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STATE OF INDIANA

ANNUAL PROGRESS AND SERVICES REPORT

2009 – 2014 CHILD AND FAMILY SERVICES PLAN

June 30, 2013

Protecting our children, families and future

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A. INTRODUCTION

DCS has seen many changes in administration in calendar year 2013. Governor Michael Pence took over as Indiana's Governor in January of 2013, and DCS welcomed its new director, Mary Beth Bonaventura, in March of 2013. John Ryan, Chief of Staff was the interim Director until the new Director, Mary Beth Bonaventura, completed her tenure as Juvenile Court Judge of the Superior Court in Lake County, Indiana. John Ryan retired at the beginning of June, 2013. MB Lippold, Deputy Director of Staff Development also retired in June of 2013.

B. INDIANA DEPARTMENT OF CHILD SERVICES

The Indiana Department of Child Services (DSCS) protects children and strengthens families through services that focus on family support and preservation. DCS administers child support, child protection, adoption and foster care throughout the State of Indiana.

DCS' infrastructure did not change and is still based upon local offices in ninety two (92) counties, organized into eighteen (18) regions. DCS added a centralized hotline, located in Indianapolis, in 2011, and plans to add four regional hotlines in 2013 in Blackford, Vanderburgh, Lawrence and St. Joseph counties.

The mainstay of Indiana's Practice Reform continues to be the TEAPI practice model. DCS remains committed to "**Safely Home—Families First,**" with a focus on keeping children in their homes. DCS is also committed to trauma informed care and a reduction in the use of psychotropic drugs.

Building upon the Administration for Children and Families initiative to promote the social and emotional well-being of children and youth receiving child welfare services, DCS planned and held a Statewide Conference in October of 2012, at the Indiana Convention Center in Indianapolis, Indiana. Experts in topic areas including Trauma Informed Care, Brain Development, Adverse Childhood Experiences, Evidence Based Practices and Childhood Relational Permanency gave 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. Consistent with these areas of focus, DCS established goals in its 2013 strategic plan that will allow the agency to further develop a trauma-informed system of care.

Indiana's new child welfare tracking and case management system, MaGIK (Management Gateway for Indiana's Kids), with an interactive web-based capability, is now fully operational.

C. GOALS AND OBJECTIVES

DCS selected four primary strategies (themes) to serve as guideposts for 2010-2014 CFSP goals and objectives. After careful discussion and collaboration amongst the DCS Director, Deputy Director of Field Operations, and the eighteen (18) regional managers throughout the state, it was concluded that Indiana's child welfare system must identify and focus on the strategies that would address staff development, community partnership, individualized services, and systemic change.

GOAL #1: STAFF DEVELOPMENT

DEVELOPMENT OF STAFF THAT HAVE ASSESSMENT SKILLS AND COMPETENCIES TO DETERMINE THE RISKS AND NEEDS OF CHILDREN AND THEIR FAMILIES.

Objective 1.1 All existing FCMs, FCM Supervisors, Local Office Directors, and Regional Managers will be trained in the final stages of TEAPI: planning and intervening.

Response 1.1

This objective is complete. TEAPI training, provided to all staff, has been fully incorporated into the 60 day pre-service training for new family case managers (FCMs). Advanced TEAPI training was offered regionally in 2012 through quarterly seminars conducted by Peer Coach Consultants. A workshop for all 120 Peer Coaches was also held in July of 2012 to provide additional skill development in their facilitation expertise.

Objective 1.2

Ensure consistency in timely response to CA/N (child abuse/neglect) reports across regions.

Response 1.2

This objective is complete. Timely initiation of child abuse and neglect investigations continues to be tracked in DCS' new information management system, MaGIK and in the QAR process. In 2013, DCS was given authorization to hire an additional 159 FCMs, 81 FCM Supervisors, and 25 Relative Support Specialists to assist with ongoing caseload management and timely response to assessments. Additionally, 60 new Intake Specialist FCMs and 10 Supervisors were added to assist in answering incoming calls and receiving reports during peak call volume times at the DCS central Hotline. Four regionally-based Hotlines are being added and are expected to be operational by the end of 2013.

Objective 1.3

CFTMs/case conferences will be used to develop effective and comprehensive safety planning to ensure children are safe at the time of DCS' initial involvement and thereafter until case closure.

