Region 5

Biennial Regional Services Strategic Plan

SFY 2019 - 2020

February 2, 2018

Biennial Regional Services Strategic Plan
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I. **Biennial Regional Services Strategic Plan**

SFY 2019-2020

Region 5

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Approved by:

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Regional Manager: Angela Smith Grossman **DATE:** 12/8/2017

Lois Logan-Beard
Regional Finance Manager: Lois Logan-Beard **DATE:** 12-8-17

Signatures of Regional Service Council Members Voting on BRSSP: **DATE:** 12/8/2017

Honorable Judge Faith Graham	Faith Graham
Honorable Judge Hunter Reece	
Honorable Judge Stephanie Campbell	
Paige Heath, Family Case Manager Supervisor, Tippecanoe County	Paige Heath
Jennifer Johnson, Local Office Director, Carroll County	
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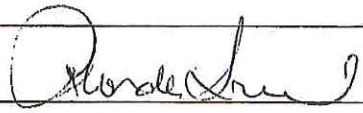
Rhonda Friend, Local Office Director, Benton-Fountain-Warren	

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II. Regional Service Council Members:

Honorable Judge Faith Graham
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Paige Heath, Family Case Manager Supervisor, Tippecanoe County
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III. Biennial Regional Services Strategic Plan 2019-2020 Overview

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

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

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

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

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

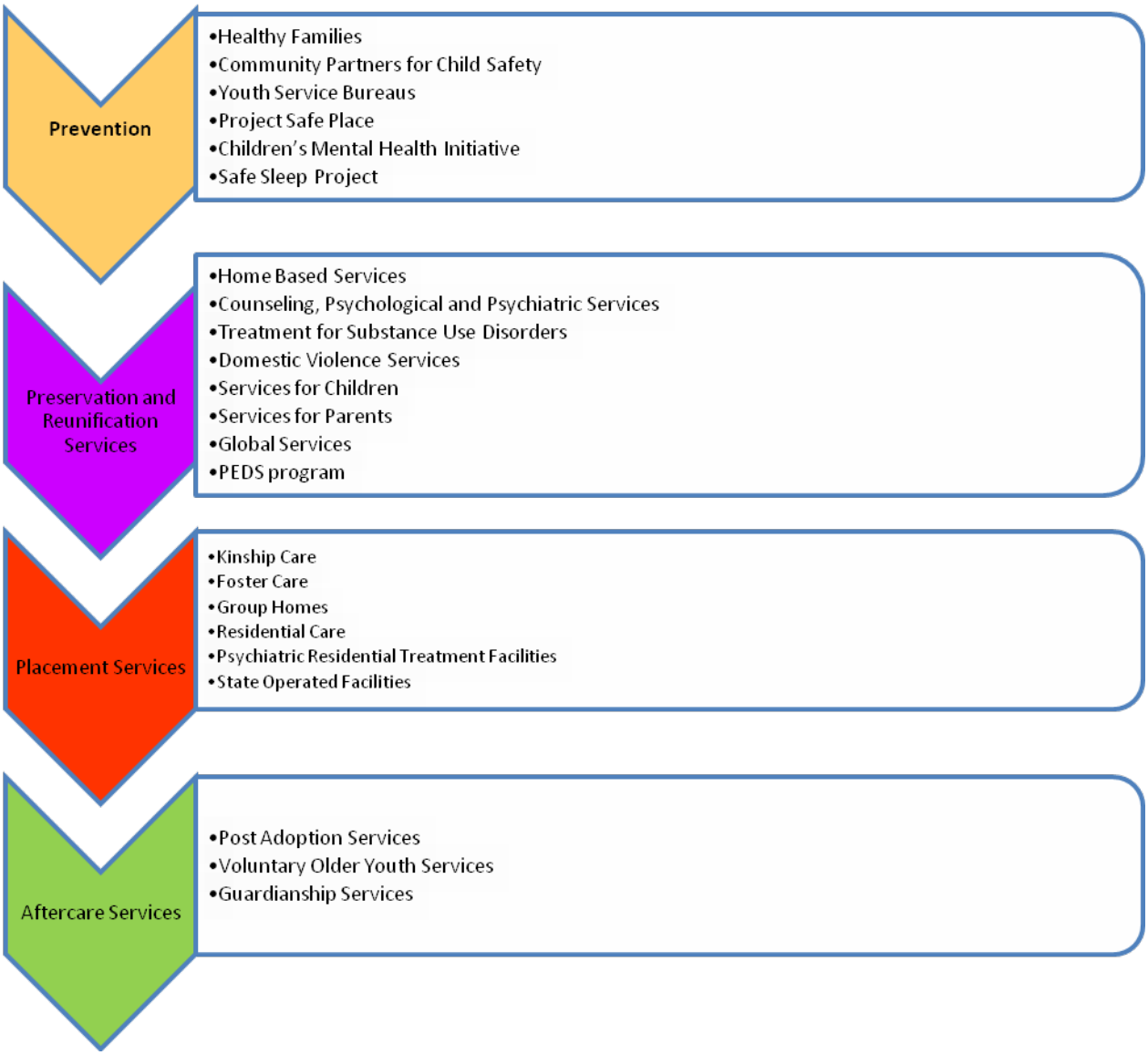
determine the appropriate utilization of available services and to identify gaps in service. As a result, the workgroup developed a regional action plan to address service needs and gaps that are specific to the region. In addition, to address known statewide system issues, the Regional Action Plan includes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

