Region 6

Biennial Regional Services Strategic Plan

SFY 2019 - 2020

February 2, 2018

INDIANA
DEPARTMENT OF
CHILD
SERVICES

Biennial Regional Services Strategic Plan

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I. Biennial Regional Services Strategic Plan

SFY 2019-2020

Region 6

Regional Coordinator: Sue Cramer

Approved by:

Elizabeth Learned
Regional Manager: _____ DATE: 12/5/2017

Katie Craft
Regional Finance Manager: Katherine A Craft DATE: 12/5/2017

Signatures of Regional
Service Council Members
Voting on BRSSP: DATE: 11/30/2017

Jamie Brown	
Brian Brown	
Judy Hobbs	
Stacy Morgan	

Terry J. Stigdon
Director: _____ DATE: 2/24/2018

II. Regional Service Council Members:

Region 6 Regional Service Council

Name	Position	Agency
Bault, Cassie	FCM Supervisor	Miami County DCS
Burns, Leo	Judge	Cass County Circuit Court
Brown, Brian	Local Office Director	Cass County DCS
Brown, Jamie	Local Office Director	Fulton County DCS
Cramer, Susan	Regional Services Coordinator	Region 6 - DCS
Cunningham, Mary	Local Office Director	Miami County DCS
Hamilton, Paige	Executive Director	SCAN, Inc
Hobbs, Julie	Local Office Director	Wabash County DCS
Learned, Elizabeth	Regional Manager	Region 6 - DCS
Lee, Christopher	Judge	Fulton County Circuit Court
McCallen, Robert	Judge	Wabash County Circuit Court
Morgan, Stacey	Local Office Director	Howard County DCS
Siccardi, Bobbi		Community Howard
Snyder, Nicole	Family Case Manager	Miami County DCS
Spahr, Tim	Judge	Miami County Circuit Court
Timmons, Tracy	FCM Supervisor	Cass County DCS
Weaver, Terri	Detective	Wabash County Circuit Court

III. Biennial Regional Services Strategic Plan 2019-2020 Overview

The Indiana Department of Child Services (DCS) was created as a standalone agency in 2005, charged with administering Indiana's child protection services, foster care, adoption and the Title IV-D child support systems throughout the state of Indiana. After the Department was formed, DCS engaged national and local organizations for guidance and support to improve the system that cares for its abused and neglected children. This collaboration marked the beginning of Indiana's practice reform efforts. Over the course of the last 10 years, DCS has launched a number of initiatives to improve the manner in which child welfare is administered in Indiana, including the DCS practice model (Teaming, Engaging, Assessing, Planning and Intervening; TEAPI) and the Safely Home Families First Initiative.

In 2008 State legislation was passed that added the requirement for a Biennial Regional Services Strategic Plan that would be tailored toward the provision of services for children in need of services or delinquent children. The "Biennial Plan" incorporates the "Early Intervention Plan" and the "Child Protection Plan" as well as new requirements under the Biennial Plan. The Early Intervention Plan was a focus on programs and service to prevent child abuse and neglect or to intervene early to prevent families from entering the child welfare or delinquency system. The Child Protection Plan describes the implementation of the plan for the protective services of children. It included the following information: Organization; Staffing; Mode of operations; Financing of the child protection services; and the provisions made for the purchase of services and interagency relations.

The Regional Services Council is the structure responsible for this Biennial plan. The purpose of the Regional Services Council is to: Evaluate and address regional service needs, regional expenditures, and to Serve as a liaison to the community leaders, providers and residents of the region.

The Biennial Plan includes an evaluation of local child welfare service needs and a determination of appropriate delivery mechanisms. Local service providers and community members were represented in the evaluation of local child welfare service needs. A survey was sent to local providers as well as interested community partners. In addition, the regional services council conducted a meeting to take public testimony regarding local service needs and system changes.

The Department of Child Services began the process of analyzing service availability, delivery and perceived effectiveness in the summer of 2017. The planning process to develop the Plan involved a series of activities led by a guided workgroup composed of representatives from the Regional Service Council and others in the community. The activities included a needs assessment survey, public testimony, and review of relevant data. While DCS has several other means with which to determine effectiveness of DCS provided services, such as Federal Child and Family Services Review measures, practice indicator reports, Quality Service Reviews (QSRs) and Quality Assurance Reviews (QARs), this process took that information and looked at it through a contracted service lens. The workgroup considered this information in conjunction with the needs assessment, previous service utilization and public testimony to

