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

November 16, 2016

Mary Beth Bonaventura
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) 2017 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 2017 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 2017 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 2017 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 2016 caseworker visit data must be submitted to the Regional Office by December 15, 2016. 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, Children and Families Program Specialist, at (312) 886-4938 or by e-mail at lois.blackmore@acf.hhs.gov.

Sincerely,

Rafael López
Commissioner
Administration on Children, Youth and Families

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
Charlene Blackmore, Children and Families Program Specialist; CB, Region 5; Chicago, IL

Michael R. Pence, Governor
Mary Beth Bonaventura, Director

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317-234-KIDS
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Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

June 30, 2016

Charlene Blackmore, MSW
Child Welfare Program Specialist
Children's Bureau – Region V
Administration of Children and Families
233 N. Michigan Ave. Suite 400
Chicago, IL 60601

Dear Ms. Blackmore

In accordance with Program Instruction ACYF–CB-PI-16-03, enclosed please find Indiana's 2017 Annual Progress and Services Report (APSR) and request for funding for FFY 2017. This APSR is an update to Indiana's 2015-2019 Child and Family Services Plan (CFSP), submitted on June 30, 2014.

Indiana is requesting consideration for any additional FFY 2017 funding that may become available in PSSF (IVB2) and MCV (IVB2 Caseworker Visits) in the coming year. This is due to a 12.93% increase (2,832 additional cases) from May 2015 to May 2016 in the areas of In Home and Out of Home CHINS and Informal Adjustments. The requested increase is included in the CFS 101-Part I.

The CFSP and previous APSRs can be found on the DCS website under Reports and Statistics at http://www.in.gov/dcs/2329.htm. The 2017 APSR will be added to the website as soon as we receive your approval.

The State of Indiana continues to diligently work toward achieving the goals and objectives outlined in the CFSP. In FFY 2017, the agency will integrate the findings from its recently completed Round 3 of the Child and Family Services Review and continue to partner with stakeholders to further its mission of protecting children from abuse and neglect. If you have any questions or need any additional information with regards to this submission, please do not hesitate to contact me.

Sincerely,

Kyle D. Gaddis
Compliance and Reporting Manager
(317)234-6626
Kyle.Gaddis@dcs.IN.gov

Protecting our children, families and future

Michael R. Pence, Governor
Mary Beth Bonaventura, Director
Indiana Department of Child Services
302 West Washington Street, E306
Indianapolis, IN 46204

INDIANA
CHILD AND FAMILY SERVICES PLAN
2015 - 2019

ANNUAL PROGRESS AND SERVICES REPORT

JULY 1, 2016-JUNE 30, 2017

Submitted to Children's Bureau
Administration for Child and Families
U.S. Department of Health and Human Services
on
June 30, 2016

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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.

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. Ongoing collaboration efforts with the stakeholders mentioned below will continue as Indiana develops any necessary program improvement plans and/or initiatives during FFY 2017 following the Round 3 CFSR completed on June 6-10, 2016.

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**.**

2. Community Mental Health Centers

Meetings with the CMHC Workgroup continue to occur monthly to discuss initiatives and current challenges. DCS and the CMHCs collaborated on a number of projects during 2015-2016. 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 will be 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, currently planning a joint leadership meeting with DCS in August 2016 focusing of 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 hopes to launch a 3rd site in 2016.

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.

For current/upcoming projects, DCS and its CMHC Workgroup completed a 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.

- 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.
- 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 once a month 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. In May 2016, the CJA Task Force completed and submitted its three (3) year assessment that detailed recommendations and findings around Indiana's investigative, administrative and judicial handling of cases of child abuse and neglect. Included in the Task Force recommendations was for DCS to continue to build collaborative community and industry relationships to address gaps in services and develop strategies for effectively addressing identified

needs. The Task Force also reviewed the 2016 APSR for an update on the progress being made toward the stated goals and objectives.

- 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 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. DCS will 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.

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. Sean Keefer from the Office of the Governor (Chair), Loretta Rush, Chief Justice of Indiana, Mary Beth Bonaventura, Director of the Indiana DCS, Representative David Frizzel, and Senator Travis Holdman. 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 Senator Cariln Yoder (Chair), Senator Broden, Hon. Christopher Burnham, 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 ways to evaluate staffing and improve worker retention, human trafficking legislation, and foster care recruitment efforts.

Don Travis, the DCS Deputy Director of Juvenile Justice Initiatives and Support, serves on the Dual Status Children Subcommittee which addresses issues affecting youth who are involved in both the juvenile justice and the child welfare system and children involved in multiple systems.

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.

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.

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, improved newborn screening, and related child health issues.

Sam Criss, DCS Deputy Director of Services and Outcomes, serves on the Substance Abuse and Child Safety Subcommittee. Their mission is to "Explore best practices and evidenced-based research to create positive, lasting outcomes for children who abuse drugs, live in households where drug abuse exists, or who are in need of mental health treatment."

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 is moving into phase 2 of implementing CQI as each provider is responsible for implementing a CQI project.

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, 14 YAB meetings were held with over 75 youth participants. YAB members also participated in the stakeholder interviews as part of Indiana's Round 3 CFSR. The current YAB vendor contract expires on 6/30/16 and DCS will be entering in to a new contract with a vendor to administer the board. This 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 will manage 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.
- 2016 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 Rowlison, 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.

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)

- 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

Licensed Child Placing Agencies

- Improve quality of services provided to children placed in licensed foster home settings.
- Improve relationship and communication between DCS and LCPAs.
- Reasonable and Prudent Parent Standard - DCS held a training with the licensed child placing agency licensing workers on May 2, 2016, related to the reasonable and prudent parent standard. The Reasonable and Prudent Parent standard has been incorporated into the Resource and Adoptive Parent Training (RAPT). DCS also reviewed the implementation of the new statutory requirements with DCS licensed residential providers and licensed child placing agency providers in 2015. DCS is currently planning a computer assisted training to be available to residential and foster care workers to train them on the implementation of the reasonable and prudent parent standard. In addition, DCS will be adding a requirement to the upcoming Master Residential Treatment Services Provider Contract (will be effective 1/1/2017) requiring facilities to designate an individual to implement the reasonable and prudent parent standard. The audit compliance tools for providers review the implementation of the standard by looking at extracurricular activities of the child.

Residential Providers

- Improve access to high quality residential services
- Improve relationship and communication between DCS and residential providers.
- DCS is currently planning a computer assisted training to be available to residential and foster care workers to train them on the implementation of the reasonable and prudent parent standard. In addition, DCS will be adding a requirement to the upcoming Master Residential Treatment Services Provider Contract (will be effective 1/1/2017) requiring facilities to designate an individual to implement the reasonable and prudent parent standard. The audit compliance tools for providers review the implementation of the standard by looking at extracurricular activities of the child.

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

- Education development and implementation of CANS
- Development of reports for evaluation and tracking
- Continuous review of CANS projects such as the Breakthrough Series
- Specialized modification of CANS for DCS including the addition of the Trauma module in 2014.
- 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.
- DCS collaborated with the Center for Child Trauma Assessment and Service Planning (CCTASP) and the Family Informed Trauma Treatment Center (FITT) to promote trauma-focused, family-informed comprehensive assessments and applications in practice with use of the CANS; this was called the Breakthrough Series Collaborative (BSC). The mission of the BSC was to assist DCS with the implementation of CANS as authentic family engagement, information gathering/integration, and service/treatment planning tools in order to deliver high quality assessment, treatment, and services to youth and families.

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 Cultural Affairs Liaison also holds *quarterly meetings* with the Consulate General of Mexico in Chicago. These meeting are mainly held with the assigned Consular agent of their Protection Department, Mayra Castillo. As with the Mexican Consulate in Indianapolis, DCS has established an excellent working relationship with the Consulate General of Mexico in Chicago and we have developed a partnership providing support for Mexican families involved with DCS. 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 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 Judicial Center (IJC)/Court Improvement Program

- Juvenile Detention Alternatives Initiative (JDAI) – DCS collaborates with the IJC (along with other state agencies) in the implementation and rollout of JDAI statewide.
- During the recent Round 3 CFSR, an employee of the IJC, Angela Reid-Brown, Court Improvement Program Manager, participated as a reviewer and will be participating in upcoming program improvement plan development.

- Dual System Youth (DSY) – As a certain percentage of youth are identified in both the juvenile delinquency and CHINS systems, DCS has collaborated with IJC 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 IJC collaborated on which helps define dually identified, dually involved and dually adjudicated youth.

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

- Director Bonaventura is a member of Governor's Task Force on Drug Enforcement, Treatment, and Prevention Task Force to evaluate the growing drug problem in Indiana. The Task Force is tasked with performing a statewide assessment by looking at enforcement, treatment, and prevention services and presenting recommendations to the Governor.

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, 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 thus far.

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

- Review of children eligible for adoption and adoptive parent licenses
- 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-16-03, for Indiana's Update on Assessment of Performance (and Systemic Factors), please see Indiana's Round 3 CFSR Statewide Assessment submitted in April 2016.

IV. 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. Although final results will not be ready by the due date of the 2017 APSR, DCS will be utilizing initial feedback and preliminary findings from the CFSR to comprehensively reexamine and adjust accordingly the below goals and objectives, specifically as it relates to evaluating the effectiveness of objectives already completed and identifying how to integrate any necessary program improvement planning.

A. SAFETY GOALS, OBJECTIVES AND INTERVENTIONS

Goal 1: Ensure the safety of Hoosier children through informed decision-making beginning from initial assessment.

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.

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 was ongoing in 2015-2016. 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 as of 5/10/2016	
Children's Mental Health Initiative	1532 Assessment referrals made 1081 cases referred for wrap facilitator and services
Comprehensive Home-based Services	
Cognitive Behavioral Therapy	70
Family Centered Treatment	631
Intercept	524
Motivational Interviewing	240
Trauma Focused Cognitive Behavioral Therapy	214
Alternatives for Families Cognitive Behavioral Therapy	15

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.

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 every two weeks 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.

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 statewide. 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. See a. for a description of the pilot program being planned for Central Indiana.

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.

c) Iincorporate 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.

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.

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 will be used by DCS's Executive Team to address any barriers identified and build on strengths.

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 DSC and the CMHCs hope to address ongoing efforts to combat these issues at a joint summer conference planned for August 2016. DCS and the Indiana Council of Community Health Centers will be planning an agenda focusing on the critical issues of substance abuse and ways each system can continue to improve services and outcomes for this vulnerable population.

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 and it will soon be submitting its annual report for consideration. The subcommittee continues to have stakeholders present on issues around substance abuse and work to develop ideas for improving system response.

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**.**

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.

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 2017.

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 ongoing. 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. This process continues as workgroups continue to work on writing for experienced FCM curricula, Resource and Adoptive Parent curricula and supervisor and management curricula.

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.

A copy of the excerpt from the Trainer Manual – Holding a CFTM When DV is Identified in the Family is attached as Attachment 1**.**

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.

b)Improve monitoring of service provider response times.

This objective is not yet initiated. Anticipated start date is October 2016**.**

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 goal 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 goal 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 CFSR 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 has recently engaged Eckerd Kids about reviewing Indiana's risk management tool and exploring the use of the Eckerd Rapid Safety Feedback® model. 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 will 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) will be assigned for an investigation.

B.PERMANENCY GOALS, OBJECTIVES AND INTERVENTIONS

Goal 2: Promote safe, timely and stable permanency options for children.

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.

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 define 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 is reviewing and exploring aspects of the Families First Act that may play a role in development of this objective, including the kinship navigator.

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. 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 ongoing. LCPAs will be required to use the SAFE home study format with the families they license as foster parents beginning in the new contract cycle on January 1, 2017. Over the course of summer and fall 2016, DCS is hosting five (5) trainings by the Consortium for Children to train licensing workers and supervisors of LCPAs in the SAFE home study model.

All Family Prep agencies are required by contract to become certified in the SAFE home study process, and begin utilizing the process with all DCS adopt-only families referred to them, no later than July 1, 2016 (a year after the start of their contract). Therefore, after 7/1/2016, all adopt-only families (those not licensed for foster care but who wish to adopt from DCS) will have a SAFE home study.

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.

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. 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 trauma-informed trainings in various regions throughout the state for families – 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 318 in 2015.

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 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. 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.

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). As an example of the data provided, all the slides for Region 9 are copied below:

Placement Demographics - Region 9

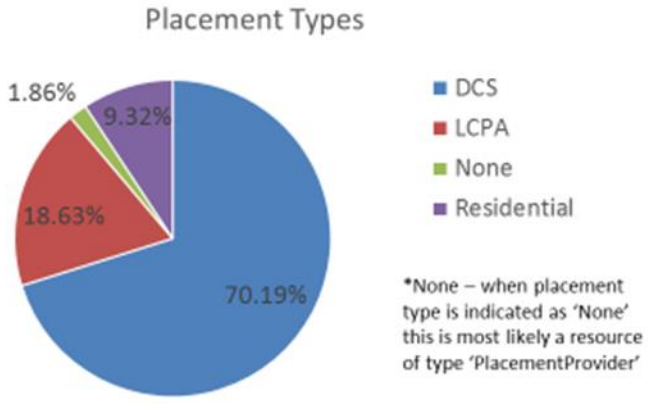
Data as of end of the month October 2015, pulled from DCS Foster Parent Recruitment report
Report is still under development

- Basic Data:
  - Boone, Hendricks, Montgomery, Morgan, and Putnam Counties
  - 161 total placements (excluding unlicensed relative placements)
  - 102 Children Placed Out of County
  - 16 Children with Developmental Disability Diagnosis

County Name	Type	Placement Count	Placed Out Of County
Boone	**Total**	**23**	**17**
	DCS	14	10
	LCPA	9	7
Hendricks	**Total**	**15**	**5**
	DCS	10	0
	None	1	1
	Residential	4	4
Montgomery	**Total**	**40**	**16**
	DCS	30	8
	LCPA	6	4
	Residential	4	4
Morgan	**Total**	**55**	**41**
	DCS	39	25
	LCPA	7	7
	None	2	2
	Residential	7	7
Putnam	**Total**	**28**	**23**
	DCS	20	19
	LCPA	8	4

Placement Demographics - Region 9

Data as of end of the month October 2015, pulled from Foster Parent Recruitment report
Report is still under development



*None – when placement type is indicated as 'None' this is most likely a resource of type 'PlacementProvider'

Placement Demographics - Region 9

Data as of end of the month October 2015, pulled from Foster Parent Recruitment report
Report is still under development

	Age Group			
County	0-4	5-9	10-13	14-18
Boone	11	6	3	3
Hendricks	5	2	5	3
Montgomery	17	13	7	3
Morgan	21	10	11	13
Putnam	12	8	5	3
Total	**66**	**39**	**31**	**25**

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Placement Demographics - Region 9

Data as of end of the month October 2015, pulled from Foster Parent Recruitment report
Report is still under development

	Health Recommendation CANS Scores							
County	No CANS Health Recom-mended	No Treatment Recom-mended	Outpatient	Outpatient with Limited Case Management	Supportive Community Services	Intensive Community Services Wraparound	Intensive Home & Community Services	High Intensive Services
Boone	5	5	7	2	0	4	0	0
Hendricks	1	5	4	1	1	0	1	2
Montgomery	2	10	7	6	13	1	0	1
Morgan	1	17	11	7	12	5	0	2
Putnam	7	4	3	6	6	1	0	1
Total	**16**	**41**	**32**	**22**	**32**	**11**	**1**	**6**

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Placement Demographics - Region 9

Data as of end of the month October 2015, pulled from Foster Parent Recruitment report
Report is still under development

	Placement Recommendation CANS Scores						
County	No CANS placement recom-mended	Regular Foster Care	Foster Care with Services	Thera-peutic Foster Care	Group Home 15 and older	Group Home 12 to 14	Residential Facility CCI or Private Secure
Boone	5	8	6	1	0	0	3
Hendricks	1	6	1	0	0	0	3
Montgomery	2	11	22	3	0	0	2
Morgan	1	24	16	3	0	0	10
Putnam	7	3	14	1	0	0	1
Total	**16**	**52**	**59**	**8**	**0**	**0**	**19**

Placement Demographics - Region 9

Data as of end of the month October 2015, pulled from Foster Parent Recruitment report
Report is still under development

		Race						
County	Hispanic/ Latino Origin	Race Uncertainty	American Indian	Asian	Black	Pacific Islander	White	Multi- Racial
Boone	0	0	0	0	0	0	23	0
Hendricks	0	0	0	0	6	0	14	0
Montgomery	3	0	0	0	0	0	40	0
Morgan	7	0	0	0	1	0	55	0
Putnam	0	0	0	0	1	0	28	0
Total	**10**	**0**	**0**	**0**	**8**	**0**	**160**	**0**

- Important to note that this data is self-reported by the client
- The client may self-identify as more than one race, and more than one option could be selected by the client in providing this data (including the possibility to select multi-racial without selecting an identified race)
- Provided to work toward goal of targeted recruitment efforts for representative population of available foster parents

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Placement Demographics - Region 9

Data as of end of the month October 2015, pulled from Foster Parent Recruitment report
Report is still under development

	Sibling Group			
	2	3	4	5+
County				
Boone	3	3	0	0
Hendricks	0	1	0	1
Montgomery	10	2	0	0
Morgan	11	1	0	1
Putnam	6	2	1	0
Total	**30**	**9**	**1**	**2**

- Sibling data shows distribution of groups of siblings
- Sibling Placement Practice Indicator Report, available online, shows data on number of siblings placed together
- http://in.gov/dcs/2888.htm (currently available for September 2015)

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This data allows for targeted recruitment based upon the makeup of the children in need of out of home placement in the county.

More recently, DCS finalized a 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 there is a disparity between the distribution of foster homes that identify as Latino and children in need of out of home placement who identify as Latino. See below:

Who	**Hispanic/ Latino Origin**	**American Indian**	**Asian**	**Black**	**Pacific Islander**	**White**	**Multi-Racial**	**Race Uncertain**	**Race Not Entered**
Foster Home	2.96 %	0.21 %	0.10 %	26.17 %	0.05 %	72.45 %	0.94 %	0.08 %	0.00 %
Placements	9.82 %	0.14 %	0.21 %	21.09 %	0.15 %	65.47 %	12.86 %	0.08 %	0.01 %

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 homestudies 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. This is a target area for report development over the next year, as listed in an alternate section of this report. 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.

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 states 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 measureable 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. Currently the transition plan is not programmed in the Management Gateway for Indiana's Kids (MaGIK) so it must be completed on paper then uploaded into MaGIK. 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.

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, Accurint, 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 not yet completed. DCS continues to work with the father engagement providers to develop strategies to increase engagement.

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). The expectation is for this project to be complete early fall 2016.

C. WELL-BEING GOALS, OBJECTIVES AND INTERVENTIONS

Goal # 3: Ensure the well-being of Indiana children by integrating a trauma-informed care approach to our child welfare 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).

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.

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 **a**s 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.

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. 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.

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.

Analysis of this objective has not yet been completed. DCS has engaged Eckerd Kids about reviewing Indiana's risk management tool and exploring the use of the Eckerd Rapid Safety Feedback® model. The Eckerd model was highlighted in the final report of the federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF).

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.

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**.**

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.

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.

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. Since June, 2015, Clinical Services Specialists provided consultation in 42% of cases where youth rated a "3" on the CANS "adjustment to trauma" item. The report identifies the

following: “For the reporting period, X% of youth who were identified as having significant needs associated with trauma received consultation from a Clinical Services Specialist.”

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 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. 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. 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.

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 has been 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 Wavier 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

DCS is evaluating progress in achieving CQI goals from a completion perspective as opposed to a more quantified

data analysis method. To evaluate the agency's progress in achieving its CQI goal and objectives, the agency will monitor its success in timely developing a policy and organizational structure to support its utilization of a CQI framework. 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. During this year, DCS has been successful in developing a decision-making structure within the executive staff and field staff through the CQI Steering Committee and workgroups.

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.

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.

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.

In preparation for the start of state wide PDSA Cycles in the field, DCS PQI staff piloted a PDSA project in August 2014. The strategy implemented was to assign PQI as Site Leads to specific QSR review teams. PQI Site Leads then serve as regional contacts, assist with troubleshooting, and spend time with each regional review team staffing cases and assisting with identifying appropriate indicators for improvement. This project was completed in the fall of 2015.

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, 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.