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

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

IV. Service Array

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



Prevention Services

Kids First Trust Fund

A member of the National Alliance of Children's Trusts, Indiana raises funds through license

plate sales, filing fee surcharges, and contributions. This fund was created by Indiana statute, is overseen by a Board, and staffed by DCS. Kids First funds primary prevention efforts through the Prevent Child Abuse Indiana (PCAI), Healthy Families Indiana and the Community Partners for Child Safety program.

Youth Service Bureau

Youth Service Bureaus are created by Indiana statute for the purpose of funding delinquency prevention programs through a state-wide network. This fund supports 31 Youth Service Bureaus to provide a range of programs including: Teen Court, Mentoring, Recreation Activities, Skills Training, Counselling, Shelter, School Intervention, and Parent Education.

Project Safe Place

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

Community-Based Child Abuse Prevention

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

Healthy Families Indiana (HFI)

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

Community Partners for Child Safety (CPCS)

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

Maternal Infant Early Childhood Home Visiting (MIECHV)

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

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

Children's Mental Health Initiative

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

The Children's Mental Health Initiative is collaboration between DCS and the local Access Sites, Community Mental Health Centers and the Division of Mental Health and Addiction. Available services include:

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

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

- DSM-V Diagnosis- Youth meets criteria for two (2) or more diagnoses.
- CANS 4, 5, or 6 and DMHA/DCS Project Algorithm must be a 1
- Child or adolescent age 6 through the age of 17

- Youth who are experiencing significant emotional and/or functional impairments that impact their level of functioning at home or in the community (e.g., Seriously Emotionally Disturbed classification)
- Not Medicaid Eligible/Lack funding for service array
- Other children who have been approved by DCS to receive services under the Children's Mental Health Initiative because they are a danger to themselves or others

Note: The Children's Mental Health Initiative is a voluntary service. The caregiver must be engaged in order to access services.

The CMHI started as a pilot project in 2012 and has spread throughout Indiana in 2013 and early 2014. The CMHI and the Family Evaluation process were implemented jointly to improve service access to families without requiring entry into the probation system or the child welfare system in order to access services. As the CMHI service availability expands, the need for Family Evaluations for this target population diminishes.

Preservation and Reunification Services

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

Home Based Services

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

Counseling, Psychological and Psychiatric Services

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

Treatment for Substance Use Disorder

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

Domestic Violence Services

- Batterers Intervention Program
- Victim and Child Services

Services for Children

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

Services for Parents

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

Global (Concrete) Services

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

These services are provided according to service standards found at:

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

Services currently available under the home based service array include:

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

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

Comprehensive Home-Based Services

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

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

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

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
FCT – Family Centered Therapy	● Families that are resistant to services ● Families that have had multiple, unsuccessful attempts at home based services ● Traditional services that are unable to successfully meet the underlying need ● Families that have experienced family violence ● Families that have previous DCS involvement ● High risk juveniles who are not responding to typical community based services ● Juveniles who have been found to need residential placement or are returning	This program offers an average of 6 months of evidenced based practice that quickly engages the entire family (family as defined by the family members) through a four phase process. The therapist works intensively with the family to help them understand what their values are and helps motivate them to a sustainable value change that will improve the lives of the whole family.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
	from incarceration or residential placement	
MI – Motivational Interviewing	● effective in facilitating many types of behavior change ● addictions ● non-compliance and running away of teens ● discipline practices of parents.	This program offers direct, client-centered counseling approaches for therapists to help clients/families clarify and resolve their ambivalence about change. Motivational Interviewing identifies strategies for practitioners including related tasks for the clients within each stage of change to minimize and overcome resistance. This model has been shown to be effective in facilitating many types of behavior change including addictions, non-compliance, running away behaviors in teens, and inappropriate discipline practices of parents.
TFCBT – Trauma Focused Cognitive Behavioral Therapy	● Children ages 3-18 who have experienced trauma ● Children who may be experiencing significant emotional problems ● Children with PTSD	This program offers treatment of youth ages 3-18 who have experienced trauma. The treatment includes child-parent sessions, uses psycho education, parenting skills, stress management, cognitive coping, etc. to enhance future safety. Treatment assists the family in working through trauma in order to prevent future behaviors related to trauma, and a non-offending adult caregiver must be available to participate in services.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
AFCBT – Alternative Family Cognitive Behavioral Therapy	● Children diagnosed with behavior problems ● Children with Conduct Disorder ● Children with Oppositional Defiant Disorder ● Families with a history of physical force and conflict	This program offers treatment to improve relationships between children and parents/caregivers by strengthening healthy parenting practices. In addition, services enhance child coping and social skills, maintains family safety, reduces coercive practices by caregivers and other family members, reduces the use of physical force by caregivers and the child and/ or improves child safety/welfare and family functioning.
ABA – Applied Behavioral Analysis	● Children with a diagnosis on the Autism Spectrum	This program offers treatment for youth with autism diagnosis to improve functional capacity in speech and language, activities of daily living, repetitive behaviors and intensive intervention for development of social and academic skills.
CPP – Child Parent Psychotherapy	● Children ages 0-5 who have experienced trauma ● Children who have been victims of maltreatment ● Children who have witnessed DV ● Children with attachment disorders ● Toddlers of depressed mothers	This program offers techniques to support and strengthen the caregiver and child relationship as an avenue for restoring and protecting the child's mental health, improve child and parent domains, and increase the caregiver's ability to interact in positive ways with the child(ren). This model is based on attachment theory but integrates other behavioral therapies.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
IN-AJSOP	Children with sexually maladaptive behaviors and their families	This program offers treatment to youth who have exhibited inappropriate sexually aggressive behavior. The youth may be reintegrating into the community following out-of-home placement for treatment of sexually maladaptive behaviors. Youth may have sexually maladaptive behaviors and co-occurring mental health, intellectual disabilities or autism spectrum diagnoses. CBT-IN-AJSOP focuses on skill development for youth, family members and members of the community to manage and reduce risk. Youth and families learn specific skills including the identification of distorted thinking, the modification of beliefs, the practice of pro social skills, and the changing of specific behaviors
Intercept	Children of any age with serious emotional and behavioral problems	Treatment is family-centered and includes strength-based interventions, including family therapy using multiple evidence based models (EBM), mental health treatment for caregivers, parenting skills education, educational interventions, and development of positive peer groups.

Sobriety Treatment and Recovery Teams

The program combines a specially trained Family Case Manager, Family Mentor, and Treatment Coordinator to serve families where there are children under the age of 5 and the parent struggles with a substance use disorder. The Family Mentor is someone who has had history with the child welfare system and is currently in recovery. The Family Mentor is paired with a Family Case Manager and they work the case in conjunction with one another in a dyad structure. Monroe County has 2 dyads. The site has 1 Treatment Coordinator. DCS has seen promising results

from the program.

Trauma Assessments, TF-CBT, CPP

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

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

Successful Adulthood: Older Youth Services

Indiana's Older Youth Services delivery method utilizes the broker of resources model, which is designed to: 1) ensure youth have or establish ongoing connections with caring adults; and 2) promote youth to develop as productive individuals within their community, by the acquisition and maintenance of gainful employment, the achievement of educational/vocational goals, and the receipt of financial skills training. This model shall also aid in future program development and design for other resources to facilitate the successful transition to adulthood for foster youth.

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

V. Available Services

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

VI. Needs Assessment Survey

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

VII. Public Testimony Meeting

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

The Public Testimony meeting for the Child Protection Plan/Biennial Regional Services Strategic Plan was held on 10/23/2017 at 9:00 am at 250 Main Street, Suite 301, Lafayette, IN 47901. A summary of the testimony is provided in Appendix C.

During the public meeting, testimony given reflected provider challenges with the DCS qualifications for the therapy service standard. The qualifications to find seasoned staff, experts in home based service delivery and credentialed is creating a major service gap for DCS in Region 5 and significantly challenging to locate in the area for providers to employ.