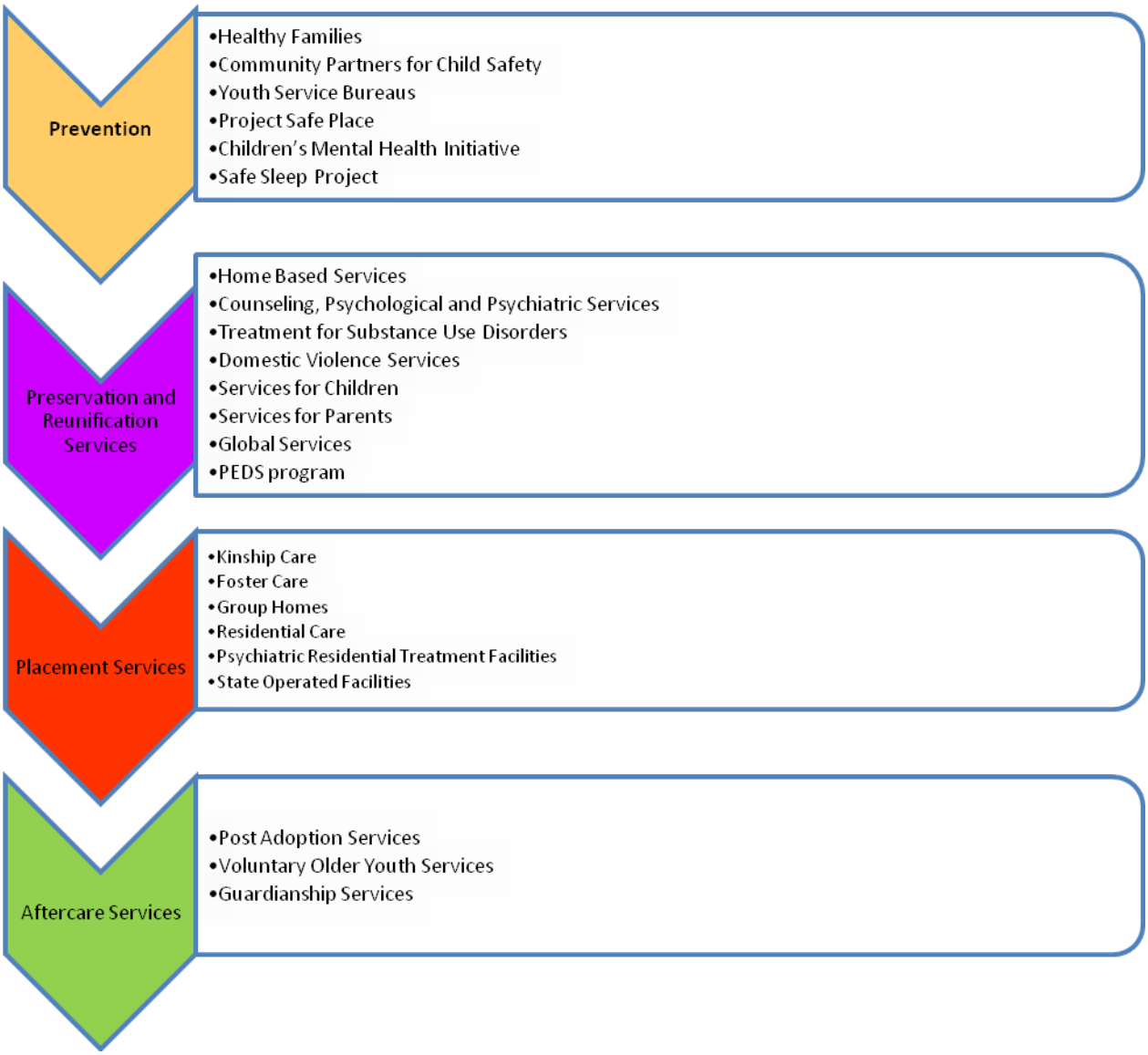
determine the appropriate utilization of available services and to identify gaps in service. As a result, the workgroup developed a regional action plan to address service needs and gaps that are specific to the region. In addition, to address known statewide system issues, the Regional Action Plan includes specific action steps to address the following areas:

1. Prevention Services
2. Maltreatment After Involvement
3. Permanency for children in care 24+ months
4. Substance Use Disorder Treatment

Biennial Regional Services Strategic Plans were approved by the Regional Service Council and subsequently submitted to the Director of the Department of Child Services on February 2, 2018 for final approval.

IV. Service Array

The Indiana Department of Child Services provides a full continuum of services statewide. Those services can be categorized in the following manner:



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 state-wide network. This fund supports 31 Youth Service Bureaus to provide a range of programs including: Teen Court, Mentoring, Recreation Activities, Skills Training, Counselling, Shelter, School Intervention, and Parent Education.

Project Safe Place

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

Community-Based Child Abuse Prevention

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

Healthy Families Indiana (HFI)

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

Community Partners for Child Safety (CPCS)

The purpose of 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 Sunny Start Healthy Bodies, Healthy Minds Initiative at the state agency level to achieve MIECHV goals.

The Indiana MIECHV funding supports direct client service through the expansion of two evidenced-based home visiting programs, Healthy Families Indiana (HFI) and Nurse Family Partnerships (NFP), to pair families—particularly low-income, single-parent families—with trained professionals who can provide parenting information, resources and support during a woman's pregnancy and throughout a child's first few years of life. These models have been shown to make a real difference in a child's health, development, and ability to learn and include supports such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance.

Children's Mental Health Initiative

The Children's Mental Health Initiative (CMHI) provides service access for children with significant mental health issues who have historically been unable to access high level services. 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. 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 mirrors that of Medicaid paid services under the Children's Mental Health Wraparound and includes:

- DSM-V 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.