The number of cases pulled for review will remain the same and encompass existing case types and assessment cases beginning round five in September 2015. 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.

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. 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.

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.

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

Further analysis of this Objective is necessary. This Objective has not been completed.

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.

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 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 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. Work towards 2017, statistically valid pull – consistent meetings.

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.

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.

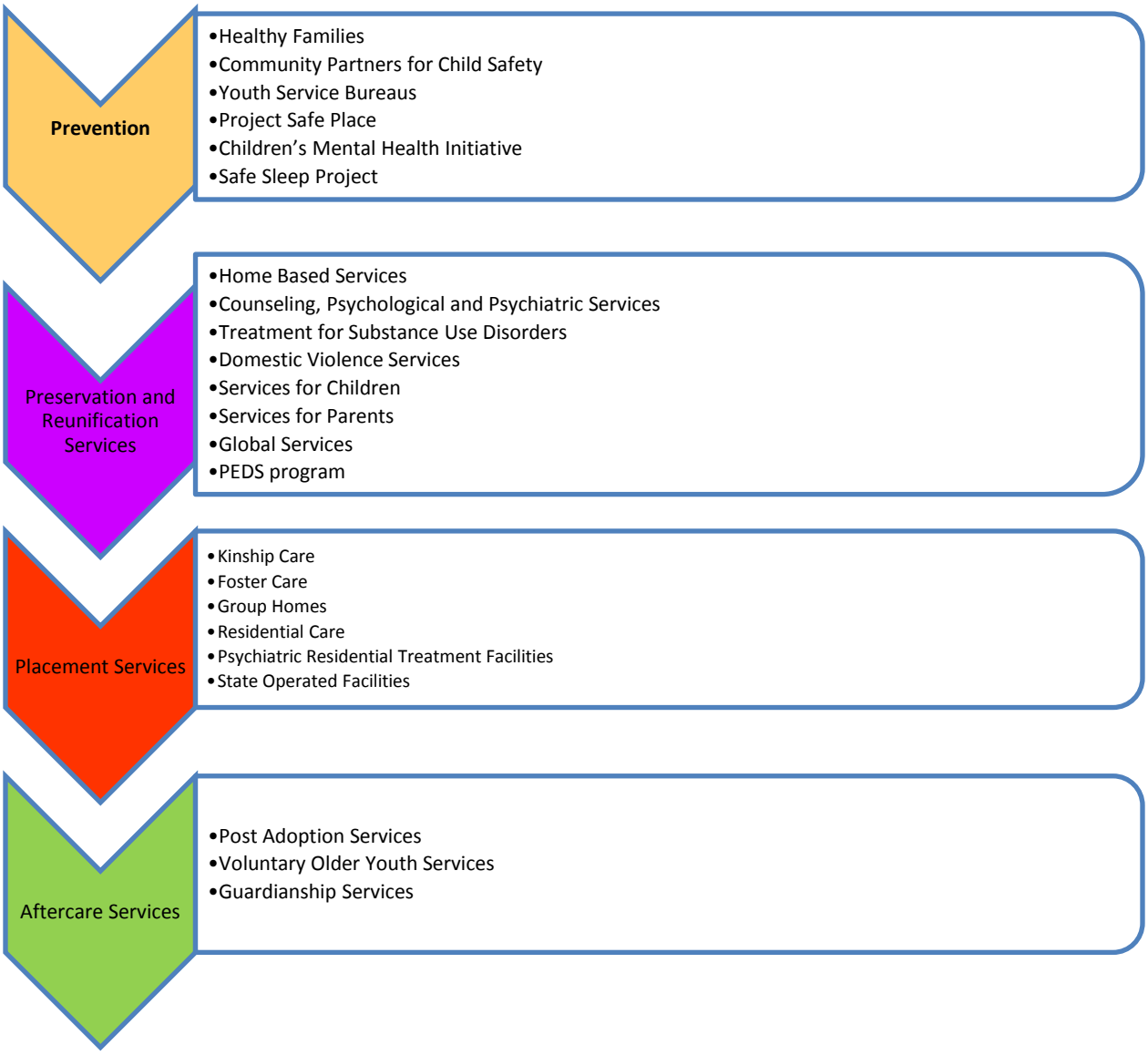
DCS remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and a broader service array. DCS has routinely monitored the effectiveness of the Practice Model in order to establish the goals and direction of the agency, Title IV-E Waiver spending, 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.

After assessing its CQI program following Round 3 of the CFSR, DCS is exploring the possibility 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.

V. 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, Counselling, 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 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 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

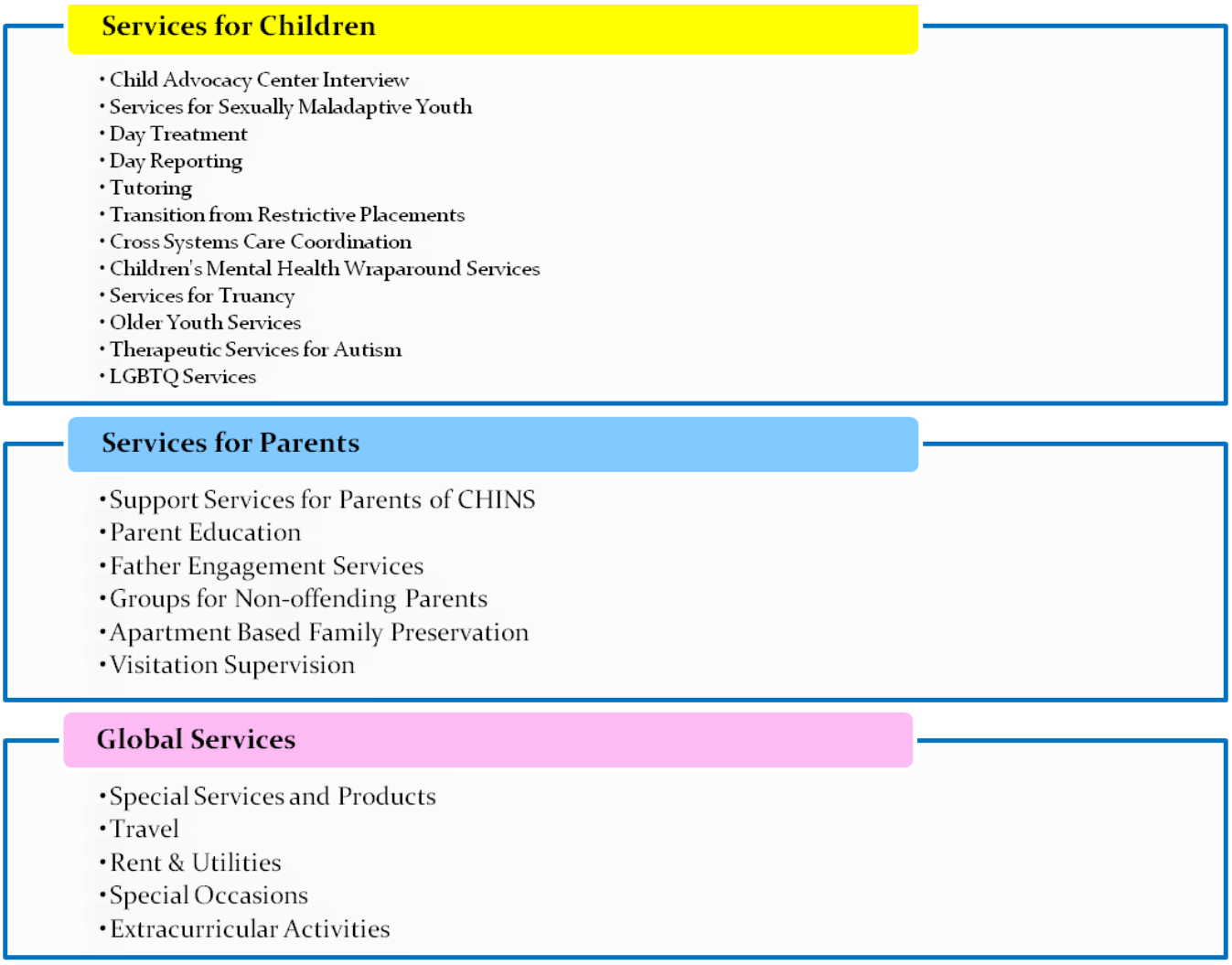
- Counseling
- Clinical Interview and Assessment
- Bonding and Attachment Assessment
- Trauma Assessment
- Psychological Testing
- Neuropsychological Testing
- Functional Family Therapy
- Medication Evaluation and Medication Monitoring
- Parent and Family Functioning Assessment

Treatment for Substance Use Disorder

- Drug Screens
- Substance Use Disorder Assessment
- Detoxification Services-Inpatient
- Detoxification Services-Outpatient
- Outpatient Services
- 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



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

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. 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 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	● 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	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.

	are returning 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.
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.
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.
CBT-Cognitive Behavioral Therapy	• Children and adults • Depression • Anxiety • Cognitive distortions • Unlearn negative emotional and behavioral reactions	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

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

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 in early implementation stages. A current third site is being determined by the Central START team.

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 9,000 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.

Maternal and Child Health (MCH):

At the state level, MCH is funded in large part by the federal Maternal and Child Health Bureau (MCHB) Title V Block Grants. MCH also houses a number of projects, programs and services that are vital to the families and children served by CPCS, as outlined in more detail below.

Early Childhood Comprehensive System (ECCS) and Project LAUNCH:

Indiana's ECCS grant provided the impetus for a much needed collaboration of statewide early childhood organizations to come together with the goal to develop coordinated services and policies so that children arrive at school healthy, safe, ready to learn, and able to succeed. Indiana has utilized the ECCS model very successfully to help build a state infrastructure that better meets the needs of infants and toddlers with social-emotional challenges. With the incorporation of Project LAUNCH in 2012 along with a shift in federal focus at HRSA to funding project focused initiatives as opposed to infrastructure-building, the ECCS partnership has reengaged its purpose and is now actively involved in quality improvement initiatives that target a broad range of needs in early childhood, including social-emotional health, behavioral health, and integrating physical health. Home visiting programs from across the state continue to play a pivotal role in identifying at-risk children at the earliest opportunity so that improvements in behavioral health outcomes are optimized.

Some other efforts supported by ECCS (which includes Project LAUNCH co- lead, DMHA, the state's Single State Agency for Substance Abuse Services) served to move the infant mental health agenda forward in Indiana:

- Development and dissemination of a module clarifying reimbursement for IMH services in Community Mental Health Center (CMHC) systems
- Coordination with Indiana University School of Social Work for graduate level classes: Early Childhood Diagnosis, a one credit course on Diagnostic Criteria Zero to Three-Revised (DC0-3R) and a 3-credit course titled Advanced Issues in Early Childhood Mental Health which provides overview of important foundational areas of early childhood mental health.
- Adoption of Michigan Association for Infant Mental Health Endorsement (IMH-E®), a widely used set of competencies and a credentialing process for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health. ISDH, Indiana Head Start State Collaborative, and DCS supported the Endorsement. DMHA provided additional funding for the training of a cadre of providers who received intensive IMH-E® training and supervision.
- Awareness and training activities such as white papers on IMH assessment and intervention through Indiana's Early Intervention System, a discussion paper on early intervention and autism, a Crosswalk between the DC 0-3R, DSM, and ICD systems, and presentations to Early Intervention Service Coordinators and foster care parents on ECMH/IMH

A white paper was published, Providing Services to Infants, Toddlers and Preschoolers within a Recovery-Oriented Behavioral Health Care System which reviews the Medicaid Rehabilitation Option that supports the acquisition of skills that lead to recovery and optimum functioning of individuals with mental health challenges.

Development of resources including Family Resource Fact Sheets, a developmental calendar, and a Child's Wellness Passport with a special health care needs addendum

The Bureau of Child Development and the Indiana Association for Child Care Resource and Referral supported the creation and presentation of the Infant Mental

Health Modules

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

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

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

The DCS Prevention Manager (CBCAP Lead) and MIECHV Coordinator are active members of Project LAUNCH including , the Home Vi*siting Sub-committee and the ECCS Social Em*otional Sub-committee which is also chaired

by the Director from the Riley Child Development Center (RCDC, described in more detail below).

Social Emotional Sub-committee

The work of the Social Emotional Sub-committee centers around increasing the number of direct service providers with knowledge, practical skills and specialization in the effects and treatment of mitigating toxic stress and trauma as well as enhancing linkages and cooperation across systems serving infants and children. The Social Emotional Sub-committee is focused on outreach and supportive efforts to increase the number of professionals and paraprofessionals in the state that are endorsed by the Indiana Association for Infant and Toddler Mental Health (IAITMH).

Endorsement Process

The Endorsement process will increase the mental health workforce capacity and create an integrated infrastructure that will ensure that all Indiana families with very young children have access to well-trained providers in their home communities.

Beginning in 2010, support to implement the Endorsement® process in Indiana has been provided by the Indiana Head Start Collaboration and the Department of Child Services. Benefits of the Endorsement® program are numerous for children and families, providers, agencies, and systems of care. Individuals who have earned the Endorsement® cite the program as leading to an increase in professional development, including the completion of a degree or adding a graduate degree. In addition to the positive provider experiences, families have benefitted from greater access to well-trained providers whether their family is in need of high quality child care or the services of a mental health professional.

Agencies have found the Endorsement® helpful in structuring training and ensuring a well-prepared early child care and intervention workforce. Finally, systems have realized improvements in agreement about best practices, increased workforce capacity, and even cost savings because prevention and promotion of behavioural health by workers at Levels I and II reduces the need for services at more costly levels.

In addition, in FY2015, the number of professionals/paraprofessionals in Indiana that achieved the endorsement more than doubled, largely in-part due to efforts to coordinate stakeholders and leverage multiple funding opportunities including a grant from the Indiana State Department of Health.

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.

Enhanced Home Visitation

Another Project LAUNCH committee that the Prevention Manager and MIECHV Coordinator are actively engaged involves Enhanced Home Visitation to a local community in the state. Through a grant awarded by Project LAUNCH in 2014 to One Community One Family, Inc., a private non-profit serving families and children in the South Eastern corner of the state. There are plans to enhance upon the providers current scope of work by including Incredible Years services to families who are eligible.

Home visiting staff in the region will also receive enhanced trainings in Motivational Interviewing, Trauma-Informed Approaches, and Mental Health First Aid in order to improve outcomes for families and children. Additionally, selected programs serving young children in the region, including at least one HFI site, will receive mental health consultation that will serve to bolster their knowledge and continually serve families in the most effective manner. Such partnerships and collaborations further demonstrate the strength and positive impacts of the DCS Prevention Teams relationships with ISDH have had to further larger prevention efforts for Indiana families and children.

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 Sunny Start Healthy Bodies, Healthy Minds Council at the state agency level to achieve MIECHV goals.

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, HFI, ISDH, and NFP 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.

Local Safe Sleep

At the local level, ISDH is also reaching out to many HFI and CPCS providers to coordinate safe sleep education and outreach efforts as well as develop formal Memorandum of Understanding (MOU) through which the provider will become a crib distribution site for the Safe Sleep program in their local communities.

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 a 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 2017, 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.

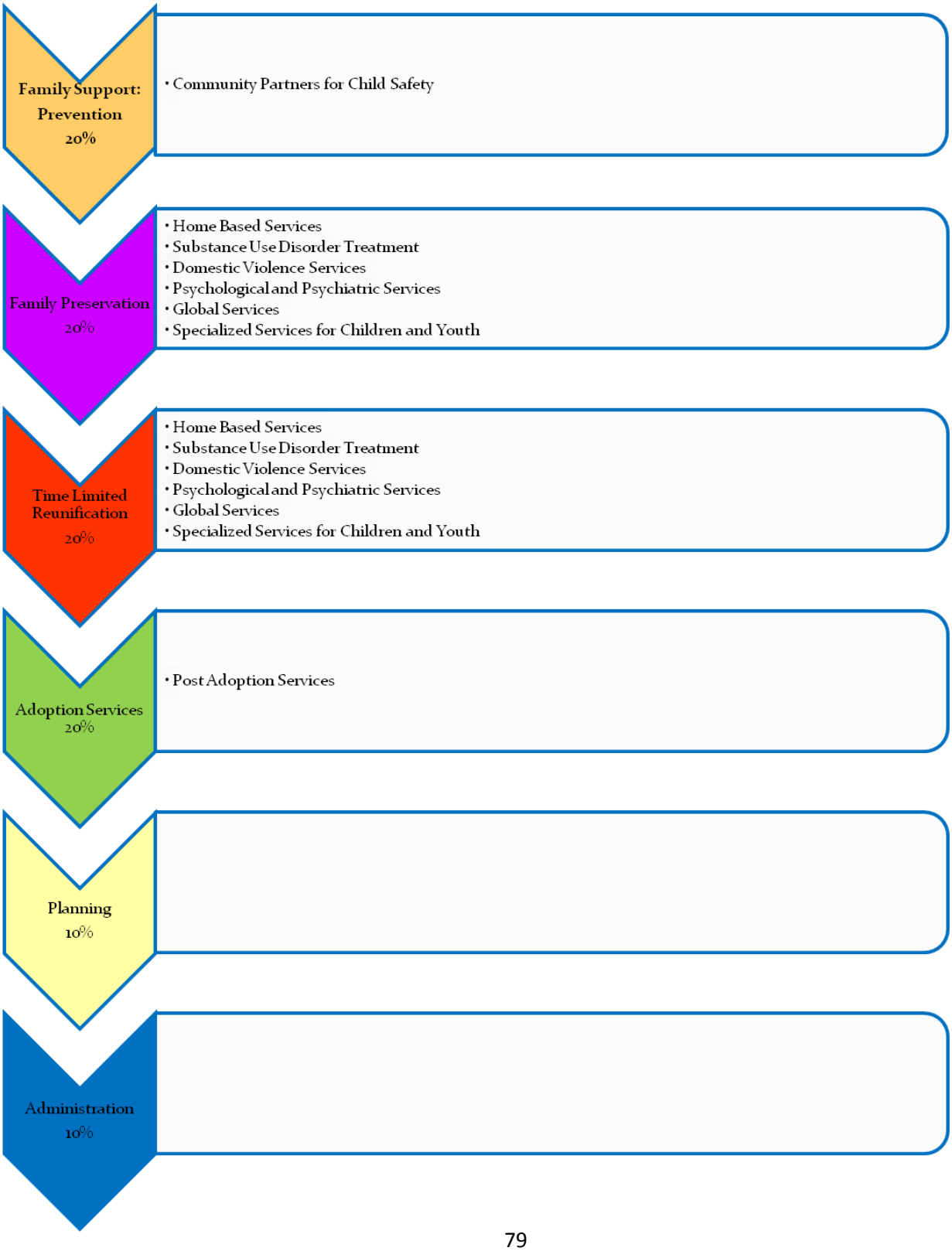
For a complete description of collaborative efforts, please review the Collaboration section under General

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 will be amended to include language ensuring that Lesbian Gay Bisexual Transgender and Questioning youth will have services provided in a culturally sensitive manner.

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.


Family Support: Prevention 20%
• Community Partners for Child Safety
Family Preservation 20%
• Home Based Services
• Substance Use Disorder Treatment
• Domestic Violence Services
• Psychological and Psychiatric Services
• Global Services
• Specialized Services for Children and Youth
Time Limited Reunification 20%
• Home Based Services
• Substance Use Disorder Treatment
• Domestic Violence Services
• Psychological and Psychiatric Services
• Global Services
• Specialized Services for Children and Youth
Adoption Services 20%
• Post Adoption Services
Planning 10%
Administration 10%

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.

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 neighboring county.

During the biennial planning process, 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. This information will be used to enhance 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.

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.

VI. 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.

DCS collaborates with Indiana University for evaluation of programs and training. 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.

VII. 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 Pokagon Band staff hosted our second semi-annual meeting of 2015 on November 10th in Dowagiac, MI. DCS staff (W. Hornbacher, General Counsel; J. Bisbee, Deputy Director of Field Operations; L. Rich, Deputy Director of Services and Outcomes; and S. Alyea, ICWA Coordinator for the International and Cultural Affairs Program) met with Social Services Director Mark Pompey and Presenting Officer/Prosecutor Annette Nickel. Discussion of the ICWA, child welfare programs, providers, and suggestions was shared by all. DCS General Counsel Hornbacher shared updated knowledge that the majority of judges in the larger cities are now responsibly asking ICWA eligibility questions in court, and from the onset of a CHINS case. It was reported by Pokagon staff that they have around 360 households in Indiana. This brought up a follow-up discussion regarding how statistically unlikely it is that our Indiana 'Pokagon' counties have no involvement/cases with Indiana DCS. Presenting Officer/Prosecutor Annette Nickel shared the importance that ICWA Notifications go to Director Mark Pompey for all Pokagon involved members. She stressed the importance of making sure the FCMs have the correct information, correct spelling of names, and correct dates of birth for all notifications, and explained how this plays a very important part in correct identification.