Advocacy was provided for continued prevention service focus, home based casework services for school aged children and also for continuation of teleservices project in rural counties that might support higher capacity of available service for the region outskirts.

More focus on a permanency timeline that is understood by all of the case parties as well as a stronger emphasis and service benchmarking on the reasons families came to the attention of the system. The starting point for some of this might be in clearer referral communication of goals and how the referred service contributes to the overarching vision of the case.

VIII. Summary of the Workgroup Activities

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

The topics of discussion included:

1. Prevention Services

During prevention discussion, it was identified by providers and DCS internal staff that there is disconnect in the identified needs and the use of existing Community Resources. It is not entirely understood by the workgroup how housing and utility assistance in various communities is under-utilized but there has been a gradual loss of community resource knowledge.

The Department of Child Services also recognizes the volume of assessment contacts that are made each year with families. The bulk of these families actually have unsubstantiated assessments but could be missed opportunities to connect with resources. Staff time and skill are likely barriers specific to that lost opportunity.

Providers also recognize that this knowledge is lost within some of their workforce as well as the many providers that are serving region 5 that are based in other areas of the state.

Money is also discussed as a barrier as prevention service dollars are decreased and benchmarking prevention into measurable outcomes is challenging.

2. Maltreatment After Involvement

Identified contributors to repeat maltreatment included absent, vague or deficit relapse plans for families exiting care that then create a family climate for failure and re-use of illegal substances. Additionally, smaller counties struggle with the lack of voluntary services to support drug and alcohol treatment post CHINS case.

Staff and partners have lost site of the Long Term View planning that fully incorporates family and informal supports and exits assessments and cases without having families fully engaged in community resources or services that will sustain them without DCS oversight.

Very few assessments are substantiated and closed with no case. If this is a Family Case Manager recommendation, the assessments are reviewed by

supervisor, Local Office Director and Regional Manager prior to approval to assure that teaming and networking occurred to assist the victim of abuse/neglect.

3. Permanency for children in care 24+ months

Some early conversation initiated around the legal barriers to permanency. DCS legal staff timeliness around filing of Termination petitions, court decision appeals and field staff setting Permanency hearings timely.

A theme that overlapped some of the other Biennial Plan areas and seemed somewhat overarching to system improvement is the lack of team cooperation and understanding around case planning processes. The links between team meetings, case plan documents, referral goals and actual concrete benchmarks is plaguing our novice workers and eroding the system effectiveness.

It appears that an opportunity in this area could be around co-education of system partners (Providers, CASA/GAL, court, attorneys) about the views in case planning process, improvement of conflict skills, and permanency driven language and vision by the whole system.

Some discussion was given to setting Permanency dates at disposition as a way to set a finite time clock for all of the system partners and family to achieve the case plan goals.

The role of service provision and effective use of home based by the DCS staff was also a key theme as to “what goes wrong?” Service provision quality has declined, DCS staff are not always benchmarking goals in referrals and communication of team members is lacking at times contributing to day to day survival of tasks in a case but not an overarching roadmap to permanency.

Placement stabilization through the use of mental health services to caregivers is also an areas of consideration for FCMs and mental health collaborations.

4. Substance Use Disorder Treatment

The macro view is that in the nationally, in Indiana and more specifically Region 5, we are experiencing rapid growth in the use/abuse of drugs and alcohol with not enough service capacity to meet the treatment need.

As we narrow that discussion, it is clear that the use of drug screens is not well understood, over-utilized as a litmus test for abuse/neglect and has driven our entire system to lack critical thinking or lack the communication of critical thinking around behavioral anchors for substance abuse. The lack of drug screening protocols and understanding of use and the gluttony and immediacy of

drug screen access has created a workforce in our system that has become focused on the negative/positive screen to inform recommendations and has not encouraged a thinking system around how to use the screen as tools. The heavy reliance on a chemical reaction has plagued our ability to develop measurable case plans or report on how behavioral change has occurred.

Client lack of engagement is also identified as a major barrier to success in drug and alcohol families. Various ideas are being tried across the region presently with some limited successes. It is also not a rapid fix in the time frames that children need permanency and has led the system to be impatient and struggling.

There was a request to discuss vision alignment around how we use drug screens to determine visit levels as right not, providers, CASA, DCS and courts are not always in agreement about how that occurs or should occur.

5. Other regional items were discussed and included some broad categories including; lack of transportation, poor translation services, need for group homes (Specifically for boys in the region), limited housing options for families with so many issues, access to mental health and service access to rural communities in general.