Preservation and Reunification Services

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

Home Based Services

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

Counseling, Psychological and Psychiatric Services

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

Treatment for Substance Use Disorder

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

Domestic Violence Services

- Batterers Intervention Program
- Victim and Child Services

Services for Children

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

Services for Parents

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

Global (Concrete) Services

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

These services are provided according to service standards found at:

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

Services currently available under the home based service array include:

Home Based Services			
Service Standard	Duration	Intensity	Conditions/Service Summary
Homebuilders ® (Must call provider referral line first to determine appropriateness of services) (Master's Level or Bachelors with 2 yr experience)	4 – 6 Weeks	Minimum of 40 hours of face to face and additional collateral contacts	**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
Home-Based Therapy (HBT) (Master's Level)	Up to 6 months	1-8 direct face-to face service hrs/week (intensity of service should decrease over the duration of the referral)	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.
Home-Based Casework (HBC) (Bachelor's Level)	Up to 6 months	direct face-to-face service hours/week (intensity of service should decrease over the duration of the referral)	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.

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

Comprehensive Home-Based Services

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

In addition, Family Centered Treatment is being supported by DCS as a model of

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

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
FCT – Family Centered Therapy	● Families that are resistant to services ● Families that have had multiple, unsuccessful attempts at home based services ● Traditional services that are unable to successfully meet the underlying need ● Families that have experienced family violence ● Families that have previous DCS involvement ● High risk juveniles who are not responding to typical community based services ● Juveniles who have been found to need residential placement or are returning	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.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
	from incarceration or residential placement	
MI – Motivational Interviewing	● 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	● 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.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
AFCBT – Alternative Family Cognitive Behavioral Therapy	● 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	● 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.
CPP – Child Parent Psychotherapy	● 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	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.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
IN-AJSOP	Children with sexually maladaptive behaviors and their families	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
Intercept	Children of any age with serious emotional and behavioral problems	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.

Sobriety Treatment and Recovery Teams

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 Family Mentor is paired with a Family Case Manager and they work the case in conjunction with one another in a dyad structure. Monroe County has 2 dyad. There is a site Treatment Coordinator. DCS has seen promising results from

the program.

Trauma Assessments, TF-CBT, CPP

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

Child Parent Psychotherapy (CPP) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) are two of the possible models that could be utilized. DCS has trained a cohort of 28 therapists to provide Child Parent Psychotherapy. This first cohort of trained therapists includes 9 teams of 3 therapists from within the CMHC network and one additional DCS clinician. These therapists completed their training in May 2014, but will receive another year of consultation through the Child Trauma Training Institute as they begin to fully implement the model. DCS began offering training to a second cohort of clinicians to ensure service availability for children in need. DCS has trained approximately 300 clinicians throughout the state to provide TF-CBT. These agencies are both CMHC's and community-based providers and will ensure that TF-CBT is available for children and families in need.

Successful Adulthood: Older Youth Services

Indiana's Older Youth Services 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.

V. Available Services:

Region 6 is predominately a rural region. There are providers in each county but some of the contracted providers do not serve the entire region. The number of assessments and CHINS cases related to substance abuse continues to increase. In the region there are limited providers of substance use disorder assessment and treatment. The region is also limited in providers of specialized services for youth with developmental needs such as Autism.

Appendix A shows all contracted services in the region as well as the most frequently used services, expenditures by service, and the projected budget for SFY 2019 and 2020.

VI. Needs Assessment Survey

Each region in the state conducted a needs assessment survey of individuals who have knowledge and experience with child welfare and juvenile probation services. During spring and summer of 2015, the surveys were administered to Family Case Managers (FCMs), service providers, and other community members to measure their perceptions of 26 services in their communities in terms of need, availability, utilization and effectiveness. The intent of the survey was to evaluate local service needs. Results of the survey were used to assist in determining the regional child welfare and juvenile probation service needs, utilization and the appropriate service delivery mechanisms. Results of the surveys are located in Appendix B. Look at the appendix to view the highest available/utilized services and those that are lowest in availability.

VII. Public Testimony Meeting

The Public Testimony meetings were advertised on the DCS web page titled “Biennial Plan Public Notices” at least 48 hours in advance of the hearing (excluding holidays and weekends). The web page included the purpose, dates, times and locations for each of the meetings throughout all 18 DCS Region’s. Additionally, the Public Testimony meetings were advertised in each of the local offices and included the purpose, dates, times and locations for each of the meetings throughout all 18 DCS Region’s. Email notifications of the public meetings were sent to all contracted providers and other community groups.

The Public Testimony meeting for the Child Protection Plan/Biennial Regional Services Strategic Plan was held on Thursday, November 30, 2017 at 3:00pm at 425 W. Main St., Peru, IN 46970. A summary of the testimony is provided in Appendix C.