DCS has continued to provide education to their staff for improvement. The link for the March 2016 Federal Register Notice which contains the current 'Designated Tribal Agents for Service of Notice' was provided to the attorneys, and is included in the standard email response for ICWA questions to the field staff. Director Pompey

and Presenting Officer/Prosecutor Annette Nickel offered to meet with the staff of the six Indiana counties. Deputy Director 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. This meeting was to take place February 10, 2016, however was cancelled due to inclement weather. The presentation has not yet been rescheduled.

The first semi-annual collaboration meeting for 2016 has been scheduled for June 28, 2016, hosted by DCS and to be held at the St. Joseph County local office.

American Indian Center of Indiana, Inc.

The DCS ICWA Coordinator has had the opportunity to collaborate with staff at the American Indian Center of Indiana, Inc. (AICI) located in Indianapolis, Indiana. Communication remains open with the Executive Director of the Indiana Native American Indian Affairs Commission (INAIAC), Kerry Steiner, who has been a long-time volunteer at AICI.

Indiana Native American Indian Affairs Commission

The DCS ICWA Coordinator maintains an open line of communication with Director Kerry Steiner. During the summer of 2015 NICWA brochures, The Indian Child Welfare Act: A Family's Guide, were available at 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.

DCS also continues to collaborate with *non-federally* recognized tribes when appropriate. During the first half of 2016, DCS entertained some questions from the field staff concerning our 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. The Council member informed that the tribe has been receiving calls approximately two times a month from members with ICWA questions. 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.

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 have met and will be pursuing the opportunity to present at one of the upcoming Miami Nation of Indiana's Council meetings and discussed a plan to have DCS staff present at upcoming events. DCS ICWA Coordinator offered an opportunity for semi-annual, yearly, or other meeting times between DCS and the Miami Nation of Indiana Council to maintain open lines of communication. DCS will plan to present this opportunity when DCS staff meets with the Council.

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.

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

The latest (Dec 2015) ICWA policy revision (DCS Child Welfare Policy 2.12) (see Attachment 2) 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.

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.

The state 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. The state 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 approximately 100 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, compliance and services. 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 eventually be able to provide support, reviews, data and statistics, from a regional level, for the state for both immigration and ICWA cases. Over the past year, training for the six MC Teams began with education on historical information which led to the ICWA. Each team also 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. In July 2015, approximately 30 staff had volunteered, however, at the statewide July 2015 and May 2016 meetings, there were an average of 20 attendees. A barrier DCS has encountered is that these staff have other full time responsibilities within their positions and often have other commitments. DCS will continue to address possible solutions as we move forward to make these teams available to the field staff in the near future.

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 this past year and was 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 us with yet another checks and balance method to utilize for each reported and/or identified case.

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 the 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 ICW 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. Policy has 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.

7. Discussions regarding Chafee Foster Care Independence Program

The Pokagon Band cares for their youth and they are not interested in CFCIP. DCS will discuss the CFCIP with

the Pokagon Band further as collaborative meetings take place throughout the year.

8. Exchange of CFSP and APSR

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

As he did during Round 2 CFSR, Social Services Director Mark Pompey again participated in Indiana's recent Round 3 CFSR. Director Pompey was interviewed as a stakeholder and provided insight on the Pokagon's Tribe involvement and collaboration with DCS.

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.

VIII. 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.

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 2013	9132	9903	92.21%		7449	9903	75.22%
November 2013	9274	10067	92.12%		7404	10067	73.55%
December 2013	9293	10010	92.84%		7428	10010	74.21%
January 2014	8985	9621	93.39%		7306	9621	75.94%
February 2014	9234	9847	93.77%		7281	9847	73.94%
March 2014	9554	10076	94.82%		7757	10076	76.98%
April 2014	9867	10410	94.78%		7788	10410	74.81%
	Children with Contacts				Children with Contacts in Home Setting		
Month	Contacted Children	Total Children	Percentage		Contacted Children	Total Children	Percentage

May 2014 Reported 6/2015	10437	10986	95.00%		8418	10437	80.66%
June 2014	10578	11078	95.49%		8984	10578	84.93%
July 2014	10576	11105	95.24%		8914	10576	84.29%
August 2014	10597	11134	95.18%		8612	10597	81.27%
September 2014	11034	11603	95.10%		8822	11034	79.95%
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%

IX. 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).

X. 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. 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.

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 and are typically only available through other funding sources.

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.

The purpose of Indiana's Waiver project remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and expanded services. 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.

The Indiana University (IU) Evaluation Team presented updated data to the Regional Managers (RM) during

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

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.

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 Substudy 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.

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. We continually review 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.

XI. 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.

XII. 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 IVE 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. All of Indiana's terms expired in June of 2014. 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 2015 Hendricks County Foster Care Advisory Board CRP Annual Report is attached as Attachment 3. 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 22, 2016, is attached as Attachment 4.

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. DCS looks forward to working with the Knox County Team and receiving their input.

3. Child Protection Team

The 2015 Switzerland County Child Protection Team CRP Annual Report is attached as Attachment 5. Their report focused on evaluating DCS' response and treatment plans for juvenile sex offenders, along with recommendations for improvement. The DCS Response to their report, dated June 22, 2016, is attached as Attachment 6.

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."

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 its plan of safe care includes the most up-to-date best practices.

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	• Perform urine and meconium or cord toxicology screening at birth • Perform Modified Finnegan scoring • Evaluate maternal support resources
• No known verbal or	Newborns with **unknown risk**	• Perform urine and

toxicology screen during pregnancy • Negative verbal screen but no known toxicology screen		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.

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

DCS is currently tracking human trafficking victims manually as they are identified in MaGIK.

By October 1st, there will be a new featured added to MaGIK for an allegation of "Human/Sexual Trafficking" to be selected 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 will be completed 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 tool will be required and a risk level will be assessed. 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. If the risk is found to be medium or high on the full tool, the FCM is prompted to make a report to the hotline unless the tool was being completed as part of an allegation of "Human/Sexual Trafficking.

In summary, by October 1st, 2016, DCS will be able 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.

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 is being planned for rollout in the fall of 2016.

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, 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 (described in subsection A above) prior to creation of the CSEC Task Force has played a pivotal role in the overall work thus far.

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. Related to this effort, DCS is in discussions with the Indiana Youth Services Association (IYSA) to partner on human trafficking initiatives statewide. 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 statewide 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 will administer and supervise contracted providers who deliver CFCIP services directly to eligible youth. Services will be available in all 92 counties across the state. DCS will utilize a fair bid Request for Proposal (RFP) process to award contracts for CFCIP services. The DCS Central Office Older Youth Initiatives (OYI) Team will provide direct oversight of program, service array and service provision of contracted providers or Older Youth Services (OYS) providers. The DCS OYI Team is a cross divisional team made up of key personnel from the Services & Outcomes and 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.

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 is moving into phase 2 of implementing CQI as each provider is responsible for implementing a CQI project in FY 2017.

Contract compliance is monitored by the DCS fiscal department.

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.

2. Service Delivery

DCS has opted to extend IV-E foster care. In 2009, DCS held focus groups with key stakeholders, including youth, to assist in restructuring the service delivery of Independent Living Services. The state moved to a Broker of Resources model prior to implementation of Collaborative Care (CC). In addition, DCS continues to strengthen its focus 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. The Independent Living Transition Plan policy has been changed to the Transition Plan for Successful Adulthood and has been 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 polices have been revised to beginning services and planning at the age of 14 as well as revising language to successful adulthood.

The restructure of DCS policy 11.6 will include a policy name change: Transition Plan for Successful Adulthood. This policy will further empower youth in foster care 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.

Collaborative Care (CC), DCS's program and practice model for case managing older youth in foster care was built upon five foundational pillars: Youth Voice; Social Capitol; Relational Permanency; Authentic Youth-Adult Partnerships; Teachable Moments and Adolescent Brain Research. Youth will 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 Collaborative Care 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 capitol. This program also allows youth to voluntarily return to foster care on or after the age of 18.

3. Specific Accomplishments

Help youth transition to self-sufficiency

DCS is undergoing changes in transition planning for youth in care. 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 is also incorporating the term successful adulthood to mean services for youth under the age of eighteen (18). DCS continues to improve services for older youth transitioning out of foster care via the Collaborative Care program. 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.

As DCS continues to focus on the wellbeing 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 effective 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 continues to focus on education and employment preparation for older youth in foster care. 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.

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

DCS continues to assist youth in identifying and achieving their educational goals. 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 2016 and 2017.

During the grant period, the ETV vendor was awarded a grant from USA Funds to develop and strengthen the support offered to foster youth on campuses. 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 enrollment 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

ETV Regional Specialists have made over 500 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. The ETV program conducted 72 ETV 101 meetings; and 44 College 101 meetings. ETV Regional Specialists also attended Provider Fairs in their regions. In 2013, INCBY25 instituted the Educational Summit, an annual meeting designed to gather professionals and engage in dialogue around the status of foster youth education. TRiO and 21st Century Scholars informational sessions are also held with foster youth each academic year. Beyond academic support, the ETV program also offers emotional support. The most formal way this support occurs is that ETV students receive care packages and gift cards each academic year. The students received Walmart or Visa gift cards at the close of the fall semester and care packages of goodies during finals week in the spring semester. Graduates receive gift cards and a congratulations card from the ETV staff. During the grant period 2011-2015, 1,120, students received a care package and gift card, and another 39 graduates received a graduation gift in acknowledgement of their accomplishments.

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 2011-2015 grant period, 20 ETV students served as a Student Ambassador. Currently, there are 7 student serving 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. 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.

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 positive 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.

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 continues to provide Chafee Voluntary Services including room and board services to all eligible youth ages 18 – 21. 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.

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.

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.

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

- 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 will eliminate the need for providers/case managers/foster parents to identify services by federal definition. Instead, they will choose the service as defined by DCS' OYS standards and will be mapped on the back end to the federal definition.
- As of July of 2015, NYTD service logs have been implemented. In order for this item to be considered "complete" for the purpose of the N-QIP, Indiana must confirm that service data element mapping has changed.
- As of September of 2015, front end systems updates have been made to the federally-recognized tribe dropdown list to include the selections "Tribe not on list", "Information not available" and "Tribal membership pending verification". In order for this item to be considered "complete for the purpose of the N-QIP Indiana must update mapping to change "Information not available" to "no" for NYTD reporting.

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. The upcoming plan is to assess the need to issue an RFP for NYTD surveys, build incentives and continuous youth engagement between survey years, and how to build youth involvement.

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 to engage youth between survey periods and conduct surveys at ages 19 and 21. The contract is expected to be implemented before cohort 3 starting 10/01/2016. 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 are in the final process of completing phase 1 and entering 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.

5. Future Planning

DCS will continue to focus on older youth in care and those transitioning out of care. More specifically, the Older Youth Initiatives Team 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 and those transitioning out of foster care.

A group of young people from the Indiana Youth Advisory Board were asked to review the plan and provide input. Youth were given a summary of how services are being provided currently in the areas outlined in CFSP PI. Youth were asked to provide input on identified areas. Youth in the group focused feedback on training of case managers and Collaborative Care case dismissal reasoning. DCS will continue to gather feedback from youth in the Collaborative Care program, those accessing Voluntary IL Services, those utilizing ETVs and will try to engage those who choose not to participate in any services. 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 capitol. 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.

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 care, 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 as security deposits, rent, utility deposits and utilities. Utilities are limited to electric, gas, water and sewage. These funds are contingent upon availability as well as verification of the youth's eligibility for voluntary services by the IL Specialists. 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. 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. In cases where the youth is unable to accept full responsibility for their rent in the sixth month, approval must be received from the DCS IL Specialist to allow payment beyond the fifth month. 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 independent living case management services to the youth.

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	March 2014	April 2015	April 2016
Relative Home	8%	8.2%	8.6%
Non Relative Foster Home	41%	36.9%	39.1%
Residential Setting	16%	18.4%	20.9%
Own Apartment	18%	14.1%	11.3%
Shared Housing	2%	1.1%	0.9%
Host Home	6%	11.3%	12.6%
College Dorm	5%	5.1%	4.0%
Other Placement	4%	4.6%	2.6%

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.

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.

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. Moving forward, all 3CMs and OYS providers will receive 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

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.

An identified area of need in this category is youth who have developmental and/or intellectual disabilities, but do no quality for BDDS. DCS will continue to examine how to best meet the needs of this population. The OYI Team will work with the Placement Support and Compliance Division regarding building provider capacity for placement and services. The OYI Team will focus on Older Youth service needs as well as transitioning services for these youth.

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.
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.

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. Currently, DCS is providing support to the Courtyard Apartment complex along with other stakeholders in the community.

DCS has a partnership with the Twenty-First Century Scholars program, which is a program supervised by the State Student Assistance Commission of Indiana (SSACI). SSACI accomplishes its mission with:

- Grant and Scholarship Programs for full-time and part-time college students;
- Early Intervention programs for Twenty-first Century Scholars;
- Research to better understand the needs of Hoosier students and families; and
- Technology to make the delivery of awards as simple as possible for students and colleges.

In addition to making awards, SSACI 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.

DCS is 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. Youth selected to participate in YAC exemplified excellence in their schools and community. YAC recognizes the accomplishments of foster youth by providing an opportunity for foster youth to share their success with friends and family.

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.

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.

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.

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 IHCDA 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 IHCDA 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 one day before 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 (ages 16-21) participated in the stakeholder interviews and provided valuable insight to the CFSR review team. Furthermore, in the summer of 2015, youth participated in surveys around the effectiveness of services as part of the IV-E Waiver Evaluation.

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 will work closely with the DCS Staff Development Division on the development of a Computerized Training to be posted on the DCS Training website. This training can be accessed by DCS staff when the training material is relevant to the DCS staff person. 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 will continue to work closely with the DCS Staff Development Division on updating the Positive Youth Development training curriculum and any additional OYS/CFCIP related trainings.

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

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. To stay ahead of developing issues, and due to the growing number of ETV participants and the various institutions of learning, 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 vendor began tracking the retention and persistence of its foster youth in academic year 2013-2014.

That year, 129 freshman were funded for fall 2013; and 91 (71%) returned in spring 2014. Similarly, in the fall of academic year 2014 -2015, there were 192 freshman, of which 129 (67%) received ETV funding. Spring 2015 opened with 91(71%) returning freshman. Persistence for ETV students over the four year period of 2011-2015 was confirmed by the National Student Clearinghouse. The data collected confirmed that 28, or 2%, of the ETV students attended college for all 4 years from 2011-2015. The data also confirmed that 35, or 2%, of ETV students completed 3-years; and 84, or 6%, completed 2 years of post-secondary education. Retention rates are higher among the freshman who received funding and participated in the program. Program graduation data shows that 62% of the graduates received a four year bachelor's degree and 31% received an associate's degree.

Finally, Indiana offers a 21st Century scholar's scholarship for low income students that covers tuition only. The 21st Century Scholarship is supported by state funding. INCBY25 works closely with the 21st Century Scholar staff and higher education institutions to address duplication of funds. The ETV staff submits student names to 21st Century Scholars and monitors student funding and progress.

The ETV recipients apply each semester (fall, spring, summer), which allows the ETV vendor to track the student's enrolment and pull quantitative data on retention and persistence each academic year. A comparative analysis is completed to extract new applicants in each academic year.

XIV. 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.

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, however, minor updates were made around psychotropic medication guidelines in 2016.

As of March 1, 2016 (the last quarterly reporting period), IU had processed a total of 187 outlier cases, and completed 80 medication reviews. In 98% of cases reviewed, inappropriate medication practices were identified. The most prevalent concern cited by reviewing physicians was medication quantity, and specifically, four or more psychotropic medications being prescribed simultaneously (73% of cases reviewed). The second most common reason for concern was inadequate documentation and monitoring, with failure to appropriately monitor laboratory values in 42% of cases, and insufficient documentation of physical exams or vital signs in an additional 42%. Indication was also a common problem, with 27% of children in the review group being prescribed medications not appropriate for their diagnosis. An additional 27% of cases were cited as problematic due to insufficient and/or non-evidence-based psychotherapeutic interventions. With respect to provider response, in 93% of cases reviewed the prescribing physician agreed with the IU recommendations, indicating substantial agreement between IU consultants and prescribing physicians about next steps toward bringing the medication regimen in line with PMAC criteria.

The DCS Health Care Oversight and Coordination Plan with minor updates around psychotropic medication guidelines made in 2016 is attached as Attachment 7.

C. DISASTER PLAN

The DCS Disaster Plan was updated 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

The DCS 2016 Training Plan is attached as Attachment 8. Revisions have been made with updated 2015 year end data along with upcoming initiatives. Over the past year, Staff Development completed updates to new hire training curriculum and provided training support for the increase in cohorts (new hires). Over the next year, Staff Development will turn its attention to supervisor training curriculum updates and enhancements to specific topical trainings.

XV. 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.

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 6/23/16

Family Case Managers and Family Case Manager Trainees

<22	22-25	26-30	31-40	41-50	51+	Total
6	421	593	734	379	203	2336
0%	18%	25%	31%	16%	9%	100%

FCM Supervisors

22-25	26-30	31-40	41-50	51+	Total
5	59	156	88	57	365
1%	16%	43%	24%	16%	100%

County Welfare Directors

26-30	31-40	41-50	51+	Total
1	30	27	26	84
1%	36%	32%	31%	100%

Executives

26-30	31-40	41-50	51+	Total
4	12	20	28	64
6%	19%	31%	44%	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-ijs-2014-probation-v1-summary.pdf

Listed below are the page numbers within the 2014 report where data can be found for juvenile justice transfers. The 2015 juvenile justice transfer data will not be available until September, 2016.

Juvenile Probation 17

Juvenile Probation Referrals 2005-2014 17

Juvenile Probation Supervisions 2005-2014 19

Juvenile Probation Supervisions Method of Disposition 21

Juvenile Supervision Levels 23

Juvenile Supervision as Result of Substance Abuse Convictions 2005-2014 23

Juvenile Supervisions as Result of Sex Offenses 2009-2014 24

Juvenile Supervision Completed Predisposition and Progress Reports 24

Juvenile Law Services Report 25

Juvenile Law Services Financial Report 29

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 Manger during the child fatality assessment is entered into MaGIK, the State's child welfare information system. In order for DCS to substantiate allegations of abuse or neglect for any child death, the alleged perpetrator must meet the statutory definition of parent, guardian, or custodian. 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:

State: Indiana: Annual Reporting of State Education and Training Vouchers Awarded: Total ETVs Awarded Number of New ETVs

Year (July – June)	Funded Students (unduplicated)	New Funded Students
2015-2016 (not including summer)	199	96
2014-2015	273	93

E. INTER-COUNTRY ADOPTIONS:

No children adopted from other countries entered into DCS custody as a result of a disruption in placement or dissolution of adoption in FY2015.

XVI. ATTACHMENTS (SEPARATE DOCUMENT)

1. Trainer Manual Excerpt– Holding a CFTM When DV is Identified in the Family……Page 3
2. DCS Child Welfare Policy Manual 2.12 – Indian Child Welfare Act……Page 7
3. 2015 Citizen Review Panel Report– Hendricks County……Page 14
4. 2015 Citizen Review Panel Response – Hendricks County……Page 18
5. 2015 Citizen Review Panel Report– Switzerland County……Page 19
6. 2015 Citizen Review Pane Response – Switzerland County……Page 20
7. Health Care Oversight Plan (updated 2016)……Page 23
8. 2016 DCS Training Plan……Page 43
9. CFS-101, Part I (signed PDF)……Page 81
10. CFS-101, Part II ……Page 82
11. CFS-101, Part III (signed PDF)……Page 83
12. Attachment E – Educational and Training Voucher Chart……Page 84
13. Section H – Financial Information……Page 85

APSR 2017 Attachments

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2. DCS Child Welfare Policy Manual 2.12 – Indiana Child Welfare Act 7
3. 2015 Citizen Review Panel Report – Hendricks County 14
4. 2015 Citizen Review Panel Response – Hendricks County 18
5. 2015 Citizen Review Panel Report – Switzerland County 19
6. 2015 Citizen Review Panel Response – Switzerland County 20
7. Health Care Oversight Plan 23
8. DCS Training Plan 43
9. CFS-101, Part I (signed PDF) 81
10. CFS-101, Part II 82
11. CFS-101, Part III (signed PDF) 83
12. Attachment E – Educational and Training Voucher Chart 84
13. Section H – Financial Information 85

Prepping the CFTM (continued) – Trainer Guide

12:50 PM

Transition

Slide# 21

In situations when the team determines it is safe to include the alleged offender in a CFTM, prepping with the offender is critical. We are going to watch a video of an interview with Josh, an alleged offender of Domestic Violence. Consider this video clip a portion of CFTM Prep with Josh, and answer the questions in your Participant Manual as if you were the FCM Prepping Josh.