   Many of the discussed items have been assertively worked on in previous Biennial Plans with little to no progress. They continue to be areas of difficulty for local offices. Even though they are sited as problem areas, each local office has shared creative strategies and best practices over time to come up with client individualized plans. There is just a desire for these issues to be less pervasive in day to day operations as a barrier for families and for a system impact to be done to remove time spent solving them in the “peck-peck” method.

   Staff turnover for all system partners was also a major impact to the effectiveness of our work together and the overwhelm each of us feels in our arm of the work. The consensus is that nurturing relationships takes time and tends to be the first thing to go in a crisis system. Finding a way to come together to get more out of the resources we have needs to be a priority. Making that happen for each of us is the question.

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

IX. Regional Action Plan

Overview

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

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

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

Measurable Outcome for Prevention Services:		**Improve access and utilization of Community Prevention resources for all partners and service clients**		
Date of Workgroup		10/16/2017		
Workgroup Participants		Angela Smith Grossman, Sandy Lock, Karen Sturgis, Jennifer Johnson, Scott Angstadt, Angela Guimond, Hong-phuc Nguyen, Vivian Leuck, Cassie Wade, Monique Kulkarni		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Develop County Resource Sheets to distribute to staff, providers, courts and community	Obtain existing resource information from community agencies to use as a starting point to compile useful, up to date and available resources.	Community Partners, Local Office Directors, Supervisors and Regional Manager	3/1/2018 through 12/31/2019	8/31/2018
	Add resources that are missing from current tools.	Community Partners, Local Office Directors, Supervisors and Regional Manager	3/1/2018 through 12/31/2019	8/31/2018
	Contact community stakeholders for assistance for accuracy	Community Partners, Local Office Directors, Supervisors and Regional Manager	3/1/2018 through 12/31/2019	8/31/2018

	Create a method to update and distribute to community members.	Community Partners, Local Office Directors, Supervisors and Regional Manager	3/1/2018 through 12/31/2019	8/31/2018
Training to staff and system partners about access to resources and assisting clients with utilization.	Create a sub-committee of cross system partners	Regional Manager, Sub-committee of region providers and CASAs with access and utilization knowledge	3/1/2018 through 12/31/2018	1/1/2019
	Develop curriculum and activity to disseminate to audience	Sub-Committee	3/1/2018 through 12/31/2018	1/1/2019
	Set training dates, locations and send invitations to local partners	Regional Manager, Local Office Directors	3/1/2018 through 12/31/2018	1/1/2019
	Set sustaining plan for new staff and stakeholder training	Regional Manager, Local Office Directors	3/1/2018 through 12/31/2018	1/1/2019
	Conduct in-service for identified audience	Sub-committee of traners from DCS,	3/1/2018 through 12/31/2018	1/1/2019

		stakeholder group		

Measurable Outcome for Permanency for children in care 24+ months:		**Reduce Length of Stay in out of home care and length of case.**		
Date of Workgroup		10/16/2017		
Workgroup Participants		Angela Smith Grossman, Sandy Lock, Karen Sturgis, Jennifer Johnson, Scott Angstadt, Angela Guimond, Hong-phuc Nguyen, Vivian Leuck, Cassie Wade, Monique Kulkarni		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Earlier identification and concrete request for Permanency Hearing at disposition	Gather DCS stakeholders to determine the best method of identifying and communicating Permanency time clock	Supervisors, Mentor Family Case Managers, Local Office Directors, Regional Manager	3/1/2018	12/31/2019
	Include the courts and legal in identifying the best communication and timeframe to make a Permanency request	Court designees, DCS attorneys, defense attorneys, CASA	3/1/2018	12/31/2019
	Accurately identify and list Permanency hearing dates for each	Supervisors, Local Office Directors	3/1/2018	12/31/2019

	out of home case by county for follow up			
	Measure Practice Indicators, MagiK pertaining to this goal for improvement and report back to the committee for modification of process.	Local Office Directors and Regional Manager	3/1/2018	12/31/2019
Develop and conduct Case Planning Training	Convene Committee for tool, curriculum and activity selection	Regional Manager, Sub-committee of regional Supervisors and FCMS	3/1/2018	7/31/2018
	Develop curriculum and sustaining plan for training over time	Regional Manager, Sub-committee of regional Supervisors and FCMS	3/1/2018	7/31/2018
	Select location, dates and send invitations to DCS staff for first round training	Regional Manager	3/1/2018	7/31/2018
	Convene Provider, CASA stakeholders to determine appropriate	Sub-committee of providers of	8/1/2018	12/31/2018

