the work of the Butler Institute for Families, Indiana has developed a Realistic Job Preview video for use during the recruitment process. Calamari Production Company, an award winning company that specializes in child welfare/juvenile justice issues was contracted to develop this video. This production company has hundreds of hours of footage from developing documentaries with unprecedented access to Juvenile Courts. In addition, several staff have been interviewed to provide a realistic review of what the position of a direct line work consists of. Coordinating interview questions and evaluation material has also been provided by the Butler Institute of Families. This video has now been incorporated into the recruitment process including the funded BSW students so that all potential family case managers view the video prior to accepting a field position. Formal research has not been completed, but anecdotal feedback indicates that several individuals have withdrawn their applications for the position after they have viewed the video.

- Tracking and adaptation of case plan goals, tasks and accomplishments
- Development of worker engagement strategies with children, families and caregivers

- Development of strategies toward team-building during visits to promote progress and stability for children and families

DCS Human Resources is currently retooling the recruitment and realistic job preview activities to improve the hiring process and better prepare new employees for the work they will be performing. DCS Human Resources is working closely with Staff Development to develop these new strategies and plans to have them finalized in the fall of 2017.

8. Providers of All Training Activities

In January of 2010, the Indiana Department of Child Services entered into a 2nd 4 Year Partnership Contract with the Indiana University School of Social Work to identify, develop, implement and provide all identified training needed to establish a well-prepared workforce in child welfare focusing on child safety, well-being and permanency. Through its Staff Development Division, DCS has full-time equivalent positions including a Deputy Director, Assistant Deputy Director, Training Manager, two supervisors, eight classroom trainers, six peer coach consultants, a curriculum writer and two support staff. The Partnership Contract provides for the following full-time equivalent staff positions: Training Manager, two supervisors, two curriculum writers, 10 trainers, 2 production staff, fiscal staff, evaluation staff, a multi-media staff person and support staff. The majority of trainings offered are by Partnership staff.

A three (3) day training of the trainers (TOT) has been developed using the Competency Based format and has been offered to all new trainers hired through the partnership. The TOT covers curriculum development, use of media and presentation skills. In addition, each newly hired trainer completes a rigorous preparation phase prior to delivering material which includes observation, co-training with feedback and mentorship/coaching by experienced trainers and supervisors. DCS has also worked with the Butler Institute of Families to further develop trainer competencies. In addition to providing this TOT to identified staff development trainers, this training has also been offered to the Regional Foster Care Specialists to assist them with providing resource parent orientations.

In 2015, Additional emphasis will also be placed on curriculum oversight/consistency now that Staff Development has created a curriculum library and is providing training to individuals with varying job responsibilities.

During the 2016-2017 fiscal year DCS Staff Development staff members included a deputy director, assistant deputy director, training manager, practice manager, five supervisors, 8 staff trainers, 9 RAPT trainers, and 9 practice consultants. Training staff for the Partnership included one director, two supervisors, and 11 trainers. Curriculum team members included a design team manager, an instructional technology professional and 5 curriculum writers.

9. Settings for Training Activities

New worker training primarily occurs in the Indianapolis Based Training Center referred to as Partnership Castleton. Due to the volume of training occurring, additional classroom space was secured and available effective April of 2013. Classroom space is also utilized through the University Partnership and referred to as Park 100 since the location is based in the Park 100 area of northwest Indianapolis. Training space has also been identified in each of the 18 Regional Hubs established so that regional classroom training can occur minimizing the travel required for staff. In addition, video teleconferencing equipment has been installed in all

of these hubs and training is now occurring through this medium with one or two trainers located in one location and 4 or 5 sites connected to observe and participate in the training. This way of providing training will be extensively used during the next 3 to 5 years so that travel costs can be minimized and staff can participate in trainings without extensive time needed for travel. The amount of training related to both new employees as well as ongoing employees has required additional training space to be identified throughout Indiana. Other Government buildings including city/county centers, libraries and local offices have also been used.

Computer Assisted trainings have been used to easily provide information to staff members in a short period of time. Legislative training and policy training is now promoted extensively through this medium. A full-time position has been established through the University partnership to continue to develop these types of trainings as appropriate. In addition, a contract has been executed with "Essential Learning", so that additional computer based relevant trainings can be offered to staff. 30 Courses have been identified and include:

10. Essential Learning course names and descriptions

- A Culture-Centered Approach to Recovery (3 hrs)

A review of the many dimensions of culture, the impact of a worldwide view on psychosocial rehabilitation practice (PSR), and the steps to becoming a culturally competent service provider. It includes exercises which help the learner explore their own culture and worldview as well as identify biases which could impact their relationships with others.

- ADHD: Diagnosis and Treatment (4 hrs)

This course will help you identify the symptoms and diagnosis of ADHD, and also understand the possible causes of the disorder. Additionally, you will learn some of the latest treatment options for children, teenagers, and adults. These skills will help you in the treatment of your clients who have ADHD.

- Adolescent Suicide (2.5 hrs)

In 2004, suicide was the third leading cause of death in children, adolescents and young adults. Common warning signs of suicide include suicidal threats both direct and indirect, dramatic changes in personality or appearance, severe drop in school performance and giving away belongings. High risk factors in this age group include a history of alcohol and substance abuse, family history of maltreatment or neglect, recent bereavement, physical illness and school failure. Important elements of suicide assessment include asking directly about the presence and nature of suicidal thoughts, a plan for suicide, determining the availability of lethality, previous thoughts or attempts, exploring beliefs and values and barriers to suicide.

- Alcohol and the Family (2.5 hrs)

Alcohol use can have a destructive effect on individuals as well as their families and loved ones. In this course, you will gain in-depth knowledge about research concerning the impact of alcohol use disorders

on the family context. You will learn the "brass tacks" of the family systems approach to understand the complicated dynamics of families struggling to deal with the impact of alcohol use disorders. Furthermore, you will be able to identify specific risk factors that are related to developing an alcohol use disorder. Vignettes and interactive exercises give you the opportunity to apply what you learn so that you can easily apply these competencies in your own setting.

- Attachment Disorders and Treatment Approaches (1.5 hrs)

This presentation given by the Center for Behavioral Health's as part of their ongoing Breakfast Learning Series addresses the concept of attachment theory and treatment of attachment disorders. Assessment parameters, treatment goals, ethical issues, and related disorders are also covered in this video course.
**Audio/Video Required

- Attitudes at Work (2 hrs)

An employee's attitude at work impacts performance, office culture, and the overall success of an organization. Unfortunately, an employee's attitude is often overlooked and considered a factor that is uncontrollable and unchangeable. Because of this perception, poor attitudes can easily infect the workplace and cause significant problems for both the employees and the organization as a whole. This course will give you valuable information about the importance of employees' attitudes in an organization, how certain attitudes can be promoted or changed, and how to create a workplace environment that fosters helpful attitudes.

- Bipolar Disorder in Children and Adolescents (1 hr)

This course discusses the signs and symptoms of Bipolar Disorder in children and adolescents, reviews the latest pharmacological and psychotherapeutic treatment for this population.

- Child and Adolescent Psychopharmacology (2 hrs)

This course – intended for non-MD mental health professionals, including marriage-family therapists and licensed clinical social workers – will give you in-depth knowledge of psychotropic medications used to treat children and adolescent psychiatric issues. This includes anxiety, mood, psychotic, and behavioral disorders. You will learn about the unique issues surrounding psychopharmacology for pediatric populations, including common uses, side effects, and timelines for medication response. Through interactive games, quizzes, and vignettes, this course will help you to take the learning back to your real-world work environment.

- Communication Skills and Conflict Management for Children's Services Paraprofessionals (2 hrs)

The ability to communicate with the children and families you serve is essential to your work with them. Passing along those basic communication skills that we take for granted--communicating successfully

with others, basic social skills, coping with conflict or anger, and solving problems--is another important part of your work. In this course, we will be focusing on various forms of communication, communication skills, and how to use communication effectively in solving problems and conflicts.

- Cultural Diversity for Paraprofessionals (1.5 hrs)

This course is an introduction to understanding the various components of cultural competence and how they apply to providing mental health and other human services to various groups of people and to individuals from within those groups.