The following persons were present to receive public testimony:

Liz Learned, Regional Manager; Katie Craft, Regional Finance Manager; Julie Hobbs, Local Office Director Wabash County; Mary Cunningham, Local Office Director Miami County;

Stacey Morgan, Local Office Director Howard County; Cassie Bault, FCM Supervisor Miami County; Jamie Brown, Local Office Director Fulton County; Sue Cramer, Regional Services Coordinator Region 6; Anne Ecklebarger, Clerical Miami County.

There was no public testimony provided.

VIII. Summary of the Workgroup Activities

Workgroups composed of representatives from the Regional Service Council and others in the community were held to review current data, information gained through public testimony, as well as the action plans created for the 2016 Biennial. The workgroups determined what items, if any, from the previous action plan have been accomplished and modified the plans accordingly for each topic area.

The topics of discussion included:

1. Prevention Services

Workgroup met and discussed Prevention Services in regards to the biennial plan. A review and revision of action steps and of identified tasks was completed. Five action steps were identified as noted below in regards to Prevention Services and the Biennial Strategic Services Plan: 1) Host a Prevention Summit; 2) Discussion around continued efforts to communicate and sustain the group's communication and efforts in carrying out associated tasks in regards to the prevention (ongoing); 3) There was also discussion regarding focusing on Domestic Violence and the lack of services available for treatment options; 4) Discussion was held addressing drug education and awareness, which includes locating drug action plans for each county and identifying educational programs for the schools and communities; and 5) Lastly, Suicide prevention was identified as a preventative for improvement.

2. Maltreatment After Involvement

Workgroup discussion included the following topics: Prior measurable outcomes and new ideas surrounding reducing repeat maltreatment; Ongoing training on risk assessments; Lack of training in cohort regarding risk assessments; Discussing potential risks during clinical supervision; Utilizing community resources to reduce the chances of repeat maltreatment; Informing families of community resources and availability across the region; creating and maintaining a regional community resources guide to provide to families at assessment closure.

3. Permanency for children in care 24+ months

During work group we discussed the importance of communication and all individuals working in a case to be working toward the same goals and outcomes. This lead the group to focused on Child Family team meetings as the main outlet for communication in a case. Work group reviewed the numbers of CFTM's held every 3 months and 6 months in a case. Regional average for cases with a CFTM in 6 months was 87.93% and CFTM in last 3 Mo 68.76%. Group also reviewed the Length of time since beginning of a case (LTBC) for region 6 and the top 10% of cases that have the longest time since the beginning of the case. The top 10% were identified as those children that are the most in need of permanency. The Measurable Outcome, Action steps and task that were identified for permanency was derived from this discussion.

4. Substance Use Disorder Treatment

The workgroup for Substance Use Disorder Treatment met on October 20th and November 17th at Wabash County DCS office. The workgroup consisted of representatives from Four County Counseling Center, Community Partners, the YWCA, and DCS. The discussion included how to increase not only providers within the region, but also how to increase specific treatment services such as detox, inpatient, and housing with supportive services for women and children. The workgroup also discussed the previous plan and the improvements that had been made based upon those recommendations. The overall plan consisted of identifying service providers outside of Region 6 that are already providing the needed services and finding out what it would take to get them to expand their services to cover Region 6.

The data considered are included in Appendix A: Service Array and Appendix D: Additional Regional Data

IX. Regional Action Plan

Overview

The Regional Action Plan presented in this section is based on all data collected that addressed regional service needs. These data sources assessed the following areas:

- Service availability (through the needs assessment survey)
- Service effectiveness (through the needs assessment survey)
- Public perception of regional child welfare services (through public hearings)
- Quality Service Review Indicators and Stress factors (4 rounds)
- Community Partners for Child Safety prevention services
- Regional services financing
- Regional workgroup determination of service available/accessibility
- Additional input provided by the workgroup

These data sources were considered by regional workgroups to determine service needs that were to be prioritized by a region for the relevant biennium. To address these service needs, regional workgroups formulated action steps which included distinct, measurable outcomes. Action steps also identified the relevant parties to carry out identified tasks, time frames for completion of tasks, and regular monitoring of the progress towards task completion.

Measurable Outcome for Prevention Services:		By June 2020 develop a collaborative / consortium to utilize prevention funds and resources to best meet the needs in the region		
Date of Workgroup:		10/20/17 and 11/17/17		
Workgroup Participants:		Elizabeth Learned, Julie Hobbs, Brian Brown, Deb Dawes, Whites, Jane Williams, Youth Services Bureau, Connie Shapiro, Whites, Paige Hamilton, SCAN, Elizabeth Avery, 4ccc, Dee, SCAN.		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Host a prevention summit	Create a RFP to identify an entity to do the following	LOD, regional service council, scan	Feb 2018	March 2018
	Send RFP to region 3-7 providers	LOD provided meetings with providers	April 2018	June 2018
	Sent summit RFP to state level providers, DV task force, Drug Task Force, Suicide Prevention, System of Care	Paige Hamilton/SCAN	April 2018	June 2018
	Review other regions and their prevention activities	Regional management team	Feb 2018	June 2018
	Find influential people in the communities to be involved in the summit	Regional management team	Start 2018	October 2018
Continual efforts to communicate and sustain the group's efforts around Prevention	Every other month meetings with meaningful agenda items	Regional management team	ongoing	ongoing