Video: Josh's Story

Click box to play Video

Participant Page 24

Show the video 'Josh's Story' (4:34)

Ask participants to answer questions in the Participant Manual

Facilitate a discussion regarding the video and questions

- Connect Josh's childhood trauma to his behaviors.
- Refer participants to Trauma Informed Care principles.
- Consider the trauma Josh's children are experiencing.
- Ensure participants are suggesting treatment for the entire family.
- Discuss why mom may have been in the hospital, then left Josh as soon as she was released.

1:20 PM

Prepping the CFTM (continued)

Video: Josh's Story

Watch the video clip of an interview with 'Josh' who is a Domestic Violence batterer. For the purpose of our discussion, assume that this is a prep meeting with Josh. We know from prep with mom, that she is currently separated from Josh. In discussions with mom, it is evident that she is not going to stay away from him, and the team should plan for an eventual reunification of this family.

Consider these questions while you watch the video:

What are Josh's underlying needs? How has his own trauma affected his life and family?

Childhood abuse from his father and his mother's boyfriends
His alcohol abuse
Financial Stress
His own trauma as a child may be a factor in his alcohol and domestic abuse now, which negatively affects his own family.

How can the FCM safety plan with Josh to protect the family?

Develop coping skills Josh can use to manage his stress
Facilitate a transparent conversation with Josh about how he is hurting his family.
Help Josh identify his triggers
Help Josh find ways to manage his need for control
Establish a 'code word' for Josh to use during the meeting if he feels he is escalating and needs a break.

What are some outcomes the family might set?

Develop good communication
Josh will heal from his own trauma
The family will feel safe and free from harm in their own home
The family will be able to live together (Reunification)

Prepping the CFTM (continued) – Trainer Guide

1:20 PM

Prepping with Parents

Slide# 22 (Interactive Slide)

Participant Page 25

Trainer Notes:

- Add participant responses to the interactive PPT slide (or chart on paper) as you progress through the discussion. Encourage participants to copy answers in their Participant Manuals.
- If participants are having trouble creating general questions, connect this section to Josh's Family and ask for specific examples

Ask:

When you prep with the **DV Victim**, what types of information are you trying to gather?
What types of questions will you ask?
What type of information will you need to gather to create a safety plan?

Explain – The details and situation of each case will be different, and so you will need to ask different questions. **Ask…**

- Is the couple in a honeymoon period? (Recall the Cycle of Violence)
- How does this affect the dynamics of the prep meeting?
- Is the DV victim still living with/married to/etc. the offender?
- How is the situation affected when the DV victim has made the decision to leave the abuser?
    - Approx. 75% of DV victims who are killed by their batterers are murdered when they attempt to leave or after they have left the relationship (www.domesticabuseshelter.org)

Offending Parent Prep

Ask

- Would you ask the abuser the same question as the DV victim?
- How would you change the question?

Ask

- When you prep with the other team members for the CFTM, what types of information are you trying to gather?
- What types of questions will you ask?
- How are your questions the same/different than what is charted?

Trainer Note – Policy Tool 5.A lists sample prep questions (found in the Trainer Resources section of the curriculum package). Use the policy tool as a guide to prompt participants and add to the depth of the list. Do not read the list in its entirety.

1:30 PM

Prepping the CFTM (continued)

Prepping with Parents

DV Victim (Parent)	Offending Parent
How is this person prepped?	How is this person prepped?
Questions/Information to Gather	Questions/Information to Gather

POLICY [REVISED]

The Indiana Department of Child Services (DCS) shall take measures to ensure that any child who is a member of a federally recognized Indian tribe is afforded all rights under the Indian Child Welfare Act (ICWA).

DCS will begin utilizing active efforts[1] immediately upon learning of the possible removal, formal or informal involvement with an Indian child. DCS will make active efforts to determine if a child is a member of an Indian tribe or eligible for membership in an Indian tribe. These efforts will continue throughout DCS involvement with the child(ren) and family. DCS will comply with all rules, regulations, and laws governing ICWA and make an active effort to identify those children and families subject to the Act.

[REVISED] DCS will notify the child's parents, Indian custodian, and Indian tribe, whenever there is an action pending regarding parental rights involving a child who is, or is believed to be, a member or eligible for membership in an Indian tribe. DCS will also send a copy of the notice to the appropriate Area Director of the Bureau of Indian Affairs and to the United States (U.S.) Secretary of Interior. If DCS is unable to identify or locate the parent, Indian custodian, or the Indian tribe, DCS will send the ICWA notification to the appropriate Area Director of the Bureau of Indian Affairs for assistance and the U.S. Secretary of Interior. See www.bia.gov for further information.

[REVISED] DCS will provide notification of each and every court proceeding to the child's parents, Indian custodian, and Indian tribe. All notices will be sent by certified mail, return receipt requested, and DCS will not make a foster care placement or hold a Termination of Parental Rights (TPR) proceeding until at least **10 days** after receipt of notice by the parent, Indian custodian, and the tribe or the U.S. Secretary of Interior. The parent, Indian custodian and the tribe may, upon request, be granted up to **20 additional days** to prepare for the proceeding.

[REVISED] If there is imminent risk of physical harm, DCS may detain an Indian child in order to prevent imminent physical damage or harm to the child but must provide the notifications addressed above. This emergency removal only exists if the child is in imminent danger, and is

[1] From the Bureau of Indian Affairs ICWA Guidelines effective 2/25/2015 – 'Active efforts are intended primarily to maintain and reunite an Indian child with his or her family or tribal community and constitute more than reasonable efforts as required by Title IV-E of the Social Security Act (42 U.S.C. 671(a)(15)). The updated Guidelines provide 15 examples of 'active efforts' http://www.bia.gov/cs/groups/public/documents/text/idc1-029637.pdf

not to be applied when the situation is only in need of services for improvement (e.g., the family has little to no food in their home, which could be remedied by actively taking them to the food pantry). Once the emergency no longer exists and the child is no longer at risk of imminent physical harm, the child must be returned home. This temporary custody timeframe without a hearing shall only last 30 days. The emergency removal process does not authorize DCS to remove a child from a reservation where a tribe exercises exclusive jurisdiction.

Preference for placement of an Indian child must be given in the following order to:

1. A member of the child's extended family;
2. A foster home licensed, approved, or specified by the Indian child's tribe;
3. An Indian foster home licensed or approved by an authorized non-Indian licensing authority; or
4. An institution for children approved by an Indian tribe or operated by an Indian Organization, which has a program suitable to meet the Indian child's needs.

DCS will follow established procedures for the transfer of responsibility for the placement and care of a child to a Tribal Title IV-E agency or Indian Tribe with a Title IV-E agreement. See Tool 2.A Procedure for Transfer of a Child to a Tribe or Tribal Agency.

[REVISED] Applicability of the ICWA depends upon whether the proceedings in question (Child in Need of Services (CHINS, Detention, TPR, etc.) involve an "Indian child" within the definition utilized in 25 U.S.C. §1903(4). To promote early identification of ICWA applicability and to ensure compliance with ICWA requirements, DCS shall make ongoing efforts to determine whether ICWA procedures may apply to the case by inquiring whether there is a reason to believe the child in an Indian child:

1. Prior to any initial removal from the parents;
2. At any detention hearing;
3. Prior to any change in foster care placement;
4. Prior to any adoptive placement;
5. At review hearings and at permanency hearings; and
6. Prior to the filing of any TPR petition.

[NEW] In the event that a tribe does not formally intervene in a DCS case, DCS is still subject to the provisions of ICWA. The tribe has the right to intervene at any time during the course of DCS involvement.

Code Reference

- 25 U.S.C. §1903(4): Indian Child Welfare Definitions
- 25 U.S.C. §1911: Indian tribe jurisdiction over Indian child proceedings
- 25 U.S.C. §1913: Parental rights; voluntary termination
- 25 U.S.C. §1915: Placement of Indian children
- 25 U.S.C. §1916: Return of custody
- 25 U.S.C. §1922: Emergency removal or placement of child; termination; appropriate action
- 25 C.F.R. §23.2: Definitions
- 25 C.F.R. §23.11: Notice

PROCEDURE [REVISED]

The Family Case Manager (FCM) will:

1. Engage the child (if age appropriate) and family, during the initial contact, to assist in determining if the child and/or family are of Indian heritage or if the child is eligible for membership in an Indian tribe;
2. **[REVISED]** Engage the family to obtain information regarding the tribe if the parent or Indian custodian indicates he or she is a member of an Indian tribe or the child is eligible for membership, and complete the Indian Status Identification Form and genogram if the child is involved in any current legal actions;
3. **[REVISED]** Provide the Indian Status Identification Form and genogram to the FCM Supervisor for review and forward to the DCS Local Office Attorney before proceeding with the steps below;
4. **[REVISED]** Document the tribal identity of the child, after tribe confirmation, in the Management Gateway for Indiana's Kids (MaGIK);
5. **[NEW]** Make a Permanency and Practice Support referral in KidTraks to the International and Cultural Affairs (ICA) liaison for state tracking purposes and to assist with any ICWA related questions or concerns; and
6. Continue to review the Indian Status Identification Form with the family throughout the life of the case.

   [REVISED] Note: If it is determined the Indian parent, or Indian custodian is a member of an Indian tribe and/or the child is eligible for membership, the FCM will complete and/or update a Permanency and Practice Support referral in KidTraks for the ICA liaison to reflect membership.

The FCM Supervisor will:

1. **[REVISED]** Ensure the FCM asks each child and family member if he or she is a member of an Indian tribe or eligible for membership;
2. Ensure the Indian Status Identification Form and genogram are completed prior to forwarding to the Local Office Attorney; and
3. Assist the FCM to ensure adherence to ICWA.

The DCS Local Office Attorney will:

1. Review the Indian Status Identification Form upon receipt to ensure it is complete;
2. Obtain the address for the tribe in the Federal Register, Volume 77, No. 148 - Indian Child Welfare Act: Designated Tribal Agents for Service of Notice (August 1, 2012) at http://www.gpo.gov/fdsys/pkg/FR-2012-08-01/pdf/2012-18594.pdf and http://www.bia.gov/cs/groups/webteam/documents/document/idc1-029026.pdf;
3. Notify the Indian tribe immediately that there is a pending proceeding in Indiana involving an Indian child;
4. Complete and send the ICWA Notification (a template can be found on the Legal SharePoint) by certified mail, with return receipt requested, to the Indian child's parents or custodian and the tribe;
5. Send **copies** of the notification, via mail, to the Midwest Regional Director and the U.S. Secretary of the Interior;

U.S. Department of Interior
Bureau of Indian Affairs
Midwest Regional Director
ATTN: ICWA
Norman Pointe II Building
5600 W. American Blvd., Suite 500
Bloomington, MN 55437

U.S. Department of Interior
U.S. Secretary of Interior
Indian Services
1849 C Street, N.W., MS 4513-MIB
Washington DC, 20240

[REVISED] Note: If contact information cannot be found for the child's parent, Indian custodian, or Indian tribe, and there is reason to believe the child is an Indian child, the ICWA Notification must be sent certified mail, with return receipt requested, to the Midwest Regional Director of the Bureau of Indian Affairs (BIA). The BIA will not make a determination of tribal membership, but may be able to identify tribes for DCS to contact. The U.S. Secretary of the Interior has **15 days** after receipt to provide the required notice to the parent or Indian custodian and the tribe. Any hearings regarding placement, including prospective placement, may not be held until **10 days** after the latest receipt by the parent, custodian, tribe, Midwest Regional Director of the Bureau of Indian Affairs, and the U.S. Secretary of Interior.

6. **[REVISED]** Notify the FCM of the child's tribal eligibility following confirmation from the Indian tribe; and
7. **[NEW**] Once an Indian tribe is designated as the child's Indian tribe, all tribes which received notice of the child custody proceeding must be notified in writing of the determination, and a copy of that document must be filed with the court and sent to each party to the proceeding and each person or governmental agency that received notice of the proceeding. Notices should also be sent in voluntary proceedings.

PRACTICE GUIDANCE

The FCM should engage every child (if age appropriate) and/or family in a discussion to determine if the child and/or family are of Indian heritage or if the child is eligible for membership in an Indian tribe. The Bureau of Indian Affairs (BIA) provides guidelines for State Courts and Child Welfare Agencies when implementing the Indian Child Welfare Act (ICWA). These guidelines are found in the Federal Register/Vol. 80, No. 37/ Wednesday, February 25, 2015/Notices, and the guidelines suggest that DCS should ask, in every child custody proceeding, "Is this child an Indian child?". Even if the child is not an enrolled member, DCS should also ask, "Is this child eligible for membership?". Whether or not a child is an Indian child for purposes of ICWA must be determined by the tribe of membership and federal law, and is not an arbitrary label assigned at the discretion of the parent. The tribe alone retains the responsibility to determine tribal membership. An Indian child does not have to be enrolled to be considered a member. See www.bia.gov for further information.

If any questions arise, contact the Midwest Regional Office for assistance:

U.S. Department of Interior
Bureau of Indian Affairs
Midwest Regional Office
Norman Pointe II Building

5600 W. American Blvd., Suite 500
Bloomington, MN 55437
Telephone: (612) 713-4400
(612) 725-4500
Fax: (612) 713-4401

Regional Director
Phone: (612) 725-4502
Fax: (612) 713-4401

Regional Social Worker
Phone: (612) 725-4571
Fax: (612) 713-4439

[NEW] International and Cultural Affairs (ICA) Resources
ICA information is available on the Permanency and Practice Support SharePoint. This information includes several helpful documents and information regarding all services provided by ICA. The Permanency and Practice Support SharePoint serves as a resource for FCMs and other DCS staff seeking information to help improve services to multicultural populations and families (e.g., immigrant: tribal; sensory-impaired; Lesbian, Gay, Bi-Sexual, Transgender, Questioning [LGBTQ]; and members of the military) by honoring the diversity of cultures and perspectives constituting the Indiana child welfare population. An email inbox is available to obtain guidance from an ICA liaison (Internationalandculturalaffairs@dcs.in.gov).

FORMS

1. ICWA Notification – Legal document
2. Indian Status Identification Form
3. Tool 2.A Procedure for Transfer of a Child to a Tribe or Tribal Agency

RELATED INFORMATION

[REVISED] Indian Child Welfare Act (ICWA)
The Indian Child Welfare Act of 1978 was initially enacted by Congress to ensure that agencies meet the cultural needs of Indian children and to protect the continued existence and integrity of Indian tribes. ICWA provides heightened protection for Indian families, and it gives the Indian child's parents or custodian and the tribe, the right to intervene or request transfer to their tribal court of any state proceedings involving an Indian child.

Pokagon Band of Potawatomi Indians
The Pokagon Band of Potawatomi Indians are a federally-recognized tribe. Six (6) northern counties in Indiana are home to some of the Pokagon members, although the Pokagon Band of Potawatomi Indians headquarters remains in Michigan. If a case involving an Indian child, identifying as a member of the Pokagon Band of Potawatomi Indians, comes to the attention of DCS, contact the Pokagon Band at the address below to verify the child's eligibility for tribal membership:

Pokagon Band of the Potawatomi Indians
Social Services Director
58620 Sink Road
Dowagiac, MI 49047

Phone: (269) 462-4277
Fax: (269) 782-4295
Mark.Pompey@pokagonband-nsn.gov

Indian Tribe Membership and Eligibility

If the child is a member of a tribe or eligible for membership in a tribe, the family, the Indian custodian, and the tribe have rights under the ICWA. These rights apply to any child protection action, adoption, guardianship, TPR, runaway, or truancy matter regarding the involvement and/or placement of an Indian child (e.g., foster care placements, prospective adoptive placements, adoptive placements, both voluntary and involuntary placements, transfers of placement, and placements due to failed adoptions). Below are definitions that apply to cases involving a child who is a member of a tribe or eligible for membership in a tribe:

1. "Foster care placement" is any action removing a child from his or her parent or Indian custodian for temporary placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, although parental rights have not been terminated**;**
2. "Termination of parental rights" is any action resulting in the termination of the parent-child relationship;
3. "Preadoptive placement" is the temporary placement of an Indian child in a foster home or institution after TPR, but prior to or in lieu of adoptive placement;
4. "Adoptive placement" is the permanent placement of an Indian child for adoption, including any action resulting in a final decree of adoption;
5. **[REVISED]** "Indian Child" is any unmarried person who is under age 18 and is either:
   a. A member of an Indian tribe; or
   b. Eligible for membership in an Indian tribe and the biological child of a member of an Indian tribe.

6. **[REVISED]** "Indian Tribe" is any Indian tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary because of their status as Indians, including any Alaska Native village as defined in 43U.S.C. 1602 (c). In the case of an Indian child who is a member or eligible for membership in more than one tribe, the Indian tribe with which the Indian child has more significant contacts will be designated as the child's tribe. See ICWA Guidelines 2015 for further information.

[REVISED] ICWA Protection for Parents and Indian Custodians

ICWA provides several protections for parents or Indian custodians of an Indian child. These protections include the right to revoke voluntary consents to placements and adoptions at any time prior to a decree of voluntary termination or adoption, whichever occurs later. If a consent is withdrawn, the Indian child shall, with court approval, be immediately returned to the parent or Indian custodian. After a final Decree of Adoption is entered, based on a voluntary consent, the parent may petition the court to vacate the adoption decree based on fraud or duress. Upon a finding that consent was obtained through fraud or duress, the court shall vacate the adoption decree and return the child to the parent. However, no adoption in effect for at least two (2) years may be challenged on this basis. A consent given prior to or within 10 days after the birth of the Indian child is not valid.

If a final Decree of Adoption is ever vacated, set aside, or the adoptive parents voluntarily consent to termination of their parental rights, the Indian child shall be returned to the biological parent or prior Indian custodian unless the court determines returning the child is not in the best interests of the child.

2015 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; 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 Infomatics.
- Wendy Crouch M.A.: Active foster parent licensed through the Villages (LCPA) and adoptive mother of one. 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.

Subsequent 2015 CRP meetings occurred as follows:

April 18	August 15
May 16	September 19
July 18	November 21

In May 2015, panel members were advised by the DCS liaison that the work on their selected project need not be completed by the end of the calendar year in order to comply with statutory requirements. At that time, the panel opted to continue their investigatory work into

2016 and make the project a three year assessment in order to more fully compile and evaluate available information due to outside time constraints on various panel members.

In addition to these meetings, four panel members (Stephanie Kerner, Bridgett Morales-Kilgore, Donna Redmond, and Jenifer Alexander) attended the 2015 National Citizen Review Panel Conference in Portland, Oregon from May 18-20, 2015. Information gathered from that conference was shared with panel members who attended the July 18, 2015 HFASI support group meeting. The panel is opted not to attend the 2016 annual conference and instead focus on completing their designated project.

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.

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. From this group, the panel chose to look at randomly chosen cases that were closed and later reopened, closed, or currently open to track (12 of each).

A meeting on November 12, 2014 was held between DCS and the panel to determine the best format for transferring the case information to the panel as the Department uses two systems to track case data. Case data has been transferred to the panel as of this date, and is currently under review.

2015 update: Cases are in the final stages of review by each panel member. 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.

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.

Respectfully submitted,

Stephanie Kerner

Chairperson, Indiana Foster Care Citizens' Review Panel

June 10, 2016

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?