Response 1.3

This objective is complete. This objective was amended and approved during a federal conference call (June 2, 2010) to allow DCS to track performance and improvement in this area through the Reflective Practice Survey (RPS). During the life of a case, Child and Family Team Meeting (CFTM) minutes will include the safety plan. FCM's will enter written minutes/safety plan in the CFTM's contact note in the MaGIK system. Safety planning will be established in the CFTM notes and the quality of the safety planning development will be observed through the Supervisory RPS review. The RPS tool is currently under revision. There has been collaboration with the field to revise the ongoing tool and create a specific tool for assessments. The ongoing tool was put into MaGIK in January, 2013. The new assessment tool was piloted and then implemented into MaGIK in April, 2013.

The RPS subcommittee continues to meet to discuss additional enhancements to the skills sections of both the ongoing and assessment tools. These enhancements include expanding the skills sections descriptions as well as developing tailored scoring guides for each skills indicator. These changes to the tools will enable supervisors to accurately assess the FCMs skill sets and ensure that assessment of the family's safety needs and appropriate safety planning is taking place.

The subcommittee has met with members of Staff Development to develop a plan to provide training to supervisors on the enhanced tools. As a result of the meeting and changes to the tools, Staff Development is creating training on the new tools. The RPS training is scheduled for all supervisors in the fall 2013. In addition, the current RPS training curriculum for new supervisors is being revised and implemented by 2013. The implementation of the enhanced RPS tools into MaGIK is currently on the priority task list for development.

Overall the previous ICWIS RPS data reports indicate that most FCMs are demonstrating the skills necessary to assess the safety of children in care. This data is supported through the current QSR data collected during monthly reviews. Appropriate assessment of the family's safety needs can lead to successful safety planning. The RPS has been revised since this data was collected to provide clarity to the supervisors assessing the FCMs skills for safety planning. As supervisors become more adept at using the RPS, the scores will be more reflective of the FCMs skills.

In addition to scoring assistance for skills, policy has been updated to strongly encourage management staff to become qualified reviewers. Regional Managers (RMs) will have to report to Central Office the reasons management staff are not trained reviewers. At this time, 72% of field management staff have been through the QSR training and are either trained reviewers or in the process of becoming trained reviewers. The QSR training will assist field management in accurately scoring the case portion of the RPS as it will further their understanding of the indicators.

Objective 1.4 Review current risk and needs assessment tools to align with TEAPI model and support the continuous assessment occurring throughout the life of the case.

Response 1.4 **This objective is complete.**

During 2012, DCS had several discussion with Casey Family Programs (CFP) regarding promotion of "Safely Home; Families First," an initiative to keep children in their own homes if they can safely remain home or to place children with a relative if they cannot remain safely in their own home.

In an effort to learn more about how FCM's make decisions on whether to leave children in their home or remove them, DCS partnered with CFP to complete a review of fifty-two (52) cases in thirteen (13) Indiana counties. Cases were chosen with the goal of including rural, urban, small, medium, large, and northern and southern counties and counties with low to high removal rates. The project will include a review of policies, practices, tools, and training as well as face to face interviews with DCS staff including FCM's, their supervisors, and local office attorneys. Other DCS partners including, but not be limited to, law enforcement, judicial officers, parents, and service providers will also be interviewed.

Beginning in April 2013, DCS, along with Casey Family Programs, initiated a Front End System initiative to review the effectiveness and challenges of our current report intake process. Part of this review focused on DCS staff's understanding of the SDM assessment tools and its effectiveness in the field.

On May 6, 2013, Tom Morton, a consultant provided by CFP, began work on this project. Six (6) counties have been chosen and relayed to CFP which cases will be reviewed. DCS is working to add five (5) additional counties. Interviews will commence as soon as CFP approves the review process.

The goal, upon completion of the review, is to make improvements to any specific areas identified in the review with the ultimate goal of keeping children safely in their own homes whenever possible.

Objective 1.5 Implement permanency planning system-wide while focusing on the "life of the case", placement stability, and timeliness.

Response 1.5 **This objective is complete.** Building on the successful experience of the pilot Regions, Permanency Round Tables (PRT) rolled out across the state in 2012, including all 18 regions. 207 PRTs were completed throughout Indiana in 2012. PRT will continue in 2014.

Objective 1.6 Local offices will monitor and improve compliance regarding statutory hearing requirements to increase timely permanency for children.