In the next community partners RFP, Domestic violence will be one of the areas of focus	Research programs that are focused on prevention based domestic violence programs that involve school aged youth	SCAN, regional management team	3 months to identify programs RFP April 2018	Sept 2018
	In service training on family stress factors and ACEs will be available to providers.	SCAN, LOD's	12 months	Oct 2018
	Each local directors meet with local county providers of ace's training and evaluate what that training looks like at the local level	LOD's	Feb 2018	April 2018
Drug education	Directors get with local programs to identify what we have and how to partner with them	LOD's	Feb 2018	April 2018
	Look to see if each county has a drug action plan	LOD's	Feb 2018	April 2018

	Identify evidence based educational programs for the schools and community (example life skills training)	LOD's, Community Partners, Regional Providers	Feb 2018	May 2018
	Reach out to Probation, LEA, community corrections on working with parents	LOD's	March 2018	June 2018
	"Call When Ready Cards" Identify provider RFP	Youth Services Bureau, LOD, SCAN	Feb 2018 March 2018	June 2018 June 2018
Suicide Prevention	Directors get with local programs to identify what we have and how to partner with them	LOD	Feb 2018	July 2018
	Adequate QPR (question, pursued, refer) instructors in each county	Youth Service Bureau, 4ccc	Sept 2018	December 2018

	Evidence based suicide prevention curriculum for each county	Youth Service Bureau, 4ccc	July 2018	December 2018
	Suicide prevention Cards	Per the provider for suicide prevention in each county	Sept 2018	December 2018
Child Maltreatment	RFP for community provided education on Child Maltreatment, Parenting	SCAN	April 2018	September 2018

Measurable Outcome for Maltreatment after Involvement:	Region 6 will reduce repeat maltreatment of children after DCS involvement to (5%) not having a 2nd incident of maltreatment during the first 12 months.
Date of Workgroup:	10/20/17 and 11/17/17
Workgroup Participants:	Mary Cunningham, LOD Miami County DCS; Sue Cramer DCS Services and Outcomes; Jamie Brown, LOD Fulton County DCS; Leticia Timmel, 4 County Counseling; Stacey Morgan LOD Howard County DCS

Action Step	Identified Tasks	Responsible Party	Time Frame	Date of Completion
Improve assessment worker effective use of risk assessment tools.	Each local office will begin discussing a process of implementing biannual review of the of the safety and risk assessment tools. Each local office will utilize risk assessments tools in all assessments through clinical supervision. Utilize wrap around program for high need youth.	RM, LOD, FCMS, Villages, Four, County Counseling	January 2018	June 2018
Enhance the effective use of quality clinical supervision in the assessment phase.	Utilizing vision alignment, region 6 will ensure all supervision has a comprehensive understanding of risk assessment tools by holding an open discussion quarterly regarding risk assessment tools. Incorporate ongoing review of risk assessment tools in clinical supervision.	Regional Manager, LOD's FCMS	March 2018	Ongoing
Develop and maintain a Regional Resource Guide/database to be distributed to all families.	Convene a work group with a representative from each local office representing the interests and resources available within their community. This work group will compile a list of community resources within the region and develop a Resource Guide/database – for identified ongoing needs for the family.	Regional Manager, LOD, FCMS, clerical staff	January 2018	Ongoing

	Within the management team, identify an individual who will ensure that the resource guide is updated and distributed biannually.			

Measurable Outcome for Permanency for children in care 24+ months:		By June of 2020 increase the percentage of CFTMs completed for every child in 6 months from 87.93 to 99% and CFTMs completed every 3 months from 68.76 to 80%. Focusing on those children that have been in out of home placement beyond the 24 month time frame assuring they have CFTMs every 3 months at 100%. Which will reduce the length of time since the beginning of a case from 426.4 days to 360 days.		
Date of Workgroup:		10/20/17 and 11/17/17		
Workgroup Participants:		Steve Hatland, Whites, Connie Shapin, Whites, Bethany Schoenradt, 4ccc, Letecia Timmel, 4ccc, Brian Brown		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Increase the # of CFTMs held in a case	Monitor the Monthly CHINS and IA CFTM status report breaking down to every 6 months and 3 months	LOD-Supervisors	Feb 2018	June 2020
	Utilize the Length of time since beginning of a case (LTBC) report to identify permanency needs	LOD-Supervisors	Feb 2018	June 2020

	Utilize the 15/22 with and without termination to assure TPR is filed timely	LOD-Supervisors	Feb 2018	
	Review Monthly with FCM's in all staff meetings	LOD-Supervisors	Feb 2018	
	Monthly review of progress on the CFTM plan with FCM on all cases beyond 24 months using clinical supervision	Supervisors	Feb 2018	
Increase the quality of CFTMS	Utilize Clinical Supervision during CFTMS	Supervisors	March 2018	
	FCMS to attend CFTMS on all cases over 24 months	Supervisors	April 2016	
	Utilize local and regional peer coach to assist in cases that exceed 24 months	Local and regional peer coach	April 2018	
	Increase local training on CFTM quality and team composition	Local and regional peer coaches	April 2018	
Seek out assistance when barriers are presented in a CFTM	Seek out guidance on legal barriers to permanency including incarcerated parents	DCS legal staff	April 2018	