Michael R. Pence, Governor
Mary Beth Bonaventura, Director

Indiana Department of Child Services
Room E306 – MS47
302 W. Washington Street
Indianapolis, Indiana 46204-2738

317-234-KIDS
FAX: 317-234-4497

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

June 28, 2016

Dear Hendricks County Foster Care Citizen's Review Panel ("Panel") Members:

DCS is in receipt of your 2015 Indiana Foster Care Citizen's Review Panel Annual Report and is appreciative of the work your group has performed over the past year to examine the policies, procedures, and practices of Indiana's child protection system. We are pleased that four members of the Panel had the opportunity to attend the 2015 National Citizen Review Panel Conference and were able to bring back helpful information to share with other members of the group.

We are glad to learn that your Panel continues to make progress on the three (3) activities as outlined in your report and we look forward to working with you as you complete your project in 2016. Below are responses to the updates you provided on your activities.

Activity 1 – Completion of survey of DCS caseworkers and foster parents. DCS will review the proposed survey you included in your report and assist you in coordinating with Field Management for approval and distribution.

Activity 2 – Case Analysis. We are encouraged to hear the Panel is in the final stages of its analysis and study of the cases it has been reviewing and looks forward to receiving the input of the Panel. DCS is working to establish a robust continuous quality improvement ("CQI") model throughout the agency and performing case reviews and receiving feedback from stakeholders are important pieces to the CQI model.

Activity 3 - Assessment Review. The findings from the Panel's review of the DCS assessment tools will be valuable to the overall improvement of the assessment process. Having effective initial and ongoing assessments play an important role in protecting children and ensuring the appropriate services are being put in place for both children and families. DCS is focused on identifying assessment methods and tools that can more effectively serve the interests of the children and families we work with.

Thank you again for volunteering your time and expertise to this important Panel and helping to improve the lives of Indiana children. Please contact your Citizen Review Panel liaison, Kyle Gaddis, for any assistance you may need.

Sincerely,

Mary Beth Bonaventura

Mary Beth Bonaventura
Director, Indiana Department of Child Services

Protecting our children, families and future

JANUARY 18,2016
SWITZERLAND COUNTY CRP

Having looked at several topics, our group chose to discuss "alternative and increased treatment strategies for juvenile sex offenders." We have great concern that more and better methods could be employed in the prevention phase as well as the treatments of these youths.

We looked at current treatments which include :
1. case management and/or counseling
   a. may be individual and/or family
2. residential placement with specifically targeted counseling and/or programs to complete

Having personally as well as statistically seen many examples of recidivism in this area, we have made the following recommendations, with the understanding that the fulfillment of these are primarily dependent upon funding.

Recommendation #1: There needs to be more education on the subject of juvenile sex offenders. With knowledge comes power and if parents, caregivers, or teachers can be made aware of what to look for in problematic behaviors that may lead to sex offenses or be able to recognize those being offended, perhaps better outcomes would be possible. Our thinking is education could bring about prevention. We would like to see programs presented in schools and communities. Statistics show that sexual abuse of children 3-7 appears to be a sensitive period when sexual abuse can do the most damage and place youth at a higher risk for engaging in sexual abusive behavior later in life (Justice Programs, chapter 2:Etiology and Typologies of Juveniles who have committed Sex Offenses)(Leversee,2015) Thus we believe education should begin very early .

Recommendation #2: We would like to see more intensive counseling available with expertise in the field of need. The general conclusion is that one hour a week is hardly sufficient to treat an offender or a victim. Perhaps DCS could develop a policy in which could be recommended to the courts to provide some sort of accountability for parents or caregivers of offenders should they not comply with getting the recommended counseling for their youth. It seems the accountability might be considered to be in the neglect category as the youth would be suffering do to the lack of support and guidance.

Recommendation #3: Our group has noted what seems to be extensive time involved between the initial offense and the intensive treatment phase. Understanding some of this is related to court schedules, but perhaps some interim intervention could be developed in order to expedite counseling and targeted care for the youth.

Respectfully submitted,
Switzerland County CRP.

Michael R. Pence, Governor
Mary Beth Bonaventura, Director

Indiana Department of Child Services
Room E306 – MS47
302 W. Washington Street
Indianapolis, Indiana 46204-2738

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June 28, 2016

Dear Switzerland County Child Protection Team Citizen's Review Panel ("Panel") Members:

DCS is in receipt of your 2015 Child Protection Team Citizen's Review Panel Annual Report and is appreciative of the work your Panel puts forth to improve Indiana's child protection system. The Panel's decision to examine treatment strategies for juvenile sex offenders is an important one and an issue DCS encounters regularly. As you are aware, many youth who come into care have experienced trauma, and as a result have symptoms that can have an adverse impact on their behavior, judgment, educational performance and ability to connect with caregivers. When a youth comes into care, a comprehensive trauma assessment helps determine which intervention will be most beneficial. One of those assessments is the Child Sexual Behavior Inventory (CSBI) which helps identify those youth that present areas of concern/risk as it relates to sexual behaviors. Thereafter, the clinician responds with a written report with a recommendation of services within 14 days from the date of assessment.

Responses to each of your recommendations are listed below:

Recommendation #1:

> *There needs to be more education on the subject of juvenile sex offenders. With knowledge comes power and if parents, caregivers, or teachers can be made aware of what to look for in problematic behaviors that may lead to sex offenses or be able to recognize those being offended, perhaps better outcomes would be possible. Our thinking is education could bring about prevention. We would like to see programs presented in schools and communities. Statistics show that sexual abuse of children 3-7 appears to be a sensitive period when sexual abuse can do the most damage and place youth at a higher risk for engaging in sexual abusive behavior later in life (Justice Programs, chapter 2: Etiology and Typologies of Juveniles who have committed Sex Offenses) (Leversee, 2015) Thus we believe education should begin very early.*

DCS shares your vision of increasing awareness and knowledge of sexual abuse and the far reaching effects it can have on children. DCS is continuously trying to identify ways to better educate the public on issues facing the children of our state. That education must involve not only being able to recognize the warning signs of sexual abuse, but also reminding the public and professionals (i.e. educators, medical professionals, etc.) of their duty to immediately report instances of child abuse and/or neglect to law enforcement or DCS. DCS continues to work closely with the Indiana Department of Education on a number of initiatives and will pass along your recommendations to their leadership.

Recommendation #2:

We would like to see more intensive counseling available with expertise in the field of need. The general conclusion is that one hour a week is hardly sufficient to treat an offender or a victim. Perhaps DCS could develop a policy in which could be recommended to the courts to provide some sort of accountability for parents or caregivers of offenders should they not comply with getting the recommended counseling for their youth. It seems the accountability might be considered to be in the neglect category as the youth would be suffering due to the lack of support and guidance.

DCS currently contracts with 47 service providers statewide for sex offender specific treatment services. Sex offender specific treatment is designed to improve public safety by reducing the risk of reoccurring sexually based offenses. The treatment is an intervention carried out in a specialized program containing a variety of cognitive behavioral and psycho-educational techniques that are designed to change offense supportive beliefs and attributions, improve handling of negative emotions, teach behavioral risk management, and promote pro-social behavior. Because programming relies on a containment approach, providers work closely with local service and treatment agencies to enhance the community's response to sexual offending.

Along with sexual offender specific treatment, containment teams are established for each referral in order to ensure consistency in service delivery and decision-making and foster collaboration. Programming provides services to children and their families who are referred by DCS Services and/or the local Juvenile Probation Department. When necessary, DCS also has residential placements that focus on treatment for sexually maladaptive youth. These programs provide highly structured, intensive sex offender specific treatment.

DCS recognizes the importance of parental involvement in achieving successful case closure and preventing a reoccurrence of child abuse and neglect in every case. As such, parental involvement is a key metric DCS monitors throughout all of its cases and an area the agency is continually trying to improve in.

Recommendation #3:

Our group has noted what seems to be extensive time involved between the initial offense and the intensive treatment phase. Understanding some of this is related to court schedules, but perhaps some interim intervention could be developed in order to expedite counseling and targeted care for the youth.

DCS strives to have services in place as quickly as possible, but as your recommendation suggests, delays often occur due to a myriad of factors, including the inherent time requirements in court proceedings. A copy of this report will be shared with DCS Executive Staff to consider the issue statewide and identify options for services which could act as bridge before more intensive treatment can begin or in the alternative, identify ways to start intensive services earlier.

Furthermore, DCS collaborates with the Indiana Judicial Center and the Court Improvement Program (CIP) to improve the child welfare practice in legal proceedings by ensuring courts are effectively providing for the safety, well-being and permanency of children and families. For example, one of the elements the CIP measures is timeliness of court proceedings, a factor that has a significant impact on

accessing services. Kyle Gaddis, your Citizen Review Panel liaison, will present your report to the Indiana Judicial Center Court Improvement Program Coordinator for their consideration.

Thank you again for volunteering your time and expertise to this important Panel and helping improve the lives of Indiana children. Please contact your Citizen Review Panel liaison, Kyle Gaddis, for any assistance you may need. We look forward to working with you as you continue your panel's activities for 2016.

Sincerely,

Mary Beth Bonaventura

Mary Beth Bonaventura
Director, Indiana Department of Child Services

Protecting our children, families and future

INDIANA'S HEALTH OVERSIGHT AND COORDINATION PLAN

Fostering Connections to Success and Increasing Adoption Act of 2008 (P.L. 110-351/H.R. 6893) contains a provision requiring each state, under Title IV-B, to create a plan to ensure ongoing oversight and coordination of health care for foster children. State child welfare agencies and state agencies that administer Medicaid are required to work collaboratively in crafting the plan and include consultation with pediatricians and other health care experts.

DCS joined forces with the Indiana Family and Social Services Administration (FSSA), which is the agency that administers Medicaid in Indiana, and collaborated with pediatricians and other health care experts in Indiana to develop the Health Care Oversight and Coordination Plan.

Reflecting all recent amendments, the Health Care Oversight and Coordination Plan, developed in coordination with the State Medicaid agency, must now include an outline of the items listed below:

1. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
2. How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home;
3. How medical information will be updated and appropriately shared, which may include developing and implementing an electronic health record;
4. Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care;
5. The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
6. How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and
7. Steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met.

P.L. 110-351 stipulates that the Health Oversight and Coordination provision does not reduce or limit the responsibility of Medicaid agencies in administering and providing care to children served by the state child welfare system.

BACKGROUND:

The following outlines Indiana's coordinated strategy to identify and respond to the health care needs, including mental and dental, of foster children.

The Indiana Department of Child Services (DCS) joined forces with the Indiana Family and Social Services Administration (FSSA), the state agency responsible for administering Medicaid, to ensure that the physical, dental, and mental health needs of DCS foster children and youth are being met. They also

work to ensure that all DCS foster children and youth are enrolled in Medicaid and therefore eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and managed care services.

There are several program options available under Indiana Medicaid, with programs designed to meet the medical needs of certain groups of people. Indiana Medicaid programs include:

- Traditional Medicaid
- Care Connect
- Hoosier Healthwise
- M.E.D. Works
- Healthy Indiana Plan
- Waivers
- Medicaid Pharmacy Benefits
- Presumptive Eligibility
- Family Planning Eligibility Program

DCS foster children and youth are enrolled in Traditional Medicaid unless they have a qualifying medical condition. Those with qualifying medical conditions are enrolled in *Care Connect*. Both Medicaid plans provide reminders and educational materials, as well as assistance with scheduling and transportation for EPSDT appointments. Enrollment of all eligible wards of DCS and youth in foster care in Medicaid provides the basis for a coordinated interagency strategy to identify and respond to the health, mental, and dental care needs of wards of DCS and youth in foster care.

DCS and FSSA created an administrative, legal, and technical framework for more efficiently facilitating wards of DCS and youth in foster care onto Medicaid and improving health outcomes. The framework between the two state agencies is supported through: bi-weekly and monthly project and program specific meetings between the DCS and FSSA; Memorandums of Understanding (MOU); the creation of a specialized Medicaid Eligibility Unit (MEU) within DCS to enroll wards of DCS and youth in foster care in Medicaid; as well as, an on-going and regularly scheduled exchange of relevant medical data between the two agencies.

TRADITIONAL MEDICAID

Traditional Medicaid provides assistance for medical expenses such as doctor visits, prescription drugs, dental and vision care, family planning, mental health care, surgeries, and hospitalizations. It does not require that the member choose a specific doctor or provider of services.

CARE CONNECT:

On April 1, 2015, Indiana Medicaid began a new managed care program called Hoosier Care Connect. Hoosier Care Connect replaced the previous health care program in Indiana, Hoosier Select. Hoosier Care Connect is a new coordinated care program for individuals that are aged, blind, or disabled, in addition to some groups of children in foster care. Hoosier Care Connect is a managed care program. Children on Hoosier Care Connect will receive the same benefits as those children on traditional Medicaid, in addition to receiving the following services:

- Care coordination, including assistance in coordinating health care appointments and transportation
- Assistance in connecting with healthcare providers and specialists

- Disease management and wellness programs
- Access to a 24 hour Nurse Helpline

Those eligible for Hoosier Care Connect will select a Managed Care Entity (MCE), which is a health plan that will work in partnership with medical providers to coordinate health care. Each MCE has a network of physicians, pharmacies, and hospitals that will provide health care to Hoosier Care Connect members. Care coordination will be customized based on an individual's level of need as determined by a health screening.

MCE care coordinators assist the family case manager and/or the child's foster care provider in coordinating health care appointments and transportation. Care coordinators will also provide reminders of upcoming health care appointments and can assist in identifying health care providers and specialists appropriate to a child's needs. Depending on the MCE selected, there may also be programs and educational opportunities available for the child to assist with their specific healthcare needs.

DCS wards that are eligible for Title IV-E, youth in Collaborative Care, and former foster care youth may be eligible for Hoosier Care Connect. Initially, only children and youth currently on Care Select that are eligible will be enrolled in Hoosier Care Connect.

The DCS Medicaid Enrollment Unit (MEU) assists with the initial enrollment of eligible children on Hoosier Care Connect. Once a child is enrolled, those individuals that are authorized to talk to the MCE about the child's health care, including the child's FCM and foster care provider, are provided to the MCE.

MEU contacts the FCM to obtain the name of an eligible child's physicians and other health care providers so that an MCE plan can be selected. Each child must have an initial health assessment completed upon entry into the Hoosier Care Connect program. The initial health assessment helps determine the level of care coordination that is needed for the child.

Once an MCE is selected, a care coordinator from the MCE contacts the FCM to obtain the names of the child's physicians and other health care providers so that a primary medical provider (PMP) can be identified. The PMP is the doctor that the child will see for most of his/her health care services. The care coordinator may also contact the FCM to assist in coordinating the child's health care appointments and transportation.

ADMINISTRATIVE FRAMEWORK:

MEDICAID ELIGIBILITY UNIT (MEU)

DCS works collaboratively with Indiana FSSA, Division of Family Resources (DFR,) to facilitate enrollment of DCS wards and youth in foster care in Medicaid.

DCS created a specialized, internal, Medicaid Enrollment Unit (MEU) which was piloted in select counties and then implemented statewide effective August 1, 2010. MEU workers partner with Indiana's DFR and OMPP to ensure coverage and appropriate category choice for each DCS child or youth in placement. MEU enrolls IV-E eligible children in Medicaid and facilitates the Medicaid application process for non-eligible children in care as the authorized representative for the child. The following addresses how these functions are carried out.

DCS is engaged in an on-going dialogue with FSSA, the Office of Medicaid Policy and Planning (OMPP), the Division of Mental Health and Addictions (DMHA), and the Division of Family Resources (DFR) to coordinate strategies for responding to the physical and behavioral health needs of wards of DCS and youth in foster care.

LEGAL FRAMEWORK:

A legal framework for interagency collaboration to meet the health needs of wards of DCS and youth in foster care is supported and guided by Memorandums of Understanding (MOU).

The purpose of this MOU between DCS and OMPP is to define the programmatic and administrative responsibilities of DCS, DFR, and OMPP, in order to administer state aid to wards and foster children, and to work collaboratively in formulating a plan and sharing information to ensure that the health needs of children in foster care are being adequately met.

DCS is also engaged with FSSA Division of Mental Health and Addictions through an MOU.

The purpose of this MOU is to define DMHA and DCS' programmatic and administrative responsibilities for the provision and management of behavioral health services for wards of DCS and youth in foster care. The MOU provides for the implementation of uniform assessments through the use of the CANS assessment tool discussed earlier. It provides for the exchange of data to support the programs, staff training and certification, and ongoing interagency communication. Additionally, it provides for outcome quality management processes using data to support decisions at the child and family intervention, program and policy levels.

TECHNICAL FRAMEWORK:

DCS and OMPP are working together to develop a technical framework that allows for the sharing of relevant medical data and other information related to health. The intent is to allow for a mutual and regularly scheduled electronic exchange of medical information for wards of DCS and youth in foster care. This information is used to enhance detail already contained in the electronic health record or Medical Passport for each youth and assists in ensuring that all wards of DCS and youth in foster care receive the most appropriate medical care possible.

Additionally, the technical framework assists in facilitating statewide enrollment in Medicaid, as well as enhanced case management in regard to health outcomes by allowing for limited real time access to medical data, including prescription medications. This interagency collaboration was finalized with the completion of an MOU between DCS and OMPP in January, 2013. In late 2013 and throughout 2014 and into 2015, the agencies continue to work together to establish the technical infrastructure to support exchange of this information.

THE PLAN

1. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.

Efforts to improve health outcomes for DCS children and youth in foster care are supported through improved consistency and the frequency of initial and follow-up health screens. Improvement is being addressed by implementing statewide use of a standardized assessment tool by all DCS Family Case Managers, as well as increasing the frequency of youth receiving an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screen.

THE CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) ASSESSMENT

To improve consistency and provide for better mental health outcomes for children and youth in the care of DCS, DCS partnered with the FSSA Division of Mental Health and Addictions to implement the Child and Adolescent Needs and Strengths Assessment (CANS) Comprehensive tool. The CANS refers to a group of outcome management tools that have been developed by John Lyons, PhD, University of Ottawa, in collaboration with stakeholders across multiple states.

In January 2008, DCS contractually required that DCS licensed residential providers administer the age appropriate CANS assessment unless an assessment had been completed on the child within 30 days of admission by another qualified resource (most often a mental health provider). In August of 2009, DCS began the implementation of the CANS Pilot Protocol by DCS Family Case Managers (FCMs), with the statewide rollout completed in April 2010.

Statewide use of the CANS allows DCS to document the intensity of behavioral health services needed by the child and family and is the basis for planning individualized services for children. The implementation of this tool provides a more uniform initial assessment of the behavioral and mental health needs of wards of DCS and youth in foster care. The CANS assessment also plays a critical role in informing decision-making regarding the type and level of placement a child needs once the decision to place has been made. The CANS assessment is completed by FCMs who are trained and certified in its use.

In 2012, DCS developed three CANS Consultants who provide Education and Support to field staff and all levels of management to ensure consistent level of understanding in CANS administering and its understanding. These CANS Consultants received specialized training from Dr. Lyons in 2014 and are certified CANS Trainers.

Two versions of the CANS were previously used by DCS staff – the short CANS and the comprehensive CANS. In 2014, DCS eliminated use of the short CANS, requiring staff to complete the comprehensive CANS in all circumstances. DCS learned that when it was utilizing the short CANS that it did not provide the comprehensive information needed about the child/family. Below please find a summary of the DCS policy requirements for CANS completion.

Comprehensive CANS

- Will be completed within 5 days of removal;
- Will be completed for every child under the supervision of DCS, regardless of age, who is in an out of home placement prior to the initial Case Plan being due;
- Will be completed for every substantiated assessment which does not result in an open case.

Reassessments

- After the initial comprehensive CANS, reassessments are due every 180 days (prior to the updated Case Plan being due) and anytime there is an apparent change in the child's needs that might need a different intensity of services.

Assessment information regarding an individual child is used by residential providers, children and families, DCS FCMs, and other members of the Child and Family Team to plan appropriate interventions, monitor progress, and adjust intervention plans based on the child and family's needs and strengths. The CANS guides the FCM and the Child and Family Team in deciding what type of behavioral health services the child needs and what level of placement best suits his/her needs. Additionally, this information can be incorporated in the Care Plan developed as a part of the four-step Care Management Model.

Early and Periodic Screening Diagnosis and Treatment

DCS strives to make certain that every DCS child or youth in foster care has an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) evaluation completed by an approved physician. This practice is supported by DCS Policy 8.29 -Routine Health Care – which addresses continuity of healthcare services to vulnerable children, as well as requires DCS to facilitate the provision of a general health exam, consistent with the HealthWatch/EPSDT screening protocols, to all children in out-of-home care within 10 business days of placement.