- Domestic and Intimate Partner Violence (2 hrs)

This course gives an overview of domestic violence, discusses the risk factors and clinical issues associated with domestic violence. It also describes the psychology of abuse and the best treatment strategies.

- Dual Diagnosis Treatment (3 hrs)

Dual Diagnosis Treatment is for people who have co-occurring disorders: Mental illness and a substance abuse addiction. This treatment approach helps people recover by offering services for both disorders at the same time. In this course, we will discuss treatment options that address the various mental and substance abuse issues.

- Fundamentals of Fetal Alcohol Spectrum Disorders (1.5 hrs)

This course gives you key information about Fetal Alcohol Spectrum Disorders (FASDs) and the commonly associated complications. You will learn ways to identify common symptoms, and the benefits of proper diagnosis treatment for those who have an FASD. Strengths and difficulties for these individuals will be emphasized to help you better recognize when someone you work with has an FASD. Finally, you will learn ways that you can raise awareness for these disorders – this can ultimately result in proper treatment and prevention of FASDs. You will have a chance to review what you have learned through a series of interactive exercises and vignettes.

- Identifying and Preventing Child Abuse and Neglect (2 hrs)

This course will familiarize you with different types of child abuse, how to identify them, and what to do if you suspect that a child has been abused. Definitions of child abuse – along with how and when to report it- vary from state to state so you must always check with your local state reporting agency regarding laws and requirements. Regardless of your location, this course will give you a solid overview of the most common types of abuse that a mandated reporter is likely to encounter.

- Making Parenting Matter Part 1 (2.5 hrs)

Many parents find themselves wondering if parenting actually matters. They may ask themselves if they know what decisions a “good” parent should make and whether their parenting style is good, bad, common, or unique. Working effectively with children, adolescents, and their families can be quite challenging if you are not adequately prepared with the best tools for the job. Drawing upon content developed by Carol Hurst, Ph.D. of the Corporate University of Providence, this series of trainings is designed to empower clinicians who work with parents and their children with clear, relevant, and actionable information about best practices. This first course gives you an overview of the importance that parenting plays on child development by covering various parenting styles and typologies, as well as the theoretical perspectives of psychologists Freud, Bowlby, Baumrind, and Bandura. The instructive information, interactive exercises, and case vignettes in these courses will leave you prepared to successfully apply these concepts in your work with parents and children. *Flash required

- Methamphetamine: Effects, Trends, and Treatment (1.5 hrs)

The course provides a comprehensive overview of the drug methamphetamine including how the drug is created, the short and long term effects of meth abuse, recent law enforcement trends for manufacturing and trafficking, and the physical and psychological nature of methamphetamine dependence. It also describes treatment options and outcomes including the Matrix Model Intensive Outpatient Program. ****Audio/Video Required**

- Motivational Interviewing (4 hrs)

This course helps you understand what Motivational Interviewing is and become familiar with strategies to help you with your client counseling.

- Overview of Psychopharmacology (4 hrs)

This course describes four major categories of medications by their generic and trade names (brand names used by pharmaceutical companies): anti-psychotics, mood stabilizers, antidepressants and anti-anxiety medications. It presents information about clinical indications, dosages and side effects. Medications that specifically affect children, the elderly, and women during the reproductive years are also discussed.

- Overview of Serious Mental Illness for Paraprofessionals (3 hrs)

This course provides an overview of serious mental illness including schizophrenia, bipolar disorder, and children and adolescents mental disorders.

- Overview of Suicide Prevention (3.5 hrs)

This course is designed for professionals in the prevention, addictions, mental health, and related fields. The nature of the topic of suicide prevention also makes this course relevant to community members,

including the gatekeepers identified in this course (healthcare workers, school personnel, protective service workers, law enforcement, members of faith communities, program planners, volunteers, and juvenile justice personnel) and any community members who have been touched by suicide. The content is adapted from the National Strategy for Suicide Prevention which is published on the Substance Abuse and Mental Health Services Administration website (SAMHSA).

- Post-Traumatic Stress Disorder (3 hrs)

This course discusses the prevalence and diagnostic criteria for PTSD; it discusses treatments for PTSD including psychotherapy and medication as well as PTSD in children and adolescents.

- Safety Crisis Planning For At-Risk Adolescents and Their Families (2 hrs)

This course focuses on how social service workers and mental health clinicians can work to create effective family safety/crisis plans with high-risk families in the community. As you are probably well aware, high-risk adolescent consumers and their families face a number of obstacles that may seem impossible to manage. However, with the techniques you will learn in this course will help you to keep the family and the community safer. After completing this training, you will understand a clear step-by-step process to safety/crisis planning- and you will even get a sample crisis/safety plan form that you will use to apply the knowledge you gain during the course.

- Strength-Based Perspectives for Children's Services Paraprofessionals (1.5 hrs)

While the medically oriented “deficit model” is standard training for most staff who work directly with children, the strength-based/recovery movement emphasizes the need to have a balanced view of clients. That balanced view includes learning the values, terminology, and interventions that allow clinicians and the consumers you serve to address strengths along with challenges throughout the treatment process. In this course, you will learn about assumptions about the strength based perspective including the definition, principles, and beliefs about working with children and their families from the strengths perspective. You will also learn concrete strategies to apply these principles with children and their families at home.

- Stress Management for Mental Health Professionals (2 hrs)

As mental health professionals, you are prone to stress, which may lead to physiologic, emotional and spiritual symptoms. This course explains the sources and types of stress unique to mental health professionals like you and the physiological mechanisms of stress. The interactive course identifies symptoms of stress and discusses several stress management, reduction, and prevention techniques that you can use. It provides an opportunity for you to assess your own levels of stress through the Compassion Fatigue Inventory. The course includes current resources for you to access as you develop your personal stress management strategy. We use a blend of experiential vignettes, interactive activities, and didactic information as tools to prevent stress in the workplace. This information is especially relevant to mental health professionals in all treatment settings. You can also use this

information to teach patients stress management techniques. **Audio Included

- Substance Abuse and Violence Against Women (3.5 hrs)

This course provides a comprehensive review of the nature and prevalence of substance abuse problems and its association with violence against women. The course discusses social, family and cultural aspects associated with domestic violence. It also provides a comprehensive review of services available to women and men who are in this cycle of violence. A detailed discussion about legal options for women is also contained in this course.

- Time Management (2.5 hrs)

The bottom line in many organizations is productivity. If you find yourself overwhelmed, working too many hours, or running behind you may have room to improve your approach to time management. This course will give you an overview of the top issues related to managing your time effectively at work. You will learn ways to streamline your daily work along with skills that can help you to get more work done in less time.

- Trauma Informed Treatment for Children with Challenging Behaviors (3 hrs)

This course is about how to help children who have been severely traumatized to more effectively regulate their emotions and better manage their challenging behaviors.

- Valuing Diversity in the Workplace (2.5 hrs)

In today's increasingly diverse workplace, recognizing and valuing diversity has never been more important for an organization's success. The differences and similarities that we share with our colleagues contribute to the successes and difficulties we experience. The key to valuing differences is to be appropriate about recognizing them so that they don't hold us back from performing at the highest level possible. In this course, you will learn about your own attitudes toward diversity along with specific skills to work effectively with other employees who have different backgrounds and training.

- Working with Children in Families Affected by Substance Use (4 hrs)

This course is designed to help you assist families experiencing Substance Use Disorders (SUDs) and the child maltreatment that often results. You will learn how to address each problem by gaining an understanding of SUDs, including their dynamics, characteristics, and effects. You will also learn how Child Protective Services workers recognize and screen for SUDs in child maltreatment cases. Finally, you will find out how to establish plans for families experiencing these problems, including how to support treatment and recovery, as appropriate. By completing this training, you will have opportunities to apply what you have learned in a series of interactive exercises, games, and vignettes that are designed to

address issues you may encounter. The knowledge you gain will contribute to your understanding, helping you to identify avenues for enhanced services to families.

This form of training has been extremely popular with staff. Numbers of each selected training continue to be further reviewed so that courses not used frequently can be replaced with others from the Essential Learning catalog.