	modifications to case planning in service	Home based service standards		
Improve goal writing and measurable for referrals and case plan documents	Audit current referred services and case plans and copy for sub committee	Supervisors	8/1/2018	12/31/2019
	Identify common needs, strengths, measurables in the documents audited	Supervisors and Local Office Directors	8/1/2018	12/31/2019
	Develop a measuring tool used in conjunction with planning that holds team, FCM, providers responsible for common language and view of family progress	Supervisors	8/1/2018	12/31/2019
Conduct meaningful and practice adhering Child and Family Team Meetings	Layer committee work from goal under "MALTREATMENT" to identify the skills of benchmarking and measurement within the team meetings	Peer Coaches and Peer Coach Liaison	8/1/2018	12/31/2019
	Instruct staff to facilitate progress discussions	Peer Coaches and Peer Coach Liaison	8/1/2018	12/31/2019

	meaningfully and with permanency focus for children			
	Convene regional in-service for CFTM refresher with focus on Permanency from identified work above	Peer Coaches and Peer Coach Liaison		

Measurable Outcome for Maltreatment after Involvement:		**Reduce maltreatment after DCS contact or Involvement**		
Date of Workgroup		10/16/2017		
Workgroup Participants		Angela Smith Grossman, Sandy Lock, Karen Sturgis, Jennifer Johnson, Scott Angstadt, Angela Guimond, Hong-phuc Nguyen, Vivian Leuck, Cassie Wade, Monique Kulkarni		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Conduct meaningful and practice adhering Child and Family Team Meetings	Identify key areas of Family meetings that are under-developed or poorly executed	Peer Coaches for Region 5. Regional Manager, Local Office Director, Peer Coach Consultant	6/1/2018-5/31/2019	12/31/2019
	Identify most common families in	Local Office Directors from repeat	6/1/2018-5/31/2019	12/31/2019

	region 5 prone to recidivism.	maltreatment reports		
	Identify key strategies in group meetings that emphasize the long term view for substance using families	Local Office Directors, Supervisors and Peer Coaches	6/1/2018-5/31/2019	12/31/2019
	Create region wide agendas that address skill building in the identified areas.	Sub-committee of supervisors with Regional Manager and peer coaches.	6/1/2018-5/31/2019	12/31/2019
	Create region-wide strategy to repeat messaging and skill building over time to lessen the impact of turnover and loss of knowledge	Local Office Directors, Regional Manager	6/1/2018-5/31/2019	12/31/2019
	Gather system stakeholders to determine their role in assisting with long term view	Providers to be identified by willingness to participate in workgroup	6/1/2018-5/31/2019	12/31/2019
	Conduct skill building activities region wide	Region Supervisors	6/1/2018-5/31/2019	12/31/2019

Measurable Outcome for Substance Use Disorder Treatment:		**Improve assessment, client engagement, treatment and success of substance using parents/caregivers.**		
Date of Workgroup		10/16/2017		
Workgroup Participants		Angela Smith Grossman, Sandy Lock, Karen Sturgis, Jennifer Johnson, Scott Angstadt, Angela Guimond, Hong-phuc Nguyen, Vivian Leuck, Cassie Wade, Monique Kulkarni		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Connect Clients to treatment services within 30 days of involvement with DCS	Convene a sub-committee of regions Master's level practitioners	LODS, Supervisors and FCMs with MSW	7/1/2018	6/30/2019
	Assess current conditions and develop measurable and benchmarks that can be sustained	LODS, Supervisors and FCMs with MSW	7/1/2018	6/30/2019
	Develop best practice methods for referral of services including a tool for use with individual cases	LODS, Supervisors and FCMs with MSW	7/1/2018	6/30/2019
	Implement best practices via unit meetings, region	LODS, Supervisors and	7/1/2018	6/30/2019

	trainings, individualized FCM staffings	FCMs with MSW		
Consistent court action for non-compliance of service s in court orders	Convene workgroup identified	Local Office Attorneys and Local Office Directors, Chief Counsel and Regional Manager, Local Office Attorneys	3/1/2018	12/31/2019
	Develop template for rule to show cause to be used by staff at specified case junctures	Local Office Attorneys and Local Office Directors, Chief Counsel and Regional Manager, Local Office Attorneys	3/1/2018	12/31/2019
	Develop aggregate measuring tool to measure staff compliance with procedure and also to inform tool/process modifications	Local Office Director Committee	3/1/2018	12/31/2019
	Introduce tool and process to DCS front line staff and	Local Office Director	3/1/2018	12/31/2019