To maximize the developmental capacities of all children, regardless of circumstance and in compliance with Federal guidelines, Indiana provides EPSDT services for children and young adults enrolled in a Medicaid health insurance program. In Indiana, these services are provided through the HealthWatch/EPSDT Program.

The HealthWatch/EPSDT program screening includes:

- Comprehensive health and developmental history, including assessment of both physical and mental health development;
- Comprehensive unclothed physical exam;
- Appropriate immunizations according to age and health history;
- Laboratory tests including a lead toxicity screening;
- Nutritional Assessment;
- Health Education, including anticipatory guidance;
- Vision screens;
- Hearing screens; and
- Dental screens.

The HealthWatch/EPSDT program facilitates the provision of timely and responsive health care to Medicaid recipients' ages birth through 21 years old, capturing much of the child population with whom DCS is involved. Implemented through initial and subsequent periodic health screenings consistent with the recommendations of the American Academy of Pediatrics (AAP), the HealthWatch/EPSDT Program is designed to mitigate the risks of long-term impairment through the earliest possible detection and treatment of medical, developmental, and psychological conditions.

DCS FCMs often work with a Care Coordinator through *Care Select* to assist in finding an approved physician for conducting the EPSDT screens. The information from the EPSDT screen is then incorporated into the youth's Care Plan developed as a part of the four-step Care Management Model.

2. HOW HEALTH NEEDS IDENTIFIED THROUGH SCREENINGS WILL BE MONITORED AND TREATED, INCLUDING EMOTIONAL TRAUMA ASSOCIATED WITH A CHILD'S MALTREATMENT AND REMOVAL FROM HOME.

SCREENING

The information gathered through the CANS and EPSDT screens will be incorporated into each youth's Case Plan. Driven by the Case Plan, the FCM, Child and Family Team, and Care Coordinator (for those in *Care Select*) take the necessary steps to meet the child's physical, mental, dental, visual, auditory, and development needs. In addition to, and in conjunction with, the child's Care Management Plan, DCS will ensure:

- A general health exam within 10 days of placement.
- An initial dental exam and cleaning is scheduled no later than six months after the date of the child's last known exam and cleaning. If no records exist, the child will receive an initial exam and cleaning within 90 days of placement.
- A hearing exam is conducted every 12 months for children with corrected hearing or as recommended by the child's physician.
- FCMs complete at least annual health care surveys to ensure the youth's physical, hearing, and vision exams occur and provide updates from these screenings.
- The Child and Family Team is empowered to assist in the on-going monitoring and treatment of the youth.

In order to monitor and treat emotional trauma associated with a child's maltreatment and removal, in addition to other health needs identified through screenings, DSC will screen all youth entering the system using the CANS-Adjustment to Trauma measure. To better serve youth and families with complex trauma histories, DCS has developed and implemented a Clinical Resource Team. This team consists of twelve licensed mental health clinicians, based regionally throughout the state and supervised by a licensed psychologist. The Clinical Resource Team provides consultation to FCMs and local DCS offices on cases involving complex mental health, substance abuse and/or domestic violence issues. One of the key roles of the Clinical Resource Team is to work with contractual providers to deliver evidence based, trauma-informed services and to develop trauma-informed treatment plans on a case-by-case basis. The Clinical Resource Team may be utilized any time that DCS has a question about the mental health needs of a child or family.
DSC screens all youth entering foster care using the CANS-Trauma Module to identify trauma-related needs associated with a child's maltreatment and removal from the home. Youth who score a "3" on the CANS "adjustment to trauma" item may be referred to a DCS mental health contractor for a trauma assessment, or the child's FCM may be referred for a clinical assessment with a member of the Clinical Resource Team to determine the best course of treatment. Recommendations from the clinical assessment are incorporated into the DCS case plan, including any recommendations for specific, trauma-informed services.

TRAUMA-INFORMED SERVICES

DCS has also developed a "Trauma-Informed System of Care" training curriculum in collaboration with the Indiana University School of Social Work (and based on NCTSN materials). In the past year, workshops on this topic have been provided to Local Office Directors and Supervisors, as well as Juvenile Judges, Guardian ad Litems and Court Appointed Special Advocates (CASAs) across the state. The new training curriculum was piloted in two Regions during the first quarter of 2013, and a regional training schedule has been developed to ensure that all staff receives this training in 2013.

At the programmatic level, DCS requires contractual providers to include trauma-informed care as a "core competency" in their programs and services. For additional information on the evidence-based, trauma-informed service array and associated provider trainings, please see Section V, B. Preservation and Reunification Services in the 2015-2019 Child and Family Services Plan.

In recent years, DCS has developed a strong collaboration with the Indiana Community Mental Health Centers (CMHC). Meetings with the CMHC Workgroup occur bi-weekly with a focus on improving access and effectiveness of services for DCS clients. The Indiana Council of Community Mental Health Centers partners with DCS to provide an annual conference which includes CMHC leadership and DCS local and central office leadership. The main initiatives of the collaborative include improving access and effectiveness of:

- Medicaid Rehabilitation Option services,
- Children's Mental Health Initiative, and
- Substance Use Disorder treatment.

This conference will occur in July 2014 and will bring the DCS local office management together with the management of the local Community Mental Health Centers a day-long meeting.

3. HOW MEDICAL INFORMATION FOR FOSTER CHILDREN WILL BE UPDATED AND APPROPRIATELY SHARED, WHICH MAY INCLUDE THE DEVELOPMENT OF AN ELECTRONIC HEALTH RECORD:

DCS maintains written and electronic (detailed in Technical Framework section) documentation of healthcare services received by wards of DCS and youth in foster care.

A written summary of the child's medical history is included in each child's Case Plan. All children who are placed in out-of-home care are issued a Medical Passport, as well as additional forms for authorization for medical services; consent to release mental health and addiction records, record of medical treatments, and a log of medical treatment. These forms are included with the Medical Passport. The Medical Passport is the place of record for a broad range of health care services, including medical, dental, mental health, developmental, vision, hearing and speech care. The Medical Passport remains with the child and in the possession of the resource family throughout all out-of-home placements.

DCS requires the child's resource family to keep the child's Medical Passport up-to-date with the child's most recent healthcare information. Additionally, DCS keeps a separate record of the child's healthcare information in Indiana Child Welfare Information System (ICWIS) Medical Passport. When the child achieves permanency (e.g., reunification, adoption), DCS requires that the permanent caregiver or the child, if released from substitute care after his or her 18th birthday, receives the Medical Passport. DCS completed an MOU with the Indiana Office of Medicaid Planning and Policy (OMPP) which, allows for the exchange of medical claim history from the Medicaid system to DCS' MaGIK system. This will

allow FCMs to view wards' medical events such as doctor visits, ER visits, prescriptions, and immunizations by selecting the appropriate medical screen in MaGIK. It will also allow for the management or psychotropic medications as outlined in section 5d. The DCS technical team is currently working with the technical team from OMPP to establish the framework to allow this information sharing to occur.

4. STEPS TO ENSURE CONTINUITY OF HEALTH CARE SERVICES, WHICH MAY INCLUDE ESTABLISHMENT OF A MEDICAL HOME FOR EVERY FOSTER CHILD.

To ensure the continuity of health care services for DCS foster children and youth with significant mental or medical needs, DCS has worked in collaboration with FSSA to implement the use of a Care Management Model (detailed earlier) through *Hoosier Care Connect.* As discussed above MCE Care Coordinators work in a collaboration with the youth, the Primary Medical Provider, the Family Case Manager, the Resource Family or care giver, the Child and Family Team, and other stakeholders to implement the individualized health care plan the youth. Additionally, Indiana's system of care provides that each child is linked to a Primary Medical Provider (PMP) who becomes the child's Medical Home enhancing continuity of care.

5. THE OVERSIGHT OF PRESCRIPTION MEDICINES, INCLUDING PROTOCOLS FOR THE APPROPRIATE USE AND MONITORING OF PSYCHOTROPIC MEDICATIONS.

INFORMED AND SHARED DECISION MAKING

DCS Policy 8.30 – Psychotropic Medication – addresses current procedures for handling of psychotropic medication for DCS foster children and youth who are in out-of-home placement. By policy, DCS requires that informed consent be obtained from the parent, guardian, or custodian and from the appropriate DCS Local Office Director or designee before a child in out-of home care is placed on psychotropic medication. DCS provides an exception to the requirement to obtain parental consent, if:

1. The parent, guardian, or custodian cannot be located;
2. Parental rights have been terminated;
3. The parent, guardian, or custodian is unable to make a decision due to physical or mental impairment; or
4. Prior court authorization has been obtained.

If the parent, guardian, or custodian denies consent, a Child and Family Team Meeting (CFTM) is convened immediately to determine if DCS will seek a court order for authorization of the recommended medication. Medication can be administered without prior consent if it is needed to address an emergency condition in which the child is a danger to himself or herself or others, and no other form of intervention will mitigate the danger. Consent must be obtained within 24 hours of administering the initial dose of medication on the weekends or holidays.

DCS has the right to request a second opinion, if there are questions surrounding the need for and/or use of psychotropic medication.

Information about all medications is maintained in child's Medical Passport. In addition to the information maintained in the paper Medical Passport, oversight of prescription medications will be enhanced through DCS' collaboration with OMPP in developing the technical framework for sharing

relevant medical data electronically. The monthly electronic exchange will include information regarding prescription medications. This will allow for oversight as well as the opportunity for enhanced case management to improve health outcomes for wards, foster and adoptive children.

PSYCHOTROPIC MEDICATION ADVISORY COMMITTEE (PMAC)

The Indiana Psychotropic Medication Advisory Committee (PMAC) was initiated in January, 2013, to provide oversight and guidance for psychotropic medication utilization among DCS-involved youth. This committee includes representatives from Indiana University Department of Psychiatry, DCS, OMPP, DMHA, pediatricians, social workers, psychologists, pharmacists, child advocates and other identified stakeholders. The advisory committee monitors Federal legislation, reviews best-practice guidelines for psychotropic medication use, monitors Indiana prescription patterns, reviews formularies and makes policy recommendations to DCS. 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.

PSYCHOTROPIC MEDICATION GUIDELINES FOR YOUTH IN CARE WITH INDIANA'S DEPARTMENT OF CHILD SERVICES (GUIDELINES)

This document was developed in 2014 by the Psychotropic Medication Subcommittee of the PMAC (Leslie Hulvershorn, MD, DMHA – Chair), with input and guidance from a wide variety of medical and behavioral health professionals across the state. The Guidelines provide "best practice" recommendations for the use of psychotropic medications in child and adolescent populations, including research-based dosage parameters, "red flag" indicators, etc.

The Guidelines were recently updated and approved at the 4/28/16 PMAC meeting to include recommendations for long-term antipsychotic injectables, as well as recommendations for medically-assisted treatment for substance abuse disorders. A copy of the updated (2016) Guidelines has been posted on the DCS internet site, under the Psychotropic Medication link (http://in.gov/dcs/3635.htm). DCS requires all contracted providers to adhere to the Guidelines when using psychotropic medications with our youth. In addition, the Guidelines have been approved by the Mental Health Quality Assurance Committee (FSSA) and are being considered for broader adoption with all Medicaid-eligible youth in Indiana.

MENTAL HEALTH/TRAUMA SCREENING

All DCS youth are screened using the CANS upon entry into the system and at critical case junctures thereafter. The CANS identifies mental health needs, and a placement algorithm is used to generate a level of care recommendation. In addition, all youth entering the foster care system receive a comprehensive mental health evaluation within the first 30 days of placement.
To identify trauma-related needs associated with a child's maltreatment and removal from the home, DSC will screen all youth entering the system using the CANS-Trauma Module. Youth who score a "3" on the CANS "adjustment to trauma" item may be referred for a trauma assessment with one of our contractual providers, or the case may be staffed with a member of the Clinical Resource Team to determine the best course of treatment. Recommendations from these clinical assessments will be incorporated into the DCS case plan, including any recommendations for specific, trauma-informed services. Training materials have been developed regarding the reliable rating of trauma needs using the CANS, and all DCS Family Case Managers have been trained on these measures.

ASSESSMENT

All children receive a comprehensive health evaluation and identification of acute medical problems prior to the administration of psychotropic medications. The physical evaluation is performed by a physician or other healthcare professional qualified to provide this service. Except in the case of an emergency, consent for psychotropic medication will not be provided until the child has received a thorough health history, psychosocial assessment, mental status exam and physical exam. In some cases, medical problems mimic and/or occur co-morbidly with psychiatric disorders. In those instances, the identification of target symptoms will be critical. When pharmacologic intervention is identified as part of the treatment plan, considerations such as diagnostic medical evaluations, drug-drug interactions, polypharmacy, treatment compliance, informed consent, and the safe storage and administration of medications will need to be documented.

The assessment of a medication trial is facilitated by the initial identification of target symptoms and the regular evaluation of those target symptoms. Secondly, the consideration of ongoing life events, particularly in children and adolescents, is essential in assessing benefits of medication. Removal from the home, a change in living situation, physical illness, parental functioning, traumatic events, etc. can all impact functioning and can confound the evaluation of a medication trial. Thirdly, compliance may need to be investigated through pharmacy records or medication administration records in order to clearly assess efficacy of a medication trial. Once an informed decision is made about a particular medication, changes in the treatment plan may be necessary, including changes in medication regime, adjustment in non-pharmacologic treatment strategies, and re-evaluation of the diagnosis.

In children and adolescents, re-evaluation of the working diagnosis is critical not only when there is a lack of treatment response, but in other situations as well. By nature, children and adolescents are developing and changing during treatment. Longitudinal information may become available revealing temporal patterns of functioning that may alter the initial diagnosis. In addition, the successful treatment of one disorder may then expose an underlying co-morbid disorder that requires treatment. Ultimately, the resolution of a disorder or the ineffectiveness of a medication requires the medically supervised discontinuation of medications. Because withdrawal or discontinuation effects may arise and confound the clinical picture, ongoing assessment is vital to sort out the illness from the medication effects.

PSYCHOTROPIC MEDICATION CONSULTATION

The IU Psychotropic Medication Consultation Program was initiated on June 1, 2015. The Indiana University School of Medicine Department of Psychiatry was contracted by DCS to monitor and optimize psychotropic medication use in the out-of-home CHINS population by reviewing outlier cases. Outlier cases are those deemed potentially problematic, utilizing criteria developed by the Indiana Psychotropic Medication Advisory Committee (PMAC) and outlined in the 2016 Guidelines. IU psychiatrists provide direct consultation to prescribing providers in those instances where an outlier has been identified. In addition, the IU Consultation Program employs a clinical psychologist to provide evaluations when there is diagnostic uncertainty, to consult with existing providers, and to provide behavioral support to caregivers.

As part of the DCS contract with IU, a Program Evaluation Team (PET) has been established – under the direction of Dr. Brea Perry from the Indiana University, Bloomington – to review monthly evaluation data. The PET will aggregate and analyze data to determine changes that have occurred as a result of program reviews and consultation with prescribing providers. The PET will create a RedCap database to collect and synthesize basic information about outlier cases for the purposes of tracking case progress. The database will also include relevant information from patient charts, as well as supplementary information on results of case review and children's medication and mental health outcomes. Follow-up chart reviews will be conducted by the PET approximately 12 months after the psychotropic consultation to determine whether this intervention had an effect on child outcomes. As part of the contract, the PET will also produce quarterly summary reports for DCS to document progress.

As of 3/1/16 (the last quarterly reporting period), IU had processed a total of 187 outlier cases, and completed 80 medication reviews. In 98% of cases reviewed, inappropriate medication practices were identified. The most prevalent concern cited by reviewing physicians was medication quantity, and specifically, four or more psychotropic medications being prescribed simultaneously (73% of cases reviewed). The second most common reason for concern was inadequate documentation and monitoring, with failure to appropriately monitor laboratory values in 42% of cases, and insufficient documentation of physical exams or vital signs in an additional 42%. Indication was also a common problem, with 27% of children in the review group being prescribed medications not appropriate for their diagnosis. An additional 27% of cases were cited as problematic due to insufficient and/or non-evidence-based psychotherapeutic interventions. With respect to provider response, in 93% of cases reviewed the prescribing physician agreed with the IU recommendations, indicating substantial agreement between IU consultants and prescribing physicians about next steps toward bringing the medication regimen in line with PMAC criteria.

GUIDELINES FOR SAFE UTILIZATION OF PSYCHOTROPIC MEDICATIONS WITH CHILDREN AND ADOLESCENTS

In order to safeguard the health and welfare of DCS youth who are prescribed psychotropic medications, the following guidelines have been adopted in the *Psychotropic Medication Guidelines for Youth in Care with Indiana's Department of Child Services*:

General Principles:

1. In the state of Indiana, a comprehensive evaluation prior to the use of medications should be performed by a licensed professional *or a qualified professional under the supervision of a licensed professional.*
2. To clarify, a physical examination is not typically completed by a child psychiatrist or necessarily required for the use/start of psychotropic medications (excluding evaluation for extrapyramidal or other movement side effects). If warranted, it is the responsibility of the evaluating mental health professional to refer the child for a physical examination.
3. A standardized trauma assessment (e.g., CANS, Trauma Symptom Checklist) is preferred for clinical assessment of exposure of trauma and maltreatment. For youth with more extensive trauma histories, a comprehensive trauma assessment may recommended by DCS. The service standard for comprehensive trauma assessments can be found at http://www.in.gov/dcs/3159.htm.
4. In addition to the need to identify DSM-5 diagnoses to direct treatment, diagnoses outlined in the relevant version of the International Classification of Diagnoses (e.g., ICD-10) are also appropriate.
5. In addition to diagnoses, benefits/risk, lab findings, adverse events, alternatives, and risks of no treatment, informed consent should also include a discussion of possible medication interactions.
6. If a non-child psychiatrist is treating a child and they are not improving Texas Parameters recommend referral to be initiated. We would like to clarify that the window for expected improvement for most childhood psychiatric disorders is 3 months.
7. When treating youth with medication for aggression, Texas Parameters recommend a slow taper with discontinuation every 6 months. To clarify, youth with aggression resulting from any of the following disorders should be given an opportunity for a taper: oppositional defiant disorder, conduct disorder, disruptive mood dysregulation disorder, developmental disabilities and autism spectrum disorder. We would like to further note that such tapers may not be routine in current clinical practice, but they are now highly recommended.

Medication-Specific Recommendations:

1. Although short acting alpha agonists for use in the treatment of ADHD and tics are not FDA approved, they remain the recommended first line agents.
2. Tapering antipsychotics in children may require longer than a 4 week period.
3. See Tables for additions
4. Routine lipid screening is recommended to be every year, rather than every 6 months, as outlined in the Texas Parameters. If abnormal values are detected, more regular monitoring (every 3-6 months) are recommended.
5. Fasting lipids and glucose are recommended to be checked on every pediatric patient prior to starting (or at first contact if medication has already been started) medications known to impact these labs (e.g., antipsychotics).
6. Evaluation of blood pressure, heart rate, weight and height is recommended for every medication monitoring visit and initial evaluation.
7. Clomipramine is only recommended for obsessive compulsive disorder if the child or adolescent has failed to complete trials of serotonin reuptake inhibitors.
8. Due to concerns about the potential for cardiac conduction abnormalities citalopram should not be prescribed at doses greater than 40 mg daily.
9. Orap should only be used for the treatment of tics if Haldol use was a failure or intolerable.