11. Webinar Capability

Finally, a “webinar” feature called “WebEx” has been implemented allowing staff to participate in training from their office location. This includes the ability to participate, using their computers and their phone lines, so that they can both see and hear presentations and ask questions as appropriate. This feature has been used to train large groups of staff on issues relating to the Indiana Practice Model, fiscal issues, preparation of referral forms for providers, and IV-E eligibility among others. It was utilized for one of the modules from the Leadership Academy of Supervisors outlined above. It is anticipated that this medium will be used extensively in the future to disseminate information quickly throughout Indiana efficiently and effectively.

12. Develop Evaluation Infrastructure

Evaluation forms continue to be collected from all trainees after each module and cover issues relating to the training, the trainer(s) and the location. Many of these evaluations are collected on-line. They are summarized by evaluators from Indiana University. Level I addresses trainee satisfaction and Level II addresses knowledge gained from training. Level III addresses the application of skills learned in training. Added to each question for Level I is the relative rank of each question, class, or trainer by quarter and overall. Because the Partnership is committed to continually assessing training effectiveness, the reports are valuable information.

The response rate from ranged from 98.8% in the 1st quarter to 100% in the 3rd quarter. Regarding Level I, 177,146 responses were collected to evaluate the satisfaction trainees felt with the training content, process, location, and general trainer skills. Of these responses, the mean score was 4.18, indicating that trainees rated the training as “greatly exceeding” their expectations. Lowest rated were the questions about the physical locations of training (questions 9 through 11, means of 3.61, 3.76, and 3.88 respectively), the highest rated were importance of training (question 14b, with a mean of 4.56), applicability of training (question 13, with a mean of 4.51), and practicality of training (question 14a, with a mean of 4.48). These numbers are consistent with last year’s results. As mentioned above, trainer characteristics were also highly rated, with an overall mean of 4.26. Focusing on the trainees’ feelings about the training itself, rather than the furniture and locations, it can be seen that overall, trainees have very positive opinions about the training.

A summary of questions related to the curriculum was added to this report. The following classes ranked in the top 10% for the selected questions: Worker Safety, Casey Foster Family Assessment, legal Overview, Domestic Violence: Holding a CFTM and Forensic Interviewing. The following classes ranked in the bottom 10%: Supervision II: Administrative Supervision, Secondary Trauma, Advanced Developmental Disabilities, Supervision IV: Educational Supervision, and Supervision V: Supportive Supervision.

Level II evaluations are designed to assess the knowledge gained from training, through using a pre-test and a

post-test.

Level III Evaluations are designed to measure the “transfer of learning” that occurs from the classroom to the field. Both Field Mentors and Supervisors complete behaviorally anchored scales regarding competencies on various identified skills. Throughout the year, Supervisors submitted evaluations nearly as often as Mentors. Mentors tended to give most mentees very similar scores. This means that the average scores that mentors gave to new workers were essentially the same over time in each skill set. Supervisors also tended to score mentees similarly over time. Overall, mentors tended to rate new worker’s skills as “excellent.” While at first this might seem like a positive statement, upon reflection we believe that the ratings are not truly reflective of the workers’ abilities. It is not realistic to think that all new workers are “excellent” in their first few months on the job. If raters could provide more variation in their ratings, it would present an opportunity for workers to learn and grow in their skills. This is a message the agency could give mentors and supervisors, along with encouraging them to complete the Level III evaluations routinely. Supervisors ratings were overall slightly lower for mentees (than Mentor ratings), but were also somewhat high for new hires in their first few months of employment.

Level IV Evaluations; Measuring the impact of training relative to outcomes for the caseload of individual workers. In this summary, we will highlight information that shows differences between FCMs trained before and after the 2008 Practice Reform was implemented.

If the numbers are fairly similar, they will not be mentioned here. Please note that we do not know if the differences are statistically significant, and we do not know if the differences are caused by training or by other factors. This data collection and analysis is in the beginning stages and we are presenting it here more for future reference than to draw any conclusions at this time.

Below is a summary of the data.

The total number of cases were slightly higher for FCMs trained after Practice Reform.

We see that for the average total days that children were in care, for FCMs trained before and after the 2008 Practice Reform was implemented, the numbers are better for FCMs trained after Practice Reform.

Average number of days per case were lower for FCMs trained after Practice Reform.

Average total placements were lower for FCMs trained after Practice Reform.

Average number of placements per child were lower for FCMs trained after Practice Reform.

Average number of placements per case were lower for FCMs trained after Practice Reform.

For length of placement, the average percentage of cases that were less than 12 months was higher for FCMs trained after Practice Reform. This is a positive indicator for the FCMs trained after practice reform. For longer placements, the average percentage of cases that were more than 15 months was lower for FCMs trained after Practice Reform

And finally, for the type of placement being in the child’s own home or relative home, the average percentage of cases in these homes was slightly higher for FCMs trained after Practice Reform.

Again, we have just listed the comparisons in which there is some difference between the two sets of workers.

Not all comparisons yielded any difference, and we do not know what the causes are of the differences we do note. But of all the differences, the numbers are in favor of the FCMs trained after Practice Reform. As we continue to gather more data, we hope to revise and refine this method and gain more meaning.

13. Resource Parent Training

For a number of years Indiana used the Institute for Human Services curriculum for Foster/Kinship/Adoptive Parent (FAKT) training. Indiana had 11 contracts with vendors that provided 20 hours of FAKT pre-service training throughout the state. All pre-adoptive parents are required to complete this training and an additional six hours of training specific to adoption. Licensed Child Placing Agencies (LCPAs) provide training to their prospective foster parents by trainers that have been certified through the State Training of Trainers program.

During 2010, the Staff Development Division developed plans to assume responsibility for all resource parent training effective July 1, 2011. Initially, fourteen staff positions were developed, including two supervisory positions, 7 full-time trainer positions and 5 full-time coordinator positions. One full-time curriculum writer re-wrote pre-service training to better align with the vision, mission and values specific to the department. In addition, on-going training modules for licensed resource parents were developed so that consistent and quality training can be offered regionally to resource parents at convenient times and in convenient locations. Rules and policies relating to resource parent training were reviewed and updated. A contract was established with Foster Parent College to provide on-line training to resource parents and another contract with the Central Indiana American Red Cross provides for resource parents to receive appropriate certification in CPR, First Aid and Blood borne Pathogens.

During 2014 a total of 9,473 resource and adoptive parents attended 693 Resource and Adoptive Parent (RAPT) training classes. Through April of 2015 a total of 3,920 resource and adoptive parents attended 289 training classes. The trainings available to resource and adoptive parents are documented in the Training Plan completed in 2014. DCS gathers evaluations from the class participants regarding their satisfaction with the information provided in each of the trainings. DCS currently does not have a process in place to evaluate the effectiveness of resource and adoptive parent training with the exception of absence of maltreatment while in foster care report.

During 2015 a total of 9,193 resource and adoptive parents attended 705 RAPT training classes. Through May 2016 a total of 4,821 resource and adoptive parents attended 346 RAPT training classes. DCS gathers evaluations from the class participants at the end of each class regarding their satisfaction with the training content and delivery provided in each of the trainings. DCS currently does not have a process in place to evaluate the effectiveness of resource and adoptive parent training. There are two reports produced by MaGIK that provide limited information regarding placements. The Absence of Maltreatment in Foster Care documents any abuse/neglect occurrences that take place during placement episodes, and reflects the percentage of absence of any maltreatment occurrences. The Average Number of Placements report uses the total number of placements and divides that by the total number of children in placement to get an average number of placements per child. This provides an indicator of the average number of disruptions that occur, although the reasons for the disruptions are not identified.

During calendar year 2016 a total of 11,034 resource and adoptive parents attended 882 RAPT training classes

throughout the state. Class evaluations continue to be completed by participants and data is compiled through the Training Partnership Training Evaluation process. Training content and training delivery are adjusted/modified as a result of any trending responses on the evaluations.

Resource Parent Advisory Board

In July of 2012, the RAPT Advisory Board held its first meeting. Consisting of both DCS staff and external stakeholders (including a foster parent), the identified purpose of this board is to help inform the training system by reviewing training trends and data and providing additional input regarding program improvement. In the Fall of 2014, this group reconvened and decided to meet twice a year. The following were the list of training topics that were requested as result of this meeting:

- Increasing Well-Being and Building Self-Esteem
- Bullying and other Peer Challenges
- Monitoring Technology

During 2016 the RAPT Advisory Board has met in March and in June to date. Membership on the Board includes foster parents, RAPT staff, regional foster care specialist staff, and foster care programs and services staff. The Board reviews the training curricula, training numbers, successes and challenges. They make recommendations for training improvements and enhancements to the computer system.