	develop sustainable process to inform new staff			
Develop drug screening protocol for substance users and other case and boost tool use with clinical skills of FCMs and stakeholders	Review current DCS policy as well as literature from SAMSHA and other states	LODS, Supervisors and FCMs with MSW and BSW/MSW students		
	Create best practice strategies from credible sources	LODS, Supervisors and FCMs with MSW and BSW/MSW students		
	Identify needed tools, training, benchmarks and plan them for execution	LODS, Supervisors and FCMs with MSW and BSW/MSW students, Provider sub-committee of drug and alcohol practitioners		
	Determine method for dissemination to	LODS, Supervisors and		

	DCS staff and to providers	FCMs with MSW and BSW/MSW students, Provider sub-committee of drug and alcohol practitioners		
	Determine locations, dates and invitations to DCS and stakeholders for process discussion	Regional Manager and sub-committee consult		
	Implement tools, processes and training.	Sub-Committee designees with training experience		

Measurable Outcome for a region identified issue:	**Cross system collaboration that promotes quality team processing and cooperative work with families that reduces time in care for children and increases family engagement to sustainable case closure.**
Date of Workgroup	10/16/2017
Workgroup Participants	Angela Smith Grossman, Sandy Lock, Karen Sturgis, Jennifer Johnson, Scott Angstadt, Angela Guimond, Hong-phuc Nguyen, Vivian Leuck, Cassie Wade, Monique Kulkarni

Action Step	Identified Tasks	Responsible Party	Time Frame	Date of Completion
Convene partners (CASA, foster parents, Providers, courts, DCS, probation, other) and begin initial agreements	Schedule meeting time, place and invitations	Angela Smith Grossman, Hong Nguyen	April 2018	12/31/2019
	Hold meeting of partners and determine initial steps to improve communication on behalf of families	Angela Smith Grossman, Hong Nguyen, Local Office Directors, Providers, CASA, Foster Parents-identify committee	June 2018	12/31/2019
	Identify tools that benefit understanding high team functioning as well as barrier busting	Providers and DCS-Regio nal Manager facilitate with LODs	August 2018	12/31/2019
Identify reliable communication protocols	Review required complaint processes for all systems	Local Office Directors	August 2018	12/31/2019
	Review written exchanges currently	LODs, Regional Manager, partners	August 2018	12/31/2019

	being utilized or underutilized			
	Establish routine mechanism to update partners on changes, answer questions, identify emerging strategies, exchange praise and challenges.	Partner Committee	September 2018	12/31/2018
Train DCS and partners together	Identify needed areas of training or quality improvement in process	Partner Committee	October 2018	12/31/2018
	Build or identify curriculum to address most common teaming challenges and successes	Partner Committee	November 2018	1/31/2019
	Develop survey to pre and post test	Partner Committee	December 2018	1/31/2019
	Deliver curriculum with sustainable plan for new staff	Partner Committee	February 2019	12/31/2019
	Receive feedback about next step topics	Partner Committee	March 2019	12/31/2019

X. Organization, Staffing and Mode of Operation

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

1.	37		Number of Family Case Managers assessing abuse/neglect reports full time.
2.	0		Number of Family Case Managers with dual responsibilities; e.g., 50% CPS assessments and 50% ongoing services or 20% CPS and 80% ongoing services
3.	5		Number of Family Case Manager Supervisor IVs supervising CPS work only
4.	0		Number of Family Case Manager Supervisor IVs supervising both CPS work and ongoing services e.g., 50% CPS and 50% ongoing services
5.	0		Number of clerical staff with only CPS support responsibilities
6.	11		Number of clerical staff with other responsibilities in addition to CPS support
7.	Y ☒	N ☐	Does the Local Office Director serve as a line Supervisor for CPS? Carroll and White County

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

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

c. Describe your current system of screening calls and reporting allegations of child abuse and neglect. (Attach any tools you presently use if helpful.)The Indiana Child Abuse and Neglect Hotline (hereinafter "Hotline") receives all calls, faxes, e-mails, etc. from inside and outside the state regarding the suspected abuse and neglect of children occurring within the state of Indiana. Intake Specialists, most of whom have been Family Case Managers, gather the information from each caller and provide a verbal recommendation to parents, guardians, and professionals. The Intake Specialist bases that recommendation on current laws, policies, and practices regarding abuse or neglect. The Intake Specialist routes their completed report to a Hotline supervisor for approval via MaGIK. The Hotline supervisor can make edits/changes within the MaGIK system or send the report back to the Intake Specialist for changes. Once approved by the supervisor, all reports with a recommendation of assess or screen out are routed to the local county's queue for final approval. In the county queue, the local county has the ability to agree with or disagree with the Hotline recommendation. If the local county changes the decision, the local county will notify individuals who received a Hotline recommendation of that decision change. If an immediate response