Response 1.6	**This objective is complete.** Cases continue to be monitored to ensure adherence to statutory timelines.
Objective 1.7	Establish the use of Mock Trial DVD for staff training purposes to improve worker skills in court hearings.
Response 1.7	**This objective is complete.** The Mock Trial DVD, developed in 2010, continues to be used to train new staff.
Objective 1.8	FCMs will locate non-custodial parents and other relatives beginning at the assessment (investigation) process and throughout the life of the case.
Response 1.8	**This objective is complete.** FCMs continue to use GenoPro, an advanced software tool, to create automated genograms and ecomaps to identifying family members and their support systems. The "Absent Parent Search" continues to be used by FCMs to document search efforts for absent parents and to assure supervisors that appropriate efforts are being made to find absent parents. As part of a pilot project with financial assistance from Case Family Programs (CFP), DCS hired independent contractors to locate parents and relatives. The pilot was so successful that DCS, in 2013, hired 12 Parent/Relative Locate Specialists in lieu of hiring contractors. As of June, 2013, DCS had filled 11 of the 12 positions and expects the last position to be filled by August, 2013. DCS now utilizes online search capabilities through Accurint, a search program.
Objective 1.9	DCS will expand placement options to consider non-related adults when it is in the best interest of the child.
Response 1.9	**This objective is not complete.** Effective October 1, 2012, DCS Policy 8.48: Relative Placement, was revised to include reference to placements with stepparents (former and current), their families, and parents/relatives of half siblings. If placement with a noncustodial parent or relative caregiver is not possible or is not in the best interest of the child, FCMs may pursue other placement options consistent with Policy 8.1-Selecting a Placement Option (revised January 1, 2012). Additional work is being done to address placement with other non-related adults in DCS policy and practice.
Objective 1.10	DCS will emphasize to all field staff the value of proximity and preserving essential connections to the child's family, culture, religion and community.
Response 1.10	**This objective is complete.** DCS remains committed to "Safely Home - Families First" (SHFF), a renewed belief that the most desirable place for children to grow up is in their own home - as long as the family is able to provide safety and security for the child. DCS has heightened efforts to provide for the well-being of children by identifying protective factors that will help keep children safely in their homes. There are many aspects to this effort including, but not limited to, the expansion of in-home support services, wraparound services, intensive family preservation, and intensive family reunification. Having those services available in a timely manner, at any time of day or night when the services are needed and with the flexibility to adjust services based on the needs of the family are absolutely necessary to the

success of Safely Home - Families First efforts. When children are in Out-of-Home placements, they should maintain essential contacts.

There are some situations when decisions regarding the safety of a child lead to a determination that removal from the home is in the best interest of that child. When making these decisions, FCMs must weigh the risks associated with leaving a child in the home against the trauma associated with removing the child for the home. When a child cannot be safely maintained in the home, DCS is committed to finding absent parents and relatives. FCMs look for family members who know the child and with whom the child will feel safe and comfortable. These relatives have established relationships with the child, and as such the trauma of removal for the child is mitigated. Relatives help the child feel included in their family and relatives are sometimes more comfortable in maintaining relationships with the child's parents and assisting with visitations and frequent contact with the child's parents. Relatives are also more apt to accept sibling groups.

DCS Practice Indicator Reports demonstrate that children placed with relatives are more likely to find permanency faster than when they are placed in non-relative environments. http://www.in.gov/dcs/3429.htm

The Indiana Child Welfare Manual reinforces this belief and discusses essential connections in several sections of the Manual. The first section of the manual 1.0 Introduction, Section 7.5, and Section 8.43, discuss meaningful visits for placements In and Out of the home. These policies support DCS' value that the most desirable place for children to grow up is with their own families if families are able to provide safe, nurturing and stable homes.

In implementing SHFF statewide, DCS, following its practice model, had each local office and central office divisions participate in team meetings to discuss the concept of Safely Home – Families First and to identify areas of need and barriers to maintaining children in their own homes or with relatives. The information gathered during these meetings was shared with the DCS executive team during a similar team meeting in mid-2011. Since that time, the Deputy Directors, Regional Managers, and their staff have developed action plans to respond to requests and concerns. These Strategic Action Reports continue to be completed quarterly in each region.

Objective 1.11 FCMs will increase the frequency and improve the quality of visits between the family of origin and the child in care to promote faster achievement of permanency and reduce the time a child is placed in substitute care.

Response 1.11 **This objective is complete.** FCM's engage both maternal and paternal family members equally in the assessment and case planning process from the first point of intervention. FCMs develop a visitation plan for families during Child and Family Team Meetings (CFTM) and/or in case conferences. Those plans are enforced and updated throughout the child's stay in foster care. DCS contracts for much of the supervised visitation provided to families. With contracts beginning July 1, 2011, DCS instituted a standardized form for reporting information regarding the visit, including observation of functional strengths and areas for improvement. The narrative documents the interactions between the parents and child(ren), and any required interventions during the visit. Recommendations for future visits are also included. This allows FCMs to monitor the location, frequency, participating parents and also the quality of the visits.