Measurable Outcome for Substance Use Disorder Treatment:		To increase providers of comprehensive treatment options to meet families individualized needs by 2020.		
Date of Workgroup:		10/20/17 and 11/17/17		
Workgroup Participants:		Paige Hamilton, SCAN; Nicole Hyatt-Drang, Four County; Susan Cramer, DCS Services and Outcomes; Patty Godfroy, Mary Cunningham LOD Miami County DCS; Jamie Brown, LOD Fulton County DCS		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Assess and survey unmet needs related to Substance Use Disorder Treatment	Review RM appeals completed for non-contracted substance abuse services starting 4th Quarter of 2017 and ending 1st Quarter 2018 to assist in determining where unmet service needs exist.	LOD's, Supervisors, RM	April, 2018	July, 2018
	Have a work group to identify current contracted providers outside of the region.	Community Partners LOD or designee; Regional Services Coordinator	August, 2018	September, 2018
	Reach out to current contracted providers outside	LOD's, Supervisors	October, 2018	December, 2018

	of Region 6 to expand services to region 6.			
Increase current service providers in region 6 for detox, inpatient, and after-care case management using the RFP process.	Convene a work group to identify potential providers to expand services. Schedule meetings with identified providers to begin discussion of expansion of services to region 6.	RM, LOD's, Regional Services Coordinator Work Group	January, 2018 July, 2018	June, 2018 December, 2018

X. Organization, Staffing and Mode of Operation

a. Describe the number of staff and the organization of the local child protection services (CPS) including any specialized unit or use of back-up personnel. **NOTE: The term CPS refers only to the reporting and assessment of child abuse and neglect**

1.	27		Number of Family Case Managers assessing abuse/neglect reports full time.
2.	40		Number of Family Case Managers with dual responsibilities; e.g., 50% CPS assessments and 50% ongoing services or 20% CPS and 80% ongoing services
3.	1		Number of Family Case Manager Supervisor IVs supervising CPS work only
4.	9		Number of Family Case Manager Supervisor IVs supervising both CPS work and ongoing services e.g., 50% CPS and 50% ongoing services
5.	6		Number of clerical staff with only CPS support responsibilities
6.	9		Number of clerical staff with other responsibilities in addition to CPS support
7.	Y ☒	N ☐	Does the Local Office Director serve as a line Supervisor for CPS?

b. Describe the manner in which suspected child abuse or neglect reports are received.

1.	Y ☒	N ☐	Is the 24 hour Child Abuse and Neglect Hotline (1-800-800-5556) listed in your local directories with the emergency numbers as required by law?
2.	All calls concerning suspected child abuse and neglect are received through the Indiana child abuse and Neglect Hotline at 1-800-800-5556, including times when the local DCS offices are closed.		

c. Describe your current system of screening calls and reporting allegations of child abuse and neglect. (Attach any tools you presently use if helpful.)The Indiana Child Abuse and Neglect Hotline (hereinafter "Hotline") receives all calls, faxes, e-mails, etc. from inside and outside the state regarding the suspected abuse and neglect of children occurring within the state of Indiana. Intake Specialists, most of whom have been Family Case Managers, gather the information from each caller and provide a verbal recommendation to parents, guardians, and professionals. The Intake Specialist bases that recommendation on current laws, policies, and practices regarding abuse or neglect. The Intake Specialist routes their completed report to a Hotline supervisor for approval via MaGIK. The Hotline supervisor can make edits/changes within the MaGIK system or send the report back to the Intake Specialist for changes. Once approved by the supervisor, all reports with a recommendation of assess or screen out are routed to the local county's queue for final approval. In the county queue, the local county has the ability to agree with or disagree with the Hotline recommendation. If the local county changes the decision, the local county will notify individuals who received a Hotline recommendation of that decision change. If an immediate response to a report is required, the Intake specialist calls the local office via telephone during regular business hours. After hours, the Intake Specialist provides the on call designee essential information needed to immediately initiate the assessment. The written documentation is then forwarded via MaGIK to the local office's county queue. From 4:30-9:30p, Monday-Thursday, the on-call designee is notified via telephone of all 24 hour response time reports. Upon Hotline Supervisor approval, 24 hour response time reports will be routed to the county queue. From 9:30p-7:00a Sunday-Thursday, the Hotline will contact the on-call designee **ONLY** for reports requiring an immediate initiation.

From Friday at 4:30 PM to Sunday at 9:30 p.m., the Hotline will contact the on-call designee on all 24 hour reports and Information/Referrals involving open cases. The Hotline will follow weekend processes for contacting on-call on Holidays.