The RAPT Advisory Board convened in September and December 2016 to complete their quarterly meetings for 2016. In 2017 the RAPT Advisory Board also became the group that performed the Citizen’s Review Panel to provide feedback and complete a report with suggestions for response from the DCS Director. Quarterly meetings are continuing to be held. During the first quarter a list of suggested curricula to be developed was completed. The second quarter the topic was recruitment. Members were added to this group to include foster parent representation from private agencies and an employee of a child placing agency.

14. Training for Licensed Child Placing Agencies (LCPA’s)

In Indiana, therapeutic children are placed with private agencies called Licensed Child Placing Agencies (LCPA’s). To provide for consistent basic training, DCS provides quarterly trainings for representative trainers from these agencies on 10 hours of pre-service training and provides detailed curriculum to them as well. This lays the foundation for all foster parents in Indiana to have consistent, quality training as they consider whether they want to become licensed.

In addition, Indiana DCS developed a workgroup in 2013 with all LCPA agencies invited to develop additional curriculum on mutually agreed upon topics related to the therapeutic needs of many foster children. This workgroup has identified four potential topics and will further explore developing detailed curriculum available to all agencies to insure appropriate, quality training is occurring for foster parents who work with children with behavioral health needs.

During 2015 and through May 2016 DCS continued to provide quarterly train-the-trainer classes for the Licensed Child Placing Agency trainers for the 20 hours of pre-service classes that are required in Indiana for each foster parent for an initial therapeutic license. The pre-service curricula that the trainers are being trained on includes the following classes:

RAPT I—Introduction to Foster Care
RAPT II—Child Abuse and Neglect
RAPT III—Attachment, Discipline and Effects of Care Giving Overview
RAPT IV—Adoption
Trauma Informed Care
Sexual Abuse
Managing Challenging Behaviors

During calendar year 2016 train-the-trainer classes were provided by DCS trainers for newly hired trainers of the LCPA agencies each quarter on the above curricula. This quarterly TOT format continues in 2017 and has been a good partnership to ensure that the training that foster parents receive in Indiana is uniform across public/private agencies.

15. Resource and Adoptive Training Advisory Board

In July of 2012, the RAPT Advisory Board held its first meeting. Consisting of both DCS staff and external stakeholders (including a foster parent), the identified purpose of this board is to help inform the training system by reviewing training trends and data and providing additional input regarding program improvement. In the Fall of 2014, this group reconvened and decided to meet twice a year. The following were the list of training topics that were requested as result of this meeting:

- Increasing Well-Being and Building Self-Esteem
- Bullying and other Peer Challenges
- Monitoring Technology

During 2016 the RAPT Advisory Board has met in March and in June to date. Membership on the Board includes foster parents, RAPT staff, regional foster care specialist staff, and foster care programs and services staff. The Board reviews the training curricula, training numbers, successes and challenges. They make recommendations for training improvements and enhancements to the computer system.

16. IV-E Programs: Consulting Services Related to Training

Indiana has contracted with the Maximus Consulting Group to provide assistance in developing our IV-E programs. These services include a development of training presentations using PowerPoint's and supporting documents in areas of:

Best practice implementation, Centralized Eligibility Unit, eligibility reviews, technical support for audits, procedural reviews of denied cases, open eligibility cases, and SSJ eligibility.

Providing recommendations regarding resource licensing process, policies and procedures.

Conducting cost report training for providers.

In 2014, A Computer Assisted Training (CAT) was developed due to the changes within the implementation of the MaGIK computer system.

17. Staff Education and Training – MSW Program

The Indiana Partnership for Social Work Education in Child Welfare was created in 2001 to provide high quality social work education for public child welfare employees. It was designed to utilize funds from the Federal Government under Title IV-E of the Social Security Act as well as to meet the expectations of ongoing quality improvements of state child welfare programs as required by the Adoption and Safe Families Act of 1997. The initial two-year grant provided MSW education for 35 IFSSA/DFC employees at two campuses of Indiana University: IUPUI and IU South Bend. A new three-year grant was signed in 2006 and approximately 20 students joined the program in 2007 and 2008 which had expanded to include the IUN campus in Gary. Another 3 year grant was signed effective July 1, 2009 through June 30, 2012. This program has again been reviewed and continued with a new contract covering the period July 1, 2012 through June 30, 2015. Approximately 20 identified DCS Field Staff are selected each year to participate in this program. Selection criteria includes an evaluation of leadership potential by supervisory staff and an interview process which focuses on commitment to the Department of Child Services and ability to utilize MSW knowledge and skills gained to further enhance the DCS workforce.

The MSW program is currently available to agency students in Indianapolis, Gary, Fort Wayne, Richmond, New Albany and South Bend. In Indianapolis, classes are available during the evenings, or on Saturday. At the other campuses, classes are available in the evenings. Beginning in the January of 2012, an MSW program became available in Southern Indiana, addressing a need that was identified in the past.

In addition to student education, a major focus of this grant was to support the development of a child welfare concentration designed to provide the IV-E supported students, as well as other students interested in working in public or private child welfare agencies, with specific knowledge and skills for practice with children and families involved in the child welfare system. Four advanced practice courses and one child welfare policy course are now in place. The specific objectives of these courses were reviewed in relation to the Indiana Competencies as well as the list of competencies for child welfare practice developed by the University of California and currently utilized in their IV-E project. Advanced practice skills in the area of working with children impacted by family violence, family work particular to the child welfare setting and community-based practice in child welfare are taught through these specialized courses.

The IV-E grant also supports specialized practicum placements for the IV-E funded students. The Council on Social Work Education requires that each student have a minimum of 900 clock hours of field practice, supervised by an experienced and licensed MSW practitioner. All MSW students have the option of completing one of the two required practica in their employing agencies. This policy supports non-traditional students, like those in the IV-E program, who are employed full-time and have employment experiences in social-work related practice areas. Employment-based practicums require special planning and prior approval to ensure that students are able to have a learning experience beyond their day-to-day job responsibilities and are required to have a field instructor who is different from their employment supervisor to reduce conflicts of interest between work and practicum. Students in the IV-E program are encouraged to do one of their two practicums in an approved DCS program. Because of the large number of student who are involved in this undertaking, as well as the limited number of available supervisors who meet the minimum educational requirements, the IV-E program is able to arrange for field supervision from an MSW from outside of the agency. This service is not available to students who are not in the IV-E program, but is necessary for these students given our commitment to allowing the students and the agency to benefit from the special projects that students can be involved with during their practicums. Specific policy relating to work/class conflicts as well as work hours relative to practicum hours has been developed to provide more guidance to the field on how to balance these two responsibilities. See General

Administrative Policies 8 (Employee Outside Internships and Practicum), 9 (BSW Scholars IV-E Practicum), 12 (Academic Students Expectations) and 14 (MSW IV-E Scholars Employment Based Practicum)

There continues to be emphasis on providing high quality social work education for public child welfare employees through creating opportunities for MSW education, while at the same time creating and implementing curriculum that meets the competencies for child welfare practice as defined by the State of Indiana. Since 2001, approximately 239 DCS employees have begun their MSW studies and over 186 have graduated as of May 2016. Many of these employees have been promoted to supervisory or management positions within DCS and are utilizing their expanded knowledge and skills to benefit child welfare in Indiana. In 2016 there were 19 MSW scholars that began enrollment in the MSW program.

18. BSW Program

The Indiana Partnership for Social Work Education in Child Welfare expanded IV-E funded training opportunities to a Bachelor of Social Work (BSW) program offered through four universities on six campuses in January 2006. Indiana University-Purdue University Indianapolis serves as the lead university working with five other BSW programs. The partnership can include up to 36 students statewide per year. Required courses in child welfare were added to the existing BSW programs to integrate content from the DCS new worker training curriculum. A practicum experience in a local DCS office is also required of each participating student. During their time in the program, students receive support in the form of payment of tuition and fees, as well as a stipend. Upon graduation, participants are prepared for employment as a Family Case Manager. Participants have a two-year work commitment with the Department of Child Services if hired.