Guidelines retained from the Texas Psychotropic Utilization Parameters for Youth in State Care (Texas Parameters):

1. A DSM-IV-TR diagnosis should be made before the prescribing of psychotropic medications.
2. Clearly defined target symptoms and treatment goals for the use of psychotropic medications should be identified and documented in the medication record at the time of or before beginning treatment with a psychotropic mediation. These target symptoms should be assessed each clinic visit with the child and caretaker(s).
3. Except in the case of emergency, informed consent should be obtained from the appropriate party(s) prior to beginning psychotropic medication.
4. During the prescription of psychotropic medication, the presence or absence of medication side effects should be documented in the child's medical record at each visit.
5. Appropriate monitoring of indices such as height, weight, blood pressure or other laboratory findings should be documented.
6. Monotherapy regimens for a given disorder or target symptoms should be tried before polypharmacy.
7. Doses should usually be started low and titrated carefully as needed.
8. Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record.
9. The frequency of clinician follow up with the patient should be appropriate for the severity of the child's condition and adequate to monitor response to treatment, including symptoms, behavior, function and potential medication side effects.
10. In depressed children and adolescents, the potential for emergent suicidality should be carefully evaluated and monitored.
11. If the prescribing clinician is not a child psychiatrist, referral to or consultation with a psychiatrist should occur if the child's clinical status has not experienced meaningful improvement within a timeframe that is appropriate for the child's clinical status and medication regimen being used.
12. When medication changes are warranted within the same class of medications, a 60 day crossover period of titration of the new agent and taper of the agent to be discontinued is appropriate unless the agent to be discontinued is causing adverse effects.
13. Before adding additional psychotropic medications to a regimen, the child should be assessed for adequate medication adherence, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders), and the influence of psychosocial stressors.
14. If a medication is being used in a child for a primary target symptom of aggression associated with a DSM-IV-TR non-psychiatric diagnosis (e.g., conduct disorder, oppositional defiant disorder, intermittent explosive disorder), and the behavior disturbance has been in remission for six months, then serious consideration should be given to slow tapering and discontinuation of the medication. If the medication is continued in this situation, the necessity for continued treatment should be evaluated at a minimum of every six months.
15. The prescribing provider should clearly document care provided in the child's medical record, including history, mental status assessment, physical findings (where relevant), impressions, adequate laboratory monitoring specific to the drug(s) prescribed at intervals required specific to the prescribed drug and potential known risks, medication response, presence or absence of side effects, treatment plan and intended use of the prescribed medications.

Additional Recommendations:

1. Rating scales used to identify response to treatment can be identified in numerous sources. A large number of evidence-based assessment tools are available free of charge for provider use in the DSM-5 (www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures).
2. We would like to call special attention to best practices for care of very young children, particularly those laid out in Gleason et al, 2007 (see Appendix II).
3. Given problematic weight gain among youth on psychotropic agents, diet and exercise counseling with referrals to primary care physicians, dieticians and specialized pediatricians are recommended for any child with weight changes, ideally early in the treatment course.

DATA MANAGEMENT

DCS has an MOU with FSSA to share Medicaid claims data, including psychotropic medication data. As part of the MOU, OMPP produces monthly utilization reports for the out-of-home CHINS population. These reports capture psychotropic medication prescriptions on a "real time" basis, allowing for identification of cases that fall outside of best practice parameters. The monthly utilization reports identify all "red flag" outliers listed in the Guidelines (including names of the prescribing providers), and this information is used by the IU Consultation Program to select cases for review. The utilization reports are also used to generate a monthly psychotropic medication report card, allowing for comparison of Indiana psychotropic medication rates vs. other states. DCS is in the process of formatting the monthly report card data for publication on the DCS internet site, under the Psychotropic Medication link – target date 7/1/16.

"RED FLAG" INDICATORS

The Indiana PMAC has established "red flag" indicators based on the American Academy of Child and Adolescent Psychiatry practice parameters (AACAP, 2009) and the Texas Psychotropic Medication Utilization Parameters for Foster Children (2010). DCS "red flag" indicators are listed in Table 1. Any youth who meets one or more of these criteria may be referred to the IUSM Department of Psychiatry Consultation Team for case review and follow up.

Table 1. DCS "Red Flag" Indicators

Absence of a DSM-V (or comparable ICD-10) diagnosis in the child's medical record
Prescription for four (4) or more psychotropic medications
Any psychotropic medication prescribed to a child less than one (1) year of age
Prescription for two (2) or more antidepressant medications
Prescription for three (2) or more mood stabilizers
Prescription for two (2) or more antipsychotic medications
Prescription for two (2) or more stimulant medications
Prescription of an antidepressant to a child less than four (4) years old
Prescription of an antipsychotic medication to a child less than four (4) years old
Prescription of a mood stabilizer to a child less than four (4) years old
Prescription of a stimulant medication to a child less than three (3) years old
Psychotropic polypharmacy for a given mental disorder is prescribed before utilizing psychotropic monotherapy.

Psychotropic medication dose exceeds usual recommended doses (FDA and/or literature based maximum dosages)

EDUCATION AND TRAINING

The PMAC has developed a psychotropic medication training curriculum for DCS staff and other key stakeholders across the state. The training curriculum includes information about best practice guidelines, current psychotropic utilization trends and issues unique to youth in the child welfare system. In 2015, Leslie Hulvershorn, MD (DMHA Medical Director) and Kelda Walsh, MD (IU Psychiatrist) facilitated a series of trainings for DCS local office directors and supervisors, residential provider agencies, community-based provider agencies and foster care agencies. In addition, the Psychotropic Medication curriculum was posted on the DCS internet site, under the Psychotropic Medication link. In 2016, Dr. Hulvershorn plans to facilitate additional trainings for community mental health center providers, foster parents, educators and child advocates (e.g., CASA/GAL).

INFORMATION PORTAL

DCS has developed a psychotropic medication information portal through the DCS internet site. The site can be found by licking the "Psychotropic Medication" link in the left hand column of the DCS internet site. The information portal includes an overview of the DCS psychotropic medication initiative, contact information, copies of the Guidelines, report card data (target date 7/1/16), and links to relevant research, resources and Federal legislation. The information portal also includes links to relevant state agencies and resources for providers (e.g,. Medicaid, Managed Care, etc.).

ONGOING MONITORING FOR INDIVIDUAL YOUTH IN FOSTER CARE

DCS facilitates ongoing communication, through the Child and Family Team Meetings, case staffing, Permanency Roundtables and other venues, between the youth, parent/guardians and others who understand the youth's behavioral/emotional needs best. This communication is intended to ensure a) that psychotropic medication effectiveness is monitored, b) that treatment is appropriate to the youth's needs, c) that treatment includes the family and/or other essential connections, d) that treatment builds upon the youth's strengths, and e) that permanency planning is incorporated into treatment.

As youth are referred to a Permanency Roundtable, this year DCS began to consider the youth's specific needs and if warranted, placed a DCS Nurse Consultant on the Roundtable team.

In addition, the DCS Nurse Consultants are available for consultation and guidance to the FCMs. This past year the Nursing team has made themselves known to DCS staff.

6. HOW THE STATE ACTIVELY CONSULTS WITH AND INVOLVES PHYSICIANS AND OTHER APPROPRIATE MEDICAL AND NON-MEDICAL PROFESSIONALS IN ASSESSING THE HEALTH AND WELL-BEING OF FOSTER CHILDREN AND IN DETERMINING THE APPROPRIATE MEDICAL TREATMENT FOR THEM.

DCS NURSING SERVICES UNIT

The DCS Nurse Consultant program was established in 2012 which consists of a team of 13 Nurses along with a Nursing Services Manager. They are Registered Nurses with various levels of expertise and

training. Their unique educational backgrounds and knowledge base includes pediatric experience and practice areas that are focused around children and families. They are one of the specialized services in DCS available to provide support to Family Case Managers (FCMs). This team is located throughout all the regions statewide. A large number of children who come into DCS' care have health and medical concerns and may not have appropriate or significant primary medical care. Many have not received routine or adequate medical treatment or care during their lives. Along with abuse, a large percentage of the cases DCS oversees involves neglect. This may result in chronic health problems, developmental delays, and can have psychological impacts on a child as well.

Typically, family case managers do not have formal medical training. The DCS Nurse Consultant mission is to provide consultation, assist with health and medical issues, and to support FCMs in their decisions that impact positive health, safety and well-being for the children and families we serve. The DCS Nurses assist in cases (both assessment and ongoing) with children who are medically fragile / complex or have multiple medical needs. This includes understanding medical diagnosis, medication, procedures and treatments; assisting with access to treatment including medical and dental; answering medical questions; performing medical record reviews, completing summaries; assisting with terminology, medication information, treatment goals and medical / lab interpretation; participating in visits (home, provider, school, etc.); collaboration with medical providers (including PEDS and the Docs INCASE); collaboration with other DCS essential components including staffings, case conferences, CFTMs, PRTs, CANS (health and medical portions); providing resources (immunizations, research information, etc.); providing education to parents, families, and caregivers; and group training for DCS staff, Resource parents and the community. They also provide written documentation of recommendations for the cases they have consulted on. The DCS Nurses work as a team with all the other specialized services in Permanency and Practice Support Division under the DCS umbrella.

DCS Nurses attend and participate in the Indiana Oral Health Coalition (IOHC). The mission of the IOHC is a collective voice of individuals, groups, organizations and businesses working together to promote, protect and provide for the oral health of the residents of Indiana. Having the DCS Nurses attend this coalition has been helpful in collaborating efforts to provide dental care for the more severe cases in which DCS has been involved.

The DCS Nurses have all been trained and several are assisting with the facilitation of program implementation of the "Period of Purple Crying". This is an educational training initiative aimed at teaching parents to understand the crying pattern, to recognize this pattern, and to provide soothing strategies and coping skills. Research has shown "crying" to be one of the leading causes of physical abuse of young children.

The Children and Hoosier Immunization Registry Program (CHIRP) is a registry which provides documentation of immunizations and lead blood levels. All the DCS Nurses have access to this registry in order to provide updated information regarding immunizations and lead test results. This access has benefited DCS children and families by providing essential information as well as education regarding health maintenance.

PEDS CONTRACT

DCS has continued to expand and update the Pediatric Evaluation and Diagnosis (PEDS) program which was extended for a new four year contract. The PPS division / DCS Nurses are the oversight for this

program. The program is administered by the IU Child Protection Program Staff within Riley Hospital for Children and has been a service to DCS since 2008. The physicians within this program are board certified physicians in Pediatrics with the accredited subspecialty in Child Abuse Pediatrics.

The goal of the PEDS Program is to provide expert knowledge and consultation regarding medical issues and /or questionable injuries to children when the current information available renders it difficult for us to determine if abuse or neglect was the cause of injury. Since the inception of the PEDS program, we have witnessed an increased volume of cases which has resulted in the overall success of the program. Its success is noted by actual lives saved as determined by the PEDS physicians. The actual data of this program is gathered and reported to DCS quarterly.

The PEDS program entails two types of referrals: Mandatory and Non-Mandatory. Mandatory referrals are any allegation of a suspected injury to the head or neck of a child less than **6** years old; and any allegation of a bone fracture or burn to child under the age of 3. This age group is susceptible to inflicted injury, and having additional injuries that aren't easily recognizable without specific medical evaluation. In addition, many physicians report young children with fractures but are unable to provide an opinion about the likelihood of abuse. The child abuse pediatricians and IUCPP staff are ready to take on the evaluation of fractures and burns in these young children.

Non-Mandatory referrals are all the other referrals that do not fall within the guidelines of Mandatory referrals. The PEDS program is also utilized in this manner as a resource in medical diagnosis, assessment, and determination of possible accidental injuries and medical conditions. FCMs, Supervisors, and the DCS Nurses can contact the Riley / IU Child Abuse Pediatricians to staff potential cases to determine the type and appropriateness of the referral.

The DCS Nurse Consultants have been incorporated into the PEDS contract to assist with Referral questions / concerns, communication and documentation efforts as requested by the FCMs. In these instances, the Nurses are also consulted in order to ensure the requests are needed and appropriate.

The DCS Nurses receive consultation, education and training from the PEDS program. Weekly PEDS Peer Review Meetings are held in which case reviews are presented and staffed. The PEDS team also meets with the DCS Nurses monthly to do trainings on specific topics that have been identified by the Nurses. Specific cases can also be presented by the Nurses for review during these monthly trainings.

The Pediatric Center of Hope is part of the IUCPP that handles sexual abuse. A PEDS referral is not the same as a referral for a sexual abuse exam / consultation to the Pediatric Center of Hope. Many Indiana Regions have plans in place with local Child Abuse Centers (CAC) for sexual abuse evaluations.

A new component of the PEDS contract allows the Indiana University Child Protection Program (IUCPP) to provide certain education and training for Indiana physicians on child abuse and neglect identification and reporting, as well as providing training and education to certain secondary level community physicians so that they are available to DCS for medical evaluations and related services. These sub-contracted physicians are called Doctors for Indiana Child Abuse Screening and Education (Docs INCASE).

Previously, the PEDS program included a statewide Safe Sleep program. DCS is currently collaborating with the Indiana State Department of Health (ISDH) in order to develop a more comprehensive and uniform program in order to reach all the regions and every county in Indiana. The ISDH currently has an infant mortality initiative and the Safe Sleep program is a related priority. The plan for this program is to

continue to develop thru our collaboration / partnership with ISDH providing the staffing, program development, oversight, education / training and the data collection, evaluation and reporting components in order to ensure that all families have access to service; and by DCS providing the funding, technical support and assistance with program implementation.

7. STEPS TO ENSURE THE AVAILABILITY OF MEDICAL COVERAGE FOR WARDS/FORMER WARDS 18 YEARS AND OLDER.

DCS released Collaborative Care in 2012, which provides services and Medicaid for eligible youth from age 18 to age 20 and is available for former DCS foster children. DCS foster children may also remain a foster child through age 20 and in some qualifying situations, to age 21. Adoption assistance and guardianship assistance are also available to age 20 if the youth continues to meet the eligibility requirements.

To ensure the Medicaid enrollment of all eligible wards, when a child is not IV-E eligible or loses IV-E eligibility for any reason, the MEU submits a transmittal, a Referral to Medicaid Foster Care Independence Program, proof of income (if applicable), an application for Medicaid (if applicable) and eligibility conditions (if applicable) to DFR. The MEU monitors the application processing timeframes and serves as a single point of contact for DFR regarding questions or issues related to the child's Medicaid eligibility. The MEU intervenes if a child's eligibility has not been determined timely, there are questions, or there is negative result.

In order to ensure that Medicaid benefits continue whenever possible following a substantial change in the youth's income, resources, age, household composition, or foster care status, the MEU explores all other categories of Medicaid coverage for potential Medicaid eligibility. Based upon court decision in the matter of Clevidence v. Sullivan, Indiana does not discontinue Medicaid until all potential eligibility options have been explored. Coverage for individuals age 18-21 is available through a number of categories including a provision for Foster Care Independence, which extends Medicaid eligibility to individuals who were in foster care at the age of 18 years. Additionally, if a DCS case is scheduled to close at the age of 18, the FCM is required to send a notice to the Medicaid Enrollment Unit (MEU) informing them that the youth will need to be transitioned to the Medicaid Foster Care Independence Program.

8. PROVISIONS FOR THE APPOINTMENT OF A HEALTH CARE REPRESENTATIVE/ADVANCED DIRECTIVES FOR WARDS 18 YEARS AND OLDER.

In order to ensure that children aging out of the foster care system have the opportunity to discuss their future health care options, 90 days before the youth reaches age 18, the Family Case Manager (FCM) will convene a Child and Family Team Meeting to complete the Transitional Services Plan portion of the Independent Living/Transition Plan.

DCS Policy 11.6 - Independent Living/Transitional Living Plan

The Independent Living/Transition Plan is a comprehensive, written, plan, personalized for each youth and is used at each meeting with the youth and at each Child and Family Team meeting to guide the transition planning process with the youth. The Independent Living/Transition Plan is developed with the youth's participation. The Independent Living/Transition Plan must include information and specific options relating to the following:

1. Education and training;
2. Employment services and work force supports;
3. Housing, which may include a Transitional Living Placement when appropriate;
4. Health care, including prevention and treatment services and referral information;
5. Health insurance availability and options;
6. Local opportunities for mentors and continuing support services, including development of lifelong adult relationships and informal continuing supports;
7. Identification and development of daily living and problem-solving skills;
8. Procedures available under Indiana law for, and the importance of, stating in advance an individual's desires concerning:

    a. health care treatment decisions if the individual is unable to participate in those decisions when required, and
    b. designation of another person to make health care treatment decisions for an individual who is unable to make those decisions when required; and

9. Availability of local, state, and federal resources, including financial assistance, relating to any parts of the plan described above.
10. Independent living services may include any of the following kinds of services that are intended to prepare the youth for self-support and living arrangements that are self-sufficient and not subject to supervision by another individual or institution:

    a. Arrangements for and management of a transitional living placement for a youth who is seventeen (17) and six (6) months of age or older, if appropriate:
    b. Activities of daily living and social skills training
    c. Opportunities for social, cultural, recreational, or spiritual activities that are designed to expand life experiences in a manner appropriate to the youth's cultural heritage and needs and any other special needs.
    d. Matching of a youth on a voluntary basis with caring adults trained to act as mentors and assist the youth to establish lifelong connections with caring adults.

Pursuant to sections 4, 5, and 8, listed above, DCS will ensure the youth is provided information and education regarding the importance of designating a health representative to make health decisions and the importance of executing a health care power of attorney, health care proxy, or other similar document recognized under State law. The FCM will distribute an Advance Directives packet along with the information letter at the Transition Planning meeting. The FCM will also ensure that the youth has the opportunity to view the Advance Directives information video.

The Advance Directives packet advises youth that DCS is providing health care decision forms for the youth to use, but that DCS cannot provide legal advice. It advises them to seek legal advice if they have any questions and that many local communities have bar associations that provide legal services for free or at a reduced cost and that they can access these services at the following link: http://www.indianalegalservices.org/providers. Youth are also advised of services offered through Indiana Legal Services (ILS), which provides legal services to low income individuals, and they are given their toll free number, (800) 869-0212. They are also advised that they may ask their Family Case Manager to request that the Judge appoint a public defender to discuss these forms and answer any questions at the next court hearing.

Michael R. Pence, Governor

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DCS TRAINING PLAN

2016

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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 from Indiana University School of Social Work and DCS 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 35 classroom days and 29.5 transfer of learning days, along with 28 computer assisted trainings. A summary of this program is:

Unit 1

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

Unit 2

- 1 Day – **Overview of Legal Concepts** (introduction to legal aspects of the job)

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

Unit 3

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

Unit 4

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

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 typically range in size between 25-40 individuals, begin every 2 to 3 weeks, and complete the entire curriculum cycle listed 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. Due to increased staffing, three additional positions and a supervisor were hired in 2013.

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 35 classroom days, 28 Computer Assisted Trainings (CATs), 29.5 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.

A summary of the newly designed new worker pre-service is as follows:

Unit 1

1 day-Human Resource Orientation
1 day-Getting to Know DCS
1 day-Laptop and Introduction to MaGIK
1.5 days-Worker Safety
½ day-Job Skill Building-DCS Hotline
1 day-Orientation in County Office of Hire
3 days-Transfer of Learning in County

Unit 2

1 day-Overview of Legal Concepts
1 day-Culture and Diversity
1 day-Engagement and Interviewing
1 day-Child and Family Teaming
2 days-Facilitation Training Session 1
2.5 days-Transfer of Learning in County
½ day-Facilitation Training Debrief

Unit 3

1 day-Culture and Diversity
2 days-Effects of Abuse and 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-Legal Roles and Responsibilities
22 days-Transfer of Learning/On the job skill reinforcement
1 day-Cohort Evaluation and Graduation

The approximate number of individuals who received new worker training from 7/1/15-6/30/16 was 764.

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 Statewide Survey in August of 2007 identified the most pressing needs and curriculum was develop to meet those needs, both through classroom training and computer assisted training. An Individual Training Needs Assessment tool was developed and completed by over 1400 Family Case Mangers during September and October of 2009. A comprehensive analysis of these assessments was completed and training needs identified. Following a staff development strategic planning session in December of 2010, a list of priorities has been established for the development of classes, computer assisted trainings, videoconferences, and webinars. Staff time was allocated between the implementation of this strategic plan as well as training needs being implemented based on the Indiana Program Improvement Plan. Classroom trainings targeted for development and implementation during 2011 included: 1) Overview of practice Model for Non-Field Staff (Computer Assisted Training and Webinar), 2) Engaging and Working with Challenging Clients, 3) Engaging Parents with Mental Illness, 4) Facilitating a Child and Family Team Meeting in The Assessment Phase, 5) DCS Customer Service, 6) Service Standards, What Are They and How Do I Use them? 7) Advanced Developmental Disabilities, 8) Experienced Worker Reactive Attachment Disorder, 9) Advanced Domestic Violence and 10) Working with Clients Challenged with Substance Abuse Disorders. All of these curriculums were successfully developed, piloted, and are available upon request. In addition, several curriculums were updated based on new research.