to a report is required, the Intake specialist calls the local office via telephone during regular business hours. After hours, the Intake Specialist provides the on call designee essential information needed to immediately initiate the assessment. The written documentation is then forwarded via MaGIK to the local office's county queue. From 4:30-9:30p, Monday-Thursday, the on-call designee is notified via telephone of all 24 hour response time reports. Upon Hotline Supervisor approval, 24 hour response time reports will be routed to the county queue. From 9:30p-7:00a Sunday-Thursday, the Hotline will contact the on-call designee **ONLY** for reports requiring an immediate initiation.

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

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

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

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

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

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

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

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

1. **Statewide Assessments:** The Indiana Department of Child Services Hotline receives and processes reports of possible Child Abuse and/or Neglect (CA/N) that occurred in an institution setting located within the state. Licensed residential placement providers are mandated reporters and are required to report CA/N incidents and allegations. The Hotline staff will determine if the incident/allegation rises to the level of legal sufficiency to warrant further assessment and provide their recommendation to the Institutional Child Protection Services

unit (ICPS). If the CA/N report is screened in for assessment, the ICPS unit will assess allegations of abuse and neglect in group homes, residential treatment centers, emergency shelter care centers, day cares, schools, correctional facilities, etc. Allegations involving a foster home will be assessed by the local DCS office staff where the alleged incident occurred. The ICPS Director will assign the new report to the ICPS assessor in the respective Super Region for follow up. There are currently ten (10) ICPS Family Case Managers based in local DCS offices throughout the state.

The ICPS unit handles the 24 hour and 5 day response times. In cases where immediate attention is warranted, ICPS staff works in tandem with the Hotline and DCS local offices to ensure one hour response times are achieved and child safety is established. All reports are forwarded to the appropriate licensing/governing bodies at the time of report and again at completion for further review. Reports that are screened out, are forwarded to the appropriate licensing people when applicable.

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

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

   a. Residential Facility (i.e. DCS licensed Child Caring Institutions, Group Homes and Private Secure Facilities);

b. School;
c. Hospital;
d. Juvenile Correction Facility;
e. Adult Correctional Facility that houses juvenile offenders;
f. Bureau of Developmental Disabilities (BDDS) Certified Group Home;
g. Licensed Child Care Home or Center;
h. Unlicensed Registered Child Care Ministry; or
i. Unlicensed Child Care Home or Center (see Related

Information). ICPS will NOT conduct assessments

involving:

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

XI. Inter-Agency Relations

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

All offices conduct joint investigations according to DCS policy

Upon receipt of a report of suspected Child Abuse and/or Neglect (CA/N) the Indiana Department of Child Services (DCS) will contact the Law Enforcement Agency (LEA) in the appropriate jurisdiction to request a joint assessment in certain circumstances.

During a criminal investigation of CA/N, DCS will cooperate with the county or district prosecutor and LEA. However, DCS will not act as law enforcement by gathering evidence or interviewing persons for the sole purpose of a criminal investigation. The DCS focus will be on assuring the safety of children.

DCS staff stay in regular contact with LEA, including providing copies of all pertinent CA/N assessment files, when LEA and DCS are investigating the same family;
2. Follow local agreements and protocols to resolve any conflicts between DCS and LEA about differing methods of assessment; and
3. Testify at criminal hearings when subpoenaed to do so.

b. Describe the Community Child Protection Team.

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

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

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

XII. Financing of Child Protection Services

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

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

2016	2017
None	None

2. Child Advocacy Center/Other Interviewing Costs

Region 5	Total	
	Benton	$4,698
	Carroll	$6278
	Clinton	$43,346
	Fountain	$7,783
	Tippecanoe	$82,600
	Warren	$3,257
	White	$9,135

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

Average Salaries to be used in calculations (See attached computations on separate sheet)

JOB TITLES	# EMPLOYEES	average
FCM II	37	$58,620.32
FCM II	0	$23,448.13
FCM SUPERVISORS	5	$39,612.94
FCM SUPERVISORS (include LODs)	2	$34,208.26
CLERICAL SUPPORT STAFF	11	$34,208.26

XIII. Provision Made for the Purchase of Services

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