The first graduates of this program were offered positions in DCS Local Offices in the summer of 2007. Feedback on their training and preparation to provide quality casework has been positive. 20 Students completed this program during the 2007-2008 academic year and began employment in Local Offices during the summer of 2008. Additional students have participated in the program each year, and recently (June 2016) 43 students completed the required coursework and were offered positions within DCS.

Recent research completed by IU Professor Dr. Lisa McGuire established that the student's self-perceived competence for child welfare work was significantly higher than the self-perceived competence of trainees completing the established cohort training on 21 of 36 items. Also, retention analysis between the two groups demonstrated statistically significant difference between the two groups in retention with those completing the cohort training 3 times more likely to leave the job than the BSW graduates. As a result, DCS has modified its contract with the IU School of Social Work to fund 50 BSW students completing their senior year (compared with 36).

During 2016 45 BSW scholars started in 2016. In the second quarter of 2017 59 BSW students began the scholars program.

19. Training With Other External Partners


Effective in FFY 2009, the definition of trainees eligible to receive title IV-E short-term training has been expanded by Public Law 110-351 to include additional groups of non local office staff. The following groups are

included: relative guardians; State-licensed or State-approved child welfare agencies providing services to children receiving title IV-E assistance; child abuse and neglect court personnel; agency, child, or parent attorneys; guardian ad-litem; and court appointed special advocates. The federal legislation provides for enhanced funding for these new categories of trainees.

Training conducted for the expanded population of trainees as set forth in the above paragraph will be initiated through a signed Memorandum of Understanding (MOU) with the respective agency/individual. As described above, such a Memorandum was completed with the Indiana Supreme Court, Division of State Court Administration. Any subsequent contract or MOU shall contain sufficient detail to identify the costs for appropriate allocation. Costs shall include, but are not limited to, trainers, meeting space and supplies. The training activities provided through the Supreme Court MOU will include but not be limited to: 1) current Indiana statutes guiding the child protection system, 2) judicial proceedings related to the children under the court supervision, 3) Title IV-E allowed activities specified in 45 CFR 1356.60 (c), and 4) topics covering or related to guidance provided in CWPM 8.1H (8). All costs related to the MOU will be claimed at the 55% Federal Financial Participation (FFP) for appropriate federal fiscal year with subsequent increases for corresponding fiscal year.

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

For Fiscal Year 2018: October 1, 2017 through September 30, 2018

1. State or Indian Tribal Organization (ITO): Indiana		2. EIN: 35-56000158
3. Address: 402 W. Washington Street, W306 MS 08, Indianapolis, IN 46204-2739		4. Submission Type: <input checked="" type="checkbox"/> NEW <input type="checkbox"/> REVISION
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) funds		\$6,420,879
a) Total administrative costs (not to exceed 10% of title IV-B Subpart 1 estimated allotment)		\$642,088
6. Total estimated title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds This line contains a formula to display the sum of lines 6a - 6f.		\$5,766,056
a) Total Family Preservation Services		\$1,153,211
b) Total Family Support Services		\$1,153,211
c) Total Time-Limited Family Reunification Services		\$1,153,211
d) Total Adoption Promotion and Support Services		\$1,153,211
e) Total Other Service Related Activities (e.g. planning)		\$576,606
f) Total administrative costs (FOR STATES ONLY: not to exceed 10% of title IV-B subpart 2 estimated allotment)		\$576,606
7. Total estimated Monthly Caseworker Visit (MCV) funds (FOR STATES ONLY)		\$363,137
a) Total administrative costs (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)		\$36,314
8. Re-allotment of title IV-B subparts 1 & 2 funds for States and Indian Tribal Organizations:		
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS \$ _____ PSSF \$ _____ MCV (States only) _____		
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS \$ _____ PSSF \$ _____ MCV (States only) \$ _____		
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (FOR STATES ONLY) Estimated amount plus additional allocation, as available.		\$527,213
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds		\$5,172,863
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment).		\$1,551,859
11. Estimated Education and Training Voucher (ETV) funds		\$1,695,026
12. Re-allotment of CFCIP and ETV Program funds:		
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the CFCIP Program.		\$
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the ETV Program.		\$
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the CFCIP Program.		\$500,000
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the ETV Program.		\$200,000
13. Certification by State Agency and/or Indian Tribal Organization: The State agency or Indian Tribal Organization submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.		
<i>Signature of State/Tribal Agency Official</i>		<i>Signature of Central Office Official</i>
		
<i>Title</i> Director		<i>Title</i>
<i>Date</i> 6/28/17		<i>Date</i>

CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services

State or Indian Tribal Organization (ITO): **Indiana**

For FY 2018: **OCTOBER 1, 2017 TO SEPTEMBER 30, 2018**


SERVICES/ACTIVITIES	(A) IV-B Subpart I- CWS	(B) IV-B Subpart II- PSSF	(C) IV-B Subpart II- MCV *	(D) CAPTA*	(E) CFCIP	(F) ETV	(G) TITLE IV-E **	(H) STATE, LOCAL & DONATED FUNDS	(I) Number Individuals To Be Served	(J) Number Families To Be Served	(K) Population To Be Served	(L) Geog. Area To Be Served
1.) PROTECTIVE SERVICES	\$ 4,628,041			\$ 500,000			\$ 1,814,415	\$ 111,368,129	225,152	N A	Reports to AB/NE	Statewide
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	\$ -	\$ 1,153,211		\$ 27,213			\$ 99,933	\$ 88,714,943	2,237	1,271	Children/Families at risk of AB/NE	Statewide
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	\$ -	\$ 1,153,211		\$ -			\$ 44,500	\$ 133,631,900	37,019	21,035	Children / Families at risk Ab/Ne	Statewide
4.) TIME-LIMITED FAMILY REUNIFICATION SERVICES	\$ -	\$ 1,153,211		\$ -			\$ 13,640,506	\$ 33,548,659	23,998	N A	Children in Foster Care	Statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	\$ -	\$ 1,153,211					\$ -	\$ 219,288	N A	331	to Post Adopt Services	Statewide
6.) OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	\$ -	\$ 576,606					\$ 300	\$ 7,515,815	N A	N A	N A	N A
7.) FOSTER CARE MAINTENANCE: (a) FOSTER FAMILY & RELATIVE FOSTER CARE	\$ -						\$ 67,997,764	\$ 45,325,293	12,082	N A	Children In Foster Care	Statewide
(b) GROUP/INST CARE	\$ -						\$ 46,985,291	\$ 51,370,266	1,011	N A	Caregivers in Foster Care	Statewide
8.) ADOPTION SUBSIDY PYMTS.	\$ -						\$ 52,914,854	\$ 43,987,375	13,367	N A	Adoptive Children	Statewide
9.) GUARDIANSHIP ASSISTANCE PAYMENTS							\$ 264,001	\$ 1,358,195	248	N A	Assisted Guardianship	Statewide
10.) INDEPENDENT LIVING SERVICES	\$ -	\$ -			\$ 5,172,863		\$ 124,364	\$ 2,575,039	1,394	N A	All eligible Children	Statewide
11.) EDUCATION AND TRAINING VOUCHERS	\$ -				\$ -	\$ 1,695,026	\$ -	\$ 423,757	270	N A	Youth ages 18 to 20	Statewide
12.) ADMINISTRATIVE COSTS	\$ 642,088	\$ 576,606	\$ 36,314				\$ 33,961,898	\$ 100,527,435				
13.) FOSTER PARENT RECRUITMENT & TRAINING	\$ 81,900	\$ -		\$ -			\$ 112,140	\$ 65,671				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	\$ 125,500	\$ -		\$ -			\$ 1,104,562	\$ 92,679				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING							\$ -	\$ -	N A	N A	N A	N A
16.) STAFF & EXTERNAL PARTNERS TRAINING	\$ 595,000	\$ -		\$ -	\$ -	\$ -	\$ 962,915	\$ 1,774,983				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	\$ 348,350	\$ -	\$ 326,823				\$ 190,565	\$ 301,894				
18.) TOTAL	\$ 6,420,879	\$ 5,766,056	\$ 363,137	\$ 527,213	\$ 5,172,863	\$ 1,695,026	\$ 220,218,009	\$ 622,801,320	316778	22637	0	
19.) TOTALS FROM PART I	\$6,420,879	\$5,766,056	\$363,137	\$527,213	\$5,172,863	\$1,695,026	N A	N A	N A	N A	N A	N A
20.) Difference (Part I - Part II)	\$0	\$0	\$0	\$0	\$0	\$0	N A	N A	N A	N A	N A	N A

21.) Population data are included in the APSR/CFSP narrative, not above in columns I - L. YES NO

* These columns are for States only; Indian Tribes are not required to include information on these programs.