The Individual Training Needs Assessment tool was then revised to reflect current policies, procedures and best practices. It was completed by all Family Case Managers with their supervisors in the summer of 2011. Following a comprehensive analysis and detailed Individual Training Needs Assessment (ITNA) report, a subsequent strategic planning session was held to identify curriculum development needs for 2012. The results of the ITNA demonstrated a need for the following training topics among our field staff:

Teaming in the First 30 Days
Advanced Engagement & Crisis Management Advanced
Cultural Competency
Protective Factors
Advanced Developmental Disabilities Trauma
Informed Care
Experienced Worker Safety
Introduction to the Attachment Continuum

Advanced Developmental Disabilities, Experienced Worker Safety, Protective Factors, Trauma Informed Care and Culture and Diversity have all been developed and piloted during this fiscal year and are available to be trained regionally upon request. A Strategic Planning meeting held in November, 2012, identified the following curricula which were developed in 2013 based on ITNA results as well as additional surveys and feedback received. In addition to updating several new worker pre-service trainings, the following were identified as 2013 priorities:

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

Two of these curriculums, Understanding Culture and Embracing Diversity and Trauma Informed Care have been offered Regionally Statewide to DCS Staff. Other trainings will be scheduled upon request. A catalog of courses available has been developed and distributed to staff so that training requests can be made if 10 or more individuals in a region would benefit from a particular topic.

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.

From 7/1/15-6/30/16, 178 classroom trainings were provided which, along with computer assisted trainings, are utilized by ongoing employees to meet their annual training requirement mentioned above.

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. In January of 2012, Peer Coach Consultants have provided 3 hour specialized, regionally based trainings to enhance Practice Skills. In the 1st quarter of 2012 the focus was on "Start of the Team Formation" while the 2nd quarter topic was "Advanced Team and Teaming Transitions." The 3rd quarter of 2012 in-service topic was "Team Maintenance and Stability" and the 4th quarter focus was on "Preparing for Case Closure". A Workshop for all Peer Coaches was also held in July of 2012. In addition to hearing from the Director, the Peer Coaches received workshops on providing Constructive Feedback/Debriefing as well as Public Speaking. They ended the day with a celebratory release of balloons focusing on the positive work that has been done in Indiana regarding the practice model and improving outcomes for Indiana's children. These sessions and the Peer Coach Workshop were well received so they were continued in 2013.

In the 1st quarter of 2013, emphasis was placed on enhancing the skills of the Peer Coaches described above with a workshop entitled "Permanency Round Table for Peer Coaches. " Additional workshops held in 2013 included "Basics of Prep Meeting to Get to the Underlying Need", Advanced Engagement Skills for Supervisors, and Advanced Engagement Skills for Family Case Managers.

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.

Intervention and Case Planning – this will be provided in 2016 4th quarter. This will highlight ways to utilize services and service mapping within the Case Planning process.

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.

140 one day regional trainings were scheduled and delivered between May 14 and June 21, 2012 by 20 DCS trainers with materials developed by the Case Commons. In addition, DCS developed materials for new family case manager training which was incorporated into pre-service training and enhanced throughout the year as additional updates were migrated. Training continued in collaboration with MaGIK Coordinators as needed throughout DCS Regions.

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.

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. Trainings were provided by Casey Family Program staff in 2011 and early 2012 DCS Staff provided assistance and ultimately assumed a greater role in the process beginning in July of 2012. A professional video production company was engaged to videotape a "mock" permanency roundtable session which is being used in training at this time. In Fiscal Year 2013, 9 trainings were held statewide to insure that all 18 Regions were adequately trained. 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.

From 7/1/15-6/30/16, 411 DCS employees received PRT training, 42 received PRT scribe training, and 26 received facilitator training.

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. In Fiscal Year 2013, an additional 75 Supervisors were added to the staff so 4 cohorts were scheduled, 2 more than have been offered in the past.

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. These scales were updated in 2012 to reflect the many changes that have occurred throughout DCS the last three years. The completion of these scales provides additional information to both the new supervisor regarding strengths and needs as well as to the Staff Development area to identify additional training needs. A manual is provided to the supervisor mentor that includes information about learning styles, the program protocol and a description of the scales. A 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. Based on feedback, the procedure

for these trainings was modified in 2012 to include an identified trainer at each location. 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. Al 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.

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.

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.

This program was modified for the 2011/2012 academic year. An application process was used to identify individuals who demonstrated leadership potential as noted by their Local Office Directors. There were 51 applications and 30 individuals were chosen. These 30 individuals participated in the on-line sessions, 4 learning network sessions through webinars and 2 classroom training sessions. In addition, they each developed a Personal Learning Plan and a Change Initiative. Several of their completed worksheets were reviewed by staff at the IU School of Social Work as well as their Local Office Director and evaluated for thoroughness and quality. Three state-wide initiatives were also chosen and each supervisor was assigned to one of the initiatives to assist with completing critical tasks. 26 of the individuals received graduation certificates following a graduation ceremony.

After further review, the selection process was narrowed further for the 2012/2013 class which started in

January of 2013. There were 22 individuals who participated and developed their Personal Learning Plan and Change Initiative as previously described. One webinar was conducted to review the overall course and explain expectations, however, all other training are classroom based to review in depth the 5 modules that focus on leadership enhancement. Also, the IU School of Social Work has engaged 4 professors (instead of 2) to review selected worksheets which provides each individual with in-depth feedback. In addition, training was provided to the Local Office Directors/Central Office Managers so that they could provide appropriate support and mentoring to the individuals they supervise who are completing this academy. Graduation is slated for August, 2013. Indiana has continued to provide consultation and assistance to several other states through the National Child Welfare Workforce Institute (NCWWI) regarding a statewide implementation plan for this training, including participating in a national webinar which had over 800 individuals registered.

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.

c. Management Trainings

A “leadership training program” for executive staff and local office directors was initiated and completed in 2009. This included a two day workshop in January of 2009, and 5 additional half day workshops which focused on both leadership/management skills related to staff development as well as improving the organizational climate of the local offices. The Leadership Transformation Group from New York, NY, assisted with the provision of these trainings. In 2010, quarterly transfer of learning “reinforcement’ activities have occurred. Local Office Directors submitted their completed activity information for review and outstanding responses are publicly recognized, both at the annual workshop and in the Statewide DCS Newsletter.

Staff Development has now developed formal curriculum for this 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.

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 2013, DCS conducted four (4) training sessions for Providers of residential treatment services in Indiana. The focus of the training was on contract compliance audits as well as monthly critical incident

reporting. DCS first began auditing residential provider contracts in 2013. Due to provider questions over the audits, the training focused on walking providers through the various audit tools and explaining the reasons behind the need for certain information. DCS also first began to collect monthly critical incident information from residential providers in 2013. The first month of data showed that providers were collecting and reporting in different methods. The training provided additional guidance to ensure the data was being reported in a consistent manner by providers.

During Fiscal Year 2014, DCS continues 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, continues 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.

The courts participated in the CFSR process, including developing and implementing court related PIP items. There was also judicial participation in the Title IV-E review that took place the week of April 16-20, 2012. The CIP administrator and two judges attended the entrance and exit conferences. The results of the audit were shared with all Juvenile Judges at the Annual Juvenile Judges Conference held on June 21-22, 2012. Training was also provided to address some of the court related areas of concern identified during the review and presentations were given on the Clinical Resource Team, the new collaborative care program and other topics identified by Director Payne.

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.

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.

On November 1, 2011, the Court Improvement Program, Indiana Judicial Center, and the Indiana Department of Child Services sponsored a statewide summit on "Child Welfare and Juvenile Justice-Working Together to Improve Outcomes for Children." The Summit was held at the Indiana Convention Center and was attended by over 550 juvenile probation officers, chief probation officers, and Department of Child Services family case managers, supervisors, local office directors, regional managers, and probation service consultants from across the state. The purpose of the summit was to inspire collaboration and cooperation between probation officers and

Department of Child Services staff who work with children that are involved in both the child welfare and juvenile justice systems or are at risk of being involved in both systems.

The Summit provided an opportunity for probation officers and staff from the Department of Child Services to learn about each other's roles in working with children and families. The Summit included sessions on Family Case Managers and Juvenile Probation Officers: Are their roles Really So Different, Case Scenarios and Round Table Discussion; Adolescent Brain Development, and Working together on a Local Level: Success Stories. Justice Steven David provided opening remarks and James Payne, Director of the Indiana Department of Child Services gave closing remarks. Important Numbers: Over 550 Juvenile Probation Officers, Chief Probation Officers, Department of Child Services Family Case Managers, Supervisors, Regional Managers, Local Office Directors, Probation Service Consultants attended representing 88 counties in Indiana.

A Memorandum of Understanding (MOU) has been developed and signed with the Indiana Supreme Court – Division of State Court Administration which further details efforts that will be undertaken going forward.

a. Statewide Conference - "The Five Essential Steps To Excellence in Child Welfare"

Building upon the Administration for Children and Families initiative to promote the social and emotional well-being for children and youth receiving child welfare services through a memorandum issued in April of 2012, the Department of Child Services planned and implemented a statewide Conference in October of 2012 at the Indiana Convention Center in Indianapolis, Indiana. Experts in the topic areas of Trauma Informed Care, Brain Development, Adverse Childhood Experiences, Evidence Based Practices and Childhood Relational Permanency were engaged to provide presentations to over 600 individuals from both public and private agencies throughout Indiana. The presentations culminated in 5 separate workgroups that related these topics to child well-being.

Information from the presentations as well as from the group sessions were summarized and posted on the DCS website for additional review and consideration. Agencies have used this material to further educate their staff on these important topics.

Building on this conference, 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 (RAPT 1) to prospective resource parents. Staff Development provides updates as needed.

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.

f. Intensive 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. This training has been scheduled regionally for ongoing staff in both FY 2012 and FY 2013. In an effort to strengthen Intensive Family Preservations Programs, DCS has identified several Evidence Based Models that will be supported through training funds. With the assistance of Casey Family Programs, the Institute for Family Centered Treatment has provided Motivational Interviewing and Relapse prevention training to over 400 Home based caseworkers and Therapists in FY 2013. Trauma-Focused Cognitive Behavioral Training will commence during the summer of 2013 for many stakeholder therapists. Family Centered Treatment providers have also received this training in the Fall of 2013.

g. 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.

h. 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.

i. 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.

j. 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.

k. 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.

l. 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 2016.

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.

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.

During the last five years, 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 to 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 abuses. 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 reported 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. Between July 1, 2013 and June 2014 staff completed 1114 classes and 75 more individuals enrolled who have not yet launched the course. 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. The 2013 report is a synopsis of the quarterly reports which contain all the evaluations of Levels I, II, III, and IV. 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 ranted 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 ranted 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. In 2012, we collected 17 cohorts of both the pre-test and the post-test. For most of 2011, we used the original test. Participants taking the original test improved 18.4% All trainees improved from pre to post. 86% improved by 11 or more questions on average from pre-test to 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. July of 2008 is the hire date that for which an FCM would have received new worker training under the new practice model. FCMs hired by DCS before July of 2008 are "before new practice model" and those hired after July of 2008 are "after new practice model."

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.

Between July 1, 2012 and April 30, 2013, 621 foster parent trainings were scheduled. This included training for 3,305 prospective foster parents/adoptive parents in pre-service training, and 3,007 licensed individuals who were completing their annual training requirements. The volume of trainings needed regionally has resulted in additional staff being added to this division including a curriculum writer, a supervisor, and two trainers. Evaluations received continue to indicate that foster parents find the training valuable and the training delivery very good. A more formal evaluation process is being considered starting in 2014.

During calendar year 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 calendar year 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.

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.

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

15. Adoption Forum

Indiana partnered with the Indiana Association on Adoption and Child Care Services (IAACCS) in 2012 to host an adoption forum titled "Adoption: It's More Than Magic". Topics covered in workshops included: special education, adoption finalization, kinship care, adoption subsidies, autism and the adoption registry among others. Attendees included more than 200 individuals including DCS staff and other provider stakeholders.

The 2013 Adoption Forum is currently in the planning phase with the theme of "Addressing Secondary Trauma and Self-Care". It will be held in July of 2013.

16. 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.

17. 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.

18. 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.

Interviews and selection of students for the MSW program will be completed in July 2016. However, DCS expects close to 20 students being selected for the upcoming class.

19. New Staff Education and Training - 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 previously).

For the upcoming fall 2016 class, 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). 43 BSW students began employment as family case managers in May and June of 2016.

20. 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 Law110-351 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-litems; and court appointed special advocates. The federal legislation provides for enhanced funding for these new categories of trainees. The enhanced funding rates increase each year over the five year period from FFY 2009 to FFY 2013.

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

Fiscal Year 2017, October 1, 2016 through September 30, 2017

1. State or Indian Tribal Organization (ITO): Indiana	**2. EIN: 356000158**
3. Address: 403 W Washington Street, RM E306, Indianapolis, IN 46204	**4. Submission:** [X] New [ ] Revision
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds	$ 6,431,262.00
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	$ 643,126.00
6. Total estimated title IV-B Subpart 2, Provides Safe and Stable Families (PSSF) Funds. This amount should equal the sum of lines a - f.	$ 5,876,321.00
a) Total Family Preservation Services	$ 1,175,264.20
b) Total Family Support Services	$ 1,175,264.20
c) Total Time-Limited Family Reunification Services	$ 1,175,264.20
d) Total Adoption Promotion and Support Services	$ 1,175,264.20
e) Total for Other Service Related Activities (e.g. planning)	$ 587,632.10
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)	$ 587,632.10
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)	$ 370,151.00
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	$ 37,015.00
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 $___0.00__, PSSF $_0.00___, and/or MCV(States only)$_0.00__.	
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS $_0.00_, PSSF $_1,750,500.00____, and/or MCV(States only)$_110,000.00_.	
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)	$ 527,659.00
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds	$ 4,571,089.00
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)	$ 1,371,326.70
11. Estimated Education and Training Voucher (ETV) funds	$ 1,483,329.00
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 CFCIP Program	$ 0.00
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program	$ 0.00
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program	$ 500,000.00
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for ETV Program	$ 200,000.00

13. Certification by State Agency and/or Indian Tribal Organization.

The State agency or Indian Tribe 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.

Signature and Title of State/Tribal Agency Official	**Signature and Title of Central Office Official**
Mary Beth Bonaventura	
Director	

CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services

State or Indian Tribal Organization (ITO):

For FY 2017: OCTOBER 1, 2016 TO SEPTEMBER 30, 2017

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	$ -			$ 500,000			$ -	$ 83,580,153	218,486	0	Reports of AB/NE	Statewide
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	$ -	########		$ 27,659			$ 18,666,400	$ 60,490,710	5976	0	Children/Families at risk of AB/NE	Statewide
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	$ -	$ 1,175,264		$ -			$ 1,570,822	$ 30,465,018	48838	31851	Children / Families at risk AB/NE	Statewide
4.) TIME-LIMITED FAMILY REUNIFICATION SERVICES	$ -	$ 1,175,264		$ -			$ -	$ 84,577,907	15,093	0	Children in Foster Care	Statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	$ -	$ 1,175,264					$ 206,859	$ 598,614	N A	N A	Families referred to Post Adopt Services	Statewide
6.) FOR OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	$ -	$ 587,632					$ 6,680,420	$ 24,158,190	N A	N A	N A	N A
7.) FOSTER CARE MAINTENANCE: (a) FOSTER FAMILY & RELATIVE FOSTER CARE	$ -						$ 23,539,562	$ 51,402,119	14138	0	Children in Foster Care	Statewide
(b) GROUP/INST CARE	$ -						$ 15,204,884	$ 68,653,060	955	0	Children in Foster Care	Statewide
8.) ADOPTION SUBSIDY PMTS.	$ -						$ 48,475,656	$ 56,740,420	13,363	0	Adoptive Children	Statewide
9.) GUARDIANSHIP ASSIST. PMTS.	$ -						$ 350,000	$ 3,671,623	344	0	Assisted Guardianships	Statewide
10.) INDEPENDENT LIVING SERVICES	$ -	$ -			$ 4,571,089		$ 113,141	$ 1,735,435	823	0	All eligible Children	Statewide
11.) EDUCATION AND TRAINING VOUCHERS	$ -				$ -	$ 1,483,329	$ -	$ 628,633	273	0	Youth ages 18 to 20	Statewide
12.) ADMINISTRATIVE COSTS	$ 643,126	$ 587,632	$ 37,015				$ 22,229,595	$ 91,742,411				
13.) FOSTER PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ 783,143	$ 1,207,094				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ 783,143	$ 775,916				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	$ -						$ -	$ -	N A	N A	N A	NA
16.) STAFF & EXTERNAL PARTNERS TRAINING	$ -	$ -		$ -	$ -	$ -	$ 959,010	$ 959,010				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	$ 5,788,136	$ -	$ 333,136				$ -	$ 2,111,039				
18.) TOTAL	$ 6,431,262	$ 5,876,321	$ 370,151	$ 527,659	$ 4,571,089	$ 1,483,329	$ 139,562,636	$ 563,497,352	N A	N A	N A	

*** 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.**

Attachment B
OMB Approval #0970-0426
Approved through September 30,2017

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) : Fiscal Year 2014: October 1, 2013 through September 30, 2014

1. State or Indian Tribal Organization (ITO): **Indiana**	2. EIN: **35-6000158**	3. Address: **402 W. Washington Street, Rm W306, Indianapolis, Indiana 46204**				
4. Submission: [**X**] New [ ] Revision						
Description of Funds	***Estimated Expenditures***	***Actual Expenditures***	***Number Individuals served***	***Number Families served***	***Population served***	***Geographic area served***
5. Total title IV-B, subpart 1 funds	$ 6,506,901	$ 6,506,901	218,486		Reports of AB/NE	Statewide
a) Total Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	$ 650,690	$ 552,201				
6. Total title IV-B, subpart 2 funds (This amount should equal the sum of lines a - f.)	$ 5,910,166	$ 5,910,131	48,838	31,851	Children / Families at risk AB/NE	Statewide
a) Family Preservation Services	$ 1,182,033	$ 1,182,005				
b) Family Support Services	$ 1,182,033	$ 1,182,033				
c) Time-Limited Family Reunification Services	$ 1,182,033	$ 1,182,027				
d) Adoption Promotion and Support Services	$ 1,182,033	$ 1,182,033				
e) Other Service Related Activities (e.g. planning)	$ 591,017	$ 591,016				
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment after October 1, 2007)	$ 591,017	$ 591,016				
7. Total Monthly Caseworker Visit Funds (STATE ONLY)	$ 372,001	$ 372,001				
a) Administrative Costs (not to exceed 10% of MCV allotment)	$ 37,200	$ 19,774				
8. Total Chafee Foster Care Independence Program (CFCIP) funds	$ 3,779,233	$ 3,779,233				
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	$ 1,133,770	$ 1,020,312	N A	N A	N A	N A
9. Total Education and Training Voucher (ETV) funds	$ 1,216,146	$ 1,216,146	273	N A	Youth ages 18 to 20	Statewide
10. Certification by State Agency or Indian Tribal Organization (ITO). The State agency or ITO agrees that expenditures were made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.						
Signature and Title of State/Tribal Agency Official Mary Beth Bonaventura / Director	***Date*** 6/28/16	***Signature and Title of Central Office Official***				***Date***

Attachment E

Annual Reporting of Education and Training Vouchers Awarded

Name of State: **Indiana**

	Total ETVs Awarded	Number of New ETVs
Final Number: **2014-2015 School Year** (July 1, 2014 to June 30, 2015)	273	93
2015-2016 School Year* (July 1, 2015 to June 30, 2016)	199	96

Comments: 2015-2016 School Year does not include summer 2016.

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.

	FY 2005	*FY 2016*
Federal Expenditures		
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	$5,954.700.25
Child Welfare Training	$1,137,534.26	$ 552,200.75
Administration	$667,539.40	$0.00
TOTAL FEDERAL (75%)	$6,675,394.00	$6,506,901.00
Non-Federal Expenditures		
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	$1,984,900.08
Child Welfare Training	$445,026.27	$184,066.92
Administration	$222,513.13	$0.00
TOTAL STATE MATCH (25%)	$2,225,131.33	$2,168,967.00

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.

	1992 Base Year	*FY 2014*
Federal Share	$0.00	$5,910,130.84
State Share	$3,246,083.00	$1,970,043.61
Total Expenditures	$3,246,083.00	$7,880,174.45