All reports approved to a county queue will be emailed to that county's distribution list by MaGIK. All reports approved from the county queue with a decision of assess will automatically be e-mailed to that county's distribution list by MaGIK. Reports approved by the local office with a decision of screen out, can be changed after closure to assess.

d. Describe the procedure for assessing suspected child abuse or neglect reports:

1.	Please indicate when abuse assessments will be initiated		
	a.	Within 24 hours of complaint receipt. See Chapter 4, Section 38 of the Child Welfare Manual (Initiation Times for Assessment).	Y ☒
			N ☐
	b.	Immediately, if the child is in imminent danger of serious bodily harm.	Y ☒
			N ☐
2.	Please indicate who will assess abuse complaints received during and after work hours. (Check all that apply)		
	a.	CPS	☐
	b.	CPS and/or Law Enforcement Agency (LEA)	☒
	c.	LEA only	☐
3.	Please indicate when neglect assessments will be initiated. See Chapter 4, Section 38 of the Child Welfare Manual (Initiation Times for Assessment).		
	a.	Immediately, if the safety or well-being of the child appears to be endangered.	Y ☒
			N ☐
	b.	Within a reasonably prompt time (5 calendar days).	Y ☒
			N ☐
4.	Please indicate who will assess neglect complaints received during and after working hours. (Check all that apply)		
	a.	CPS only	☐
	b.	CPS and/or LEA	☒
	c.	LEA only	☐

e. Describe the manner in which unsubstantiated child abuse or neglect reports are maintained. Refer to Indiana Child Welfare Manual Chapter 2 Section 13, Expungement of Records.

Please indicate if you have received and are following the "Record Retention Guidelines."	Y ☒
	N ☐

f. Describe the policy and procedure you follow when receiving complaints of institutional child abuse/neglect from the Hotline. State assessments: Please describe procedures for reporting allegations in state institutions and facilities. Refer to Indiana Child Welfare Manual Chapter 4, Section 30 Institutional Assessments:

1. **Statewide Assessments:** The Indiana Department of Child Services Hotline receives and processes reports of possible Child Abuse and/or Neglect (CA/N) that occurred in an institution setting located within the state. Licensed residential placement providers are mandated reporters and are required to report CA/N incidents and allegations. The Hotline staff will determine if the incident/allegation rises to the level of legal sufficiency to warrant further assessment and provide their recommendation to the Institutional Child Protection Services unit (ICPS). If the CA/N report is screened in for assessment, the ICPS unit will assess allegations of abuse and neglect in group homes, residential treatment centers, emergency shelter care centers, day cares, schools, correctional facilities, etc. Allegations involving a foster home will be assessed by the local DCS office staff where the alleged incident occurred. The ICPS Director will assign the new report to the ICPS assessor in the respective Super Region for follow up. There are currently ten (10) ICPS Family Case Managers based in local DCS offices throughout the state.
   The ICPS unit handles the 24 hour and 5 day response times. In cases where immediate attention is warranted, ICPS staff works in tandem with the Hotline and DCS local offices to ensure one hour response times are achieved and child safety is established. All reports are forwarded to the appropriate licensing/ governing bodies at the time of report and again at completion for further review. Reports that are screened out, are forwarded to the appropriate licensing people when applicable.

2. **Institutional Abuse or Neglect:** Institutional Child Protection Services (ICPS) for the Department of Child Services assesses allegations of abuse or neglect regarding children in an Institutional setting, when the alleged perpetrator is responsible for the children's care and safety. Reports are received through the statewide hotline and assessments are initiated within the assigned timeframes (I hour, 24 hour or 5 day) to determine the safety of the child.

Upon completion of the assessment, ICPS will make a determination of the allegations to be either unsubstantiated or substantiated. Further services, referrals, safety plans may take place during and at the conclusion of the assessment to continue to ensure child's safety and reduce future risk. ICPS assessments are completed by the ICPS unit, consisting of Family Case Managers stationed throughout the state. The Institutional Child Protection Service (ICPS) Unit will conduct an assessment of a report of Child Abuse and/or Neglect (CA/N) if the allegations state the incident of CA/N occurred while the child was in the care of one of the following:

a. Residential Facility (i.e. DCS licensed Child Caring Institutions, Group Homes and Private Secure Facilities);
b. School;
c. Hospital;
d. Juvenile Correction Facility;
e. Adult Correctional Facility that houses juvenile offenders;
f. Bureau of Developmental Disabilities (BDDS) Certified Group Home;
g. Licensed Child Care Home or Center;
h. Unlicensed Registered Child Care Ministry; or
i. Unlicensed Child Care Home or Center (see Related Information).

ICPS will NOT conduct assessments involving:

a. Licensed Foster Homes through DCS
b. Licensed Foster Homes through a private agency
c. Fatality or near-fatality assessments regardless of allegations or where said allegations took place.
d. Abandoned infants (IC 31-9-2-0.5, as amended):

XI. Inter-Agency Relations

a. Describe the inter-agency relations and protocols in existence regarding the provision of child protection service. Describe protocols outlining information sharing between DCS, law enforcement and prosecutors.