** Only states or tribes operating an approved title IV-E waiver demonstration may enter information for rows 1-6 in column (g), indicating planned use of title IV-E funds for these purposes.

**CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence (CFCIP) and Education And Training Voucher (ETV):
 Reporting For Fiscal Year 2015 Grants: October 1, 2014 through September 30, 2016**

1. State or Indian Tribal Organization (ITO): Indiana		2. EIN: 35-56000158		3. Address: 402 W. Washington St, Rm 306, Indianapolis, Indiana 46204			
4. Submission Type: <input checked="" type="checkbox"/> NEW <input type="checkbox"/> REVISION							
<i>Description of Funds</i>	<i>Estimated Expenditures for FY 15 Grants</i>	<i>Actual Expenditures for FY 15 Grants</i>	<i>Number Individuals served</i>	<i>Number Families served</i>	<i>Population served</i>	<i>Geographic area served</i>	
5. Total title IV-B, subpart 1 funds	\$ 6,456,658	\$ 5,810,992	225,152	NA	Reports of AB/NE	Statewide	
a) Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	\$ 645,666	\$ 645,666					
6. Total title IV-B, subpart 2 funds (This line contains a formula that will display the sum of lines a-f.)	\$ 5,908,388	\$ 5,908,368	39,256	22,637	Children Families at risk AB/NE	Statewide	
a) Family Preservation Services	\$ 1,181,678	\$ 1,211,578					
b) Family Support Services	\$ 1,181,678	\$ 1,181,678					
c) Time-Limited Family Reunification Services	\$ 1,181,678	\$ 1,151,760					
d) Adoption Promotion and Support Services	\$ 1,181,678	\$ 1,181,674					
e) Other Service Related Activities (e.g. planning)	\$ 590,839	\$ 590,839					
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment)	\$ 590,839	\$ 590,839					
7. Total Monthly Caseworker Visit funds (STATES ONLY)	\$ 371,803	\$ 371,803					
a) Administrative Costs (not to exceed 10% of MCV allotment)	\$ 37,180	\$ 37,180					
8. Total Chafee Foster Care Independence Program (CFCIP) funds	\$ 4,059,701	\$ 4,059,701					
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	\$ 1,217,910	\$ 1,217,910	NA	NA	NA	NA	
9. Total Education and Training Voucher (ETV) funds	\$ 1,311,812	\$ 1,311,812	270	NA	20	Statewide	
10. Certification by State Agency or Indian Tribal Organization: The State agency or Indian Tribal Organization agrees that expenditures were made in accordance with the Child and Family Services Plan, which was jointly developed with, and approved by, the Children's Bureau.							
<i>Signature of State/Tribal Agency Official</i> 		<i>Date</i> 6/28/17		<i>Signature of Central Office Official</i>		<i>Date</i>	
<i>Title</i> Director				<i>Title</i>			

Annual Reporting of Education and Training Vouchers Awarded

Name of State: **Indiana**

	Total ETVs Awarded	Number of New ETVs
<u>Final Number:</u> 2015-2016 School Year (July 1, 2015 to June 30, 2016)	199	96
2016-2017 School Year* (July 1, 2016 to June 30, 2017)	202	142

Comments: 2016-2017 School Year does not include summer 2017.

*in some cases this might be an estimated number since the APSR is due June 30, 2015.

Section H: Financial Information

1. Payment Limitations – Title IV-B, Subpart 1

In order to verify compliance with Section 424(c) and Section 424(d) of the Act, the Indiana Department of Child Services provides the information below. The State of Indiana does not use Title IV-B Subpart 1 funds for child care, foster care maintenance and adoption assistance, nor does the State of Indiana use non-Federal funds that were expended by the State for foster care maintenance payments as part of the title IV-B, subpart 1 State match. Therefore, Indiana is in compliance with Section 424(c) and Section 424(d) of the Act which states that FY 2016 expenditures for these purposes may not exceed FY 2005 amounts.

	<i>FY 2005</i>	<i>FY 2017</i>
<i>Federal Expenditures</i>		
Child Care	\$ 0.00	\$ 0.00
Foster Care Maintenance	\$ 0.00	\$ 0.00
Adoption Assistance Payments	\$ 0.00	\$ 0.00
Child Welfare Services	\$4,870,320.34	\$4,437,570.78
Child Welfare Training	\$1,137,534.26	\$385,875.72
Administration	\$667,539.40	\$0.00
<i>TOTAL FEDERAL (75%)</i>	<i>\$6,675,394.00</i>	<i>\$4,823,446.50</i>
<i>Non-Federal Expenditures</i>		
Child Care	\$ 0.00	\$ 0.00
Foster Care Maintenance	\$ 0.00	\$ 0.00
Adoption Assistance Payments	\$ 0.00	\$ 0.00
Child Welfare Services	\$1,557,591.93	\$1,479,190.26
Child Welfare Training	\$445,026.27	\$128,625.24
Administration	\$222,513.13	\$0.00
<i>TOTAL STATE MATCH (25%)</i>	<i>\$2,225,131.33</i>	<i>\$1,607,815.50</i>

Section H: Financial Information

2. Payment Limitations – Title IV-B, Subpart 2

In order to verify compliance with the non-supplantation regulations in section 432(a)(7)(A) of the Act, the Indiana Department of Child Services provides the following illustration of FY 2014 State and local share expenditure amounts for the purposes of Title IV-B, Subpart 2 for comparison with the State's 1992 base year amount.

	<i>1992 Base Year</i>	<i>FY 2015</i>
Federal Share	\$0.00	\$5,908,388.00
State Share	\$3,246,083.00	\$1,969,462.66
Total Expenditures	\$3,246,083.00	\$7,877,850.66

Item-by-Item Guide for Administering the Tool

Section A is to be completed by the Screener and not asked of the youth.

Section A - Background Information (DO NOT READ TO YOUTH)

1. Name of Youth:

2. Youth's MaGIK ID:

3. Linked Assessment ID:

4. Linked Case ID:

5. Date of Screening:

6. Location of Screening:

7. Screener Name:

8. Reason for Screening:

- Youth's acknowledgement of being trafficked
- Youth is reported to be a victim of human trafficking by parent/guardian, law enforcement, medical or service provider, teacher, school personnel, child protective services, and/or juvenile probation officer (or other adult).
- Child is recovered from runaway episode in a hotel or known area of prostitution
- Child is or was listed on backpage.com (Or other similar web pages for the purposes of human trafficking)
- Child has a history of recruiting other children for human trafficking (sex work or has pimped out others)

If any of the above boxes are checked, the child may be a victim of human trafficking. Call the Indiana Child Abuse and Neglect Hotline at 1-800-800-5556.

- Current runaway episode or history of running away or getting kicked out, in addition to any two combination of indicators below. (Definition of running away or getting kicked out of home: Include times the youth did not voluntarily return within 24 hours, and include incidents not reported by or to law enforcement.)

If this box is checked and AT LEAST ANY TWO combination of indicators are noted below, the child may be a victim of human trafficking. Call the Indiana Child Abuse and Neglect Hotline at 1-800-800-5556.*

- Current incident or history of inappropriate sexual behaviors (not limited to prostitution)
- History of sexual abuse (either as victim or perpetrator)
- Law enforcement reports behaviors or circumstances indicative of youth being trafficked
- Child has no personal items or possessions (including identity documents if foreign born - labor trafficking)
- Child is not allowed or unable to speak for him/herself and may be extremely fearful
- Child appears to have material items that he or she cannot afford (e.g. cell phones, expensive clothing, tablets, cash, hotel keys, etc.)
- Child has sex toys, multiple condoms, lube or other sexual devices
- Child has no knowledge about the community he/she is located in
- Child shows signs of being groomed (i.e. hair done, nails done, new clothing, etc. that child cannot afford or justify how paid for)
- Suspicious tattoos or other signs of branding (e.g. traffickers' names, dollar signs, diamonds, stars, etc. May also have certain designs/logos on nails, jewelry, etc.)