Each county represented in the region has good working relationships with local law enforcement including the local sheriff's office and state police. There are new directors in four out of the five counties and they are meeting with local agency heads to refine working agreements on how to handle emergencies and sexual abuse cases. In addition the local office directors are working closely with their county prosecutor's office and advocate the needs of our agency.

b. Describe the Community Child Protection Team.

A Community Child Protection Team (CPT) is established in each county. The CPT is a multidisciplinary team comprised of members who reside in or provide services to residents of the county in which the team in formed. The team includes 13 members:

1. DCS Local Office Director (LOD) or designee
2. Two designees of the juvenile court judge

3. The county prosecuting attorney or designee
4. The county sheriff or designee
5. Either: (a) the president of the county executive in a county not containing a consolidated city or the president's designee; or (b) the executive of a consolidated city in a county containing a consolidated city or the executive's designee
6. Director of CASA or GAL program or designee
7. Either: (a) a public school superintendent or designee or; (b) a director of a local special education cooperative or designee
8. Two persons, physicians or nurses, with experience in pediatrics or a family practice
9. Two county residents
10. Chief law enforcement officer or designee

The CPT shall meet at least monthly. The CPT members are bound by confidentiality. The CPT shall receive and review child abuse and neglect cases and complaints. The CPT shall prepare a periodic report regarding the child abuse and neglect reports and complaints reviewed by the team. Additional information on periodic reports can be found in IC 31-33-3-7.

XII. Financing of Child Protection Services

a. List the cost of the following services for CPS only: **(Please do not include items which were purchased with Title IV-B or other federal monies).**

1. List items purchased for the Child Protection Team and costs

2016	2017
No items purchased	No items purchased

2. Child Advocacy Center/Other Interviewing Costs

Region 6	**Total**
Cass	$17,731
Fulton	$8,886
Howard	$33,476
Miami	$18,477
Wabash	$12,498

b. Please provide the annual salary for the following positions and total the salaries for each of the classifications listed below: (Please include all staff with dual responsibilities and estimate and indicate the percentage of salary for CPS time only. For example, if a Family Case Manager works 40% CPS and 60% ongoing child welfare services, use 40% of the salary, the CPS portion. Also, if the Local Director acts as a line supervisor for CPS, include the proper percentage of the salary on the line for Family Case Manager Supervisors. (**Attach a separate sheet showing your computations.))**

Region 6

	Caseworkers			**FCM Supvsr.**			**Local Office Dir**			**Clerical**	
	2016	2017		2016	2017		2016	2017		2016	2017
Cass	38,537.36	38,842.27		46,604.86	47,536.97		51,075.70	51,075.70		26,503.10	0.00
Fulton	37,701.56	38,489.98		42,374.80	43,222.40		50,956.36	51,624.33		23,341.89	23,808.72
Howard	36,958.97	37,933.55		42,678.48	43,327.18		60,393.06	58,139.38		26,388.90	29,774.81
Miami	38,807.09	39,400.50		47,506.55	49,114.26		54,104.70	0.00		29,493.75	30,083.69
Wabash	35,888.44	36,291.37		54,965.30	56,064.58		0.00	52,032.24		26,773.37	27,308.84
Average	37,578.68	38,191.53		46,826.00	47,853.08		54,132.46	53,217.91		26,500.20	27,744.02
Fringe	1.2375	1.2375		1.2375	1.2375		1.2375	1.2375		1.2375	1.2375
Total	46,503.62	47,262.02		57,947.17	59,218.18		66,988.91	65,857.17		32,794.00	34,333.22
Insurance	12,204.00	12,204.00		12,204.00	12,204.00		12,204.00	12,204.00		12,204.00	12,204.00
Total	58,707.62	59,466.02		70,151.17	71,422.18		79,192.91	78,061.17		44,998.00	46,537.22
Position #	69	74		10	9		4	4		12	5
Total Salary	4,050,825.88	4,400,485.73		701,511.72	642,799.66		316,771.65	312,244.67		539,976.00	232,686.09

Positions	% of CPS	2017	Positions	% of CPS	2017	Positions	% of CPS	2017	Positions	% of CPS	2017
27	100%	1,605,582.63	1	80%	57,137.75	2	30%	46,836.70	6	100%	279,223.31
10	50%	297,330.12	2	70%	99,991.06	3	20%	46,836.70	3	40%	55,844.66
24	15%	214,077.68	6	50%	214,266.55				3	25%	34,902.91
6	5%	17,839.81	1	20%	14,284.44				3	10%	13,961.17
67		2,134,830.24	10		385,679.79	5		93,673.40	15		383,932.05

XIII. Provision Made for the Purchase of Services

a. The Indiana Department of Administration's (IDOA) Request for Proposal (RFP) process is used to procure goods and services for Indiana Agencies. A RFP may be utilized to solicit providers that can satisfy the service needs for the Region. IDOA's fair bid process ensures that state agencies gain quality products/services at competitive prices while also ensuring equal opportunity to all qualified vendors and contractors. Additional information regarding RFPs for Community Based Services can be located on the DCS page http://www.in.gov/dcs/3158.htm.