- Child lives, associates and/or has relationships with age-inappropriate friends, boyfriends, or girlfriends
 - Child known to associate with confirmed or suspected youth who have been trafficked
 - Child has inappropriate, sexually suggestive activity on social media websites and/or chat apps.
 - Youth presents with other behaviors or circumstances indicative of being trafficked (please explain):
-

- None of the above

9. Mode of Screening:

- Screening with interpreter
- Unable to Communicate
- Interpreter needed but unavailable
- Screening without interpreter

10. Preferred Language:

Section B – Demographic Information

Begin the screening by reading the following introductory comments to the youth: This is an interview to better understand your current situation and experiences. I will be asking you questions about yourself. Try to be as honest as you can. Some questions may be sensitive and hard for you to answer. You do not have to answer anything you don't want to answer. You can take a break at any time, ask to finish at a later time, or stop the session. I want you to know that your safety is my priority. As we are talking through these questions, things that you tell me may not be completely confidential. I am part of a team that works to make sure you are safe. There may be times when I need to share information that you provide to me with other people so that we can provide you with the best services to fit your needs. Before we get started, do you have any questions?

I'd like to begin with some general questions about you and your personal background.

1. What is your date of birth? _____ (MM/DD/YYYY)

Refused to answer

1a. (If youth does not know, ask): Approximately how old are you? _____

2. What country were you born in? _____

Refused to answer

3. What city do you live in? _____

Refused to answer

a. (DO NOT READ TO YOUTH) Was youth arrested outside the city in which he/she resides?

No

Yes

4. Do you go to school?

Refused to answer

No (If 'no' skip to Item 4c)

Yes (If 'yes' proceed to Item 4a below)

4a. Where do you go to school? _____ (If school entered, ask Item 4b)

Refused to answer

4b. How many days have you attended school in the last two weeks?

Refused to answer

0 days

1-5 days

6-10 days

Not applicable/school not in session

4c. Tell us about the last time you went to school?

5. Do you get on the internet, Wi-Fi, or use phone or tablet apps?

Refused to answer

No (If 'no' skip to Item 6)

Yes (If 'yes' ask Item 5a below)

5a. What kind of sites or apps do you use? (Check all that apply)

- Refused to answer
- Twitter
- Instagram
- Snapchat
- Online game chat
- Instant messaging
- Facebook
- Tinder
- Craigslist
- Backpage
- KIK
- Other apps or sites

6. Have you ever agreed to meet someone you met online or through the Internet or through a phone app?

- Refused to answer
- No
- Yes (If 'yes' prompt by saying, **Tell me more about that.**)

7. Do you currently have a boyfriend or girlfriend?

- Refused to answer
- No (If 'no' skip to Item 8)
- Yes (If 'yes' ask Item 7a and Item 7b below)

7a. Approximately how old is he/she?

- Refused to answer

7b. How did you meet?

- Refused to answer
- Through a friend
- At school
- Through a family member
- Online (Facebook, internet, game console)
- Public place (mall, movies, sports event)
- Work
- Other

8. Do you have any tattoos?

- Refused to answer
- No *(If 'no' skip to Item 9)*
- Yes
- Responded no, but staff observed tattoos
(If 'yes' or 'Responded no, but staff observed tattoos', ask Item 8a through Item 8c below)

8a. What is the tattoo(s)? *(Check all that apply)*

(Screener may respond to this based on youth response and/or based on observation of the tattoo)

- Refused to answer
- Dollar/Currency sign, money bags, name
- Star/hearts
- Male name
- Female name
- Nickname or street name
- Other

8b. What does your tattoo(s) mean? *(Check all that apply)*

- Refused to answer
- Family connection
- Personal meaning

- Romantic partner's name
- Gang-related
- Suspected trafficker's name/initials
- Forced branding/ownership
- No meaning
- Don't know the meaning
- Other

8c. Who was with you when you got your tattoo(s)? *(Check all that apply)*

- Refused to answer
- Family member
- Friend
- Romantic partner
- No one
- Suspected trafficker

- Gang member
- Other

9. Do you have any scars or brands that were made intentionally, not from an accident or injury?

(Screener should respond based upon youth answer and/or observation of visible scars)

- Refused to answer
- No *(If 'no' skip to Item 10)*
- Yes *(if 'yes' ask Item 9a)*
- Screener observes mark(s), but youth denies mark(s) made intentionally

9a. Who was with you when you got your brand(s) or when you received the scar? (Check all that apply)

- Refused to answer
- Family member
- Friend
- Romantic partner
- Another Youth
- No one
- Suspected trafficker
- Gang member
- Other

Section C – Living Conditions

Read to the youth: Next, I'd like to talk to you about where you live and the people you live with.

10. Tell me about all of the places you stayed while you were gone.

(Screener may prompt the youth by listing examples from below) *(Check all that apply)*

- Refused to answer
- House
- Apartment
- Group/foster home
- Car/van
- Shelter (Emergency, domestic violence, homeless, etc)
- Staying with friends
- Rehabilitation facility
- Hotel or motel
- Part of a residence - garage, basement, shed
- Squat
- Traveling/in-between residences

- Homeless
- Other

11. Who lives with you? (Check all that apply)

- Refused to answer
- Father
- Mother
- Both parents
- Guardian
- Step-parent
- Relatives(s)
- Romantic partner (girlfriend/boyfriend)
- By myself
- Other

- Friend(s) (If yes on Friend(s), ask 11a and 11b)

11a. How did you meet your friend(s) that are living with? (Check all that apply)

- Refused to answer
- School
- Alternative School
- Hotel/Motel
- Social Media or other online site
- Out of Home Placement
- Juvenile Detention
- Neighborhood
- Mall
- Other

11b. Do you have nicknames for one another? (Check all that apply)

- Refused to answer
- Wifey
- Sister in Law
- Wife in law
- No nickname
- Other

12. Do you pay for where you live?

- No
- Yes

12a. How is your housing paid for? (Check all that apply)

- Refused to answer
- Parents/relative
- Friends
- Romantic partner
- Myself through employment/job
- Myself through selling drugs
- Myself through stealing
- Myself through engaging in sexual acts for money/material gain
- Panhandle/beg
- Other

13. Have you ever had any visits from a caseworker?

- Refused to answer
- No
- Yes
If 'yes' who was that?

Section D – Work Information

Read to the youth:

Now, I'd like to ask you some questions about work situations. What I mean by "work" is anything you have done where you have received something of value, like money, food, clothing, a place to stay, drugs, or gifts, in exchange for your efforts. This could include a job like working at a fast-food restaurant or store, but may also include things that some kids have to do to survive when away from their homes, anything where you were given something of value for your efforts. So, your boss may have been an employer or may have been a family member, friend, boyfriend or girlfriend, or someone you lived with or had a relationship with.

14. So, do you have a job or did you have one before coming here?

- Refused to answer
- No (If 'no' skip to Item 22)
- Yes (If 'yes' continue to Item 15 below)

15. What type of work do you do? (Check all that apply)

- Refused to answer
- Agricultural/farm work
- Housekeeping/janitorial work
- Door-to-door sales
- Restaurant work
- Construction
- Retail

- Nails/hair
- Massage
- Personal dancing, stripping, or similar activity
- Other

16. How much money do you make an hour?

- Refused to answer
- I do not make any money *(Screener may ask relative to the minimum wage rate)*
- At or below minimum wage *(Minimum wage is \$7.25 in Indiana)*
- More than minimum wage but less than \$15 an hour
- \$15-\$25 an hour
- More than \$25 an hour
- I make money, but it doesn't come to me.
- I do not make money, but I get other things of value.
- Does not know

17. Does your boss or supervisor owe you money?

- Refused to answer
- No
- Yes
If 'yes', specify:

18. Do any of your family members owe your boss money?

- Refused to answer
- No
- Yes
If 'yes', specify:

(Screener may prompt for something else that is owed like a favor, house, property, or land)

19. Have you ever worked or done something for your boss without getting the payment that you thought you would get?

- Refused to answer
- No *(If 'no' skip to Item 20)*
- Yes *(If 'yes' ask Item 19a through Item 19c below)*

19a. What kind of work was it?

- Refused to answer

19b. What payment did you expect?

- Refused to answer

19c. What did you receive? _____

- Refused to answer

20. Do you live and work at the same place?

- Refused to answer
 No
 Yes

21. Would you be threatened or harmed if you left your job?

- Refused to answer
 No
 Yes

22. When you think about the future, what do you want to do when you get older? _____

- Refused to answer

Section E – Leaving or Running Away from Home

Read to the youth:

I'd like for you to think about the past 12 months and times when you have been away from home.

23. Have you run away, stayed away, or left your home without permission in the past year?

- Refused to answer
 No *(If 'no' skip to Item 24)*
 Yes *(If 'yes' ask Item 23a through 23l below)*

23a. How many times have you run away or left without permission?

- Refused to answer
 1 to 5 times
 6 to 10 times
 11 to 20 times
 More than 20 times

23b. How long were you gone the last time you left home?

- Refused to answer
 Less than one day (skipped school or some other function)
 1 to 6 days
 1 to 4 weeks
 1 to 2 months
 2 to 3 months
 4 months or longer

23c. Where did you go when you left? (Check all that apply)

- Refused to answer
- Friend's place
- Relative's place/other biological parent's place
- Romantic partner's place
- Motel/hotel
- Street
- Out of town
- Pro-social adult's place
- Anti-social adult's place
- Street gang

23d. While you were away, how did you support yourself? (Check all that apply)

- Refused to answer
- Family/relative took care of me
- Friend(s) took care of me
- Romantic partner helped
- Worked (legal employment/jobs)
- Money through drugs
- Money/material gain/favors from prostitution, stripping or similar activities
- Didn't stay away long enough to need support
- Stealing
- Government assistance
- Panhandling
- Borrowed money from friends
- Trafficker/pimp
- Other

23e. While you were away, were you in control of your own money?

- Refused to answer
- Yes
- No
Who was in control of your money?

23f. Who were you with while you were away? (Check all that apply)

- Refused to answer
- No one (Skip Item 23g)
- Friend(s)
- Romantic partner
- Suspected trafficker/pimp

- Guardian
- Family/relatives
- Street gang
- Other

23g. Did that person(s) ever give you things like money, drugs or clothes?

- Refused to answer
- Yes
- No

23h. Did you leave town while you were away from home?

- Refused to answer
- No
- Yes

If yes, enter the town or city AND state where the youth went:

City:

State: -

23i. While you were away, did anyone you were with not allow you to go back home?

- Refused to answer
- No
- Yes

If yes, enter NAME OF THE PERSON:

Person Name: -

Read to the youth:

Sometimes, people find themselves in situations where they feel unsafe, threatened, controlled or even tricked into doing something they didn't want to do. I am going to ask you a few questions about things that might have made you feel unsafe, threatened, controlled or tricked into doing something you didn't want to do.

23j. While you were away, did you worry about what you would eat, where you would sleep or where you were safe?

- Refused to answer
- No
- Yes

If so, tell me about what you ate and where you slept?

23k. While you were away, was there anything that made you scared or uncomfortable?

- Refused to answer
- No
- Yes

If so, tell me about that?

23l. Sometimes, young people who are away from home can be taken advantage of and asked to do sexual activities in exchange for something of value. These activities can include dancing, stripping, posing for photos, or sex of any kind. While you were away, did anyone ever ask you to do something like that?

- Refused to answer
- No
- Yes

If so, what activities were performed or what items of value were received?

Section F – Sexual Exploitation/Coercion/Control/Medical Needs

Read to the youth:

I'd like for you to think about the past 12 months and times when you have been away from home.

24. In thinking about your past experiences, has anyone ever locked doors or windows or anything else to stop you from leaving work or home?

- Refused to answer
- No
- Yes

25. Has anyone ever forced you to get or use false identification, like a fake ID or fake green card?

- Refused to answer
- No
- Yes

26. Has anyone ever pressured you to touch someone physically or sexually when you didn't want to?

- Refused to answer
- No
- Yes *(If 'yes' ask 26a.)*

26a. Did this happen to you when you were away?

- Refused to answer
- Yes
- No

If 'no', when it occurred?

27. Has anyone ever asked/made you do anything sexually that you didn't want to do?

- Refused to answer
- No
- Yes *(If 'yes' ask 27a.)*

27a. Did this happen to you when you were away?

- Refused to answer
- Yes
- No
If 'no', when it occurred?

28. Has anyone in your home ever done anything sexually to you that you didn't want?

- Refused to answer
- No
- Yes *(If 'yes' ask 28a.)*

28a. Did this happen to you when you were away?

- Refused to answer
- Yes
- No
If 'no', when it occurred?

29. Have you or someone else received something of value like money, a place to stay, food, clothes, gifts, favors, or drugs in exchange for you to perform a sexual activity?

- Refused to answer
- No
- Yes *(If 'yes' ask 29a.)*
If 'yes', what was the item of value?

29a. Did this happen to you when you were away?

- Refused to answer
- Yes
- No
If 'no', when it occurred?

30. Did you need to be treated for any medical issues while you were away from home?

- Refused to answer
- No *(If 'no' skip to Item 31)*
- Yes *(If 'yes' ask Items 30a through 30b below.)*

30a. What medical issues did you experience while you were away? (Check all that apply)

- Refused to answer
- Sexually transmitted infection/disease

- Chronic condition (e.g., asthma, chronic pain, diabetes, etc.)
- Acute condition (e.g. cold, flu, pneumonia, etc.)

- Pregnancy (pregnancy termination, pre-natal care or post-natal care)
- Physical injuries (cuts, bruises, broken bones, etc)

30b. Where you admitted to a hospital while you were away from home?

- Refused to answer
- No
- Yes

What facility?

31. Were you seen by a doctor, nurse, or any medical personnel for medical needs while you were away from home?

- Refused to answer
- No
- Yes

If 'yes', what was the name of the facility or medical professional?

Screener, close out the interview by saying the following to the youth:

I want to thank you for being open with me and answering these questions. Do you have any questions, or is there anything that you would like to talk about?

Section G – Parent/Guardian Information

(DO NOT READ TO YOUTH AND DO NOT ASK THE PARENT/GUARDIAN QUESTIONS IF THERE IS CONCERN THAT THE PARENT OR GUARDIAN IS TRAFFICKING THE YOUTH)

Section G is to be completed by the Screener.

32. Did you speak with the child's parent(s) or guardian(s)?

- No
- Yes *(If 'yes', then ask parent/guardian Items 33 through 36)*

If 'yes', to whom did you speak?

33. Does the parent/guardian report that youth has a cell phone that a third party/trafficker pays for or might be paying for?

- No
- Yes
- Parent/guardian gives different answers. Specify the response.

34. Does the parent/guardian report that youth returns home from running away with hair/nails done, new clothing, tattoos/branding or money that were not provided by the parent/guardian?

- No
- Yes
- Parent/guardian gives different answers. Specify the response.

35. Does parent/guardian report that youth has internet postings or text/cell phone messages that indicate youth may be exchanging sex for something of value to him/her?

- No
- Yes
- Parent/guardian gives different answers. Specify the response.

36. If youth has a tattoo of someone else's name, does guardian verify this person is who youth says the person is?

- No
- Yes
- Parent/guardian gives different answers. Specify the response.

Section H – Post-Screening Assessment (DO NOT READ TO YOUTH)

Section H is to be completed by the Screener.

37. Has youth ever had any contacts or visits from the Department of Child Services?

- No
- Yes

38. Did you observe any nonverbal indicators of past victimization? (If so, explain)

Examples include: Child may not cooperate with the FCM during the interview (e.g. provide wrong information about identity and living situation) and child may have a heightened sense of fear and distrust of authority.

39. Did you observe any indicators that the youth's responses may have been false? (If so, explain)

40. Indicate the likelihood that the youth is a victim of trafficking:

- Definitely not
- Likely not
- Not sure

- likely is
- Definitely is

41. Provide at least three reasons for your answer in Item 40

Reminder: If you have knowledge that the youth is a victim of human trafficking, please call the Indiana Child Abuse and Neglect Hotline at 1-800-800-5556.