Objective 1.12 DCS will ensure FCMs' compliance with the case worker contacts policy regarding frequency and quality of visitation with parents and children.

Response 1.12 **This objective is complete.** A monthly report is generated in MaGIK on the 20th day of each month, listing all children who have not had a visit from their FCM since the 1st of the month. The report is posted on the MaGIK systems report menu. This provides sufficient time for Supervisors to follow up with front line staff to ensure that all children receive the required monthly visit from their FCM. Data from the FFY Monthly Caseworker Visits reports for FFY 2011/20012, and for 2012/2013 YTD are included below in Section G. 4. FFY 2011/2012 reflects a 92.88% success rate annually. DCS released its new computer system in July 2012. This caused some under-reporting in July-September 2012 dropping the overall annual figure to 92.88% (as reflected by the data in Section G. 4) but this still exceeds the federal standard of 90%.

A subcommittee was formed with Field Operations, PQI, and Staff Development to enhance the RPS tools through expanding the skills observations indicators and scoring guides. During the enhancement process, a new RPS indicator for the ongoing and assessment tools was created to measure the quality of FCM visits with the child as well as the family. This new indicator compliments and supports the principles of obtaining safety, permanency, well-being, and stability for children and families as instructed to DCS staff during the "Making Visits Matter" training.

The enhanced RPS curriculum is being currently added to new supervisor training and the fall 2013 training for existing supervisors. The new RPS tools are scheduled for rollout into DCS MaGIK in the first quarter of 2014.

Objective 1.13 All CHINS cases will be monitored to ensure that IL services are appropriately provided to eligible youth at the earliest possible age, and that all children are involved in the development of their IL plan.

Response 1.13 **This objective is complete.** FCM's must facilitate a child centered Child and Family Team Meeting (CFTM) to assess IL needs at least 6 months prior to every child's 16th birthday. The child's IL/Transition plan is developed with the child during the CFTM and is updated prior to every permanency hearing or within six (6) months thereafter. This process is reflected in DCS Policy, 11.6. DCS continues to have mandatory, quarterly FCM Technical Assistance Meetings on IL planning, policy, and available services and a mandatory technical assistance workshop at least once a year.

Objective 1.14 Training of supervisors to assist FCMs in identifying potential risk factors and suitability for out of home placements.

Response 1.14 **This objective is complete**. DCS continues to utilize the Child and Adolescent Needs and Strengths (CANS) Assessment to document the intensity of behavioral health services needed by the child and family. DCS FCMs and FCM Supervisors have been trained and certified to use the CANS. FCM Supervisors must be certified as CANS "SuperUsers" through additional training. DCS tracks CANS certification status and notifies the appropriate staff person when they need to recertify.

Objective 1.15	Comprehensive and appropriate safety plans will be developed for children to ensure their safety wherever they reside.
Response 1.15	**This objective is complete.** DCS continues to utilize safety plans to address safety needs of children. DCS is partnering with the Casey Foundation in 2013 to examine risk, safety, and protective factors in the assessment phase in order to address Indiana's above average use of placements and to provide more trauma informed care. The Child and Family Adolescent Needs and Strengths (CANS) tool has also been revised to reflect trauma. The addition of 160 new FCM's, many of whom will have Assessment caseloads, will further reduce workloads allowing more thoughtful development and evaluation of protective factors, community supports, and safety plans. Based on statewide Quality Service Review findings, one of DCS' statewide goals for 2013 is to improve the function and formation of DCS' Child and Family Team Meetings where many safety plans are developed.
Objective 1.16	Utilize state practice tracking system to identify specifics of maltreatment and generate a report that separates foster homes and biological homes.
Response 1.16	**This objective is complete**. An Institutional Unit has been developed to investigate all reports of abuse and neglect in foster care and the specifics of maltreatment are tracked within that unit. Foster home maltreatment is reported separately from other forms of maltreatment in the Indiana DCS Practice Indicator - Absence of Maltreatment in Foster Care Report which can be found at: http://www.in.gov/dcs/files/MaltreatmentinFosterCare201303.pdf
Objective 1.17	Case managers are to assess the needs of foster parents and provide services to meet those needs.
Response 1.17	**This objective is complete.** DCS has dedicated statewide Regional Foster Care Specialists (RFCS's), fully trained and functioning in this role, and Supervisors to provide guidance to RFCS's in these roles. The RFCS's are tasked with providing comprehensive support to foster parents (including licensed relative caregivers). This comprehensive support includes assistance with facilitation of the licensure process, completion of home visits to address issues and needs, timely responses to questions and concerns, identification of training needs, linkage to appropriate resources and opportunities, and facilitation of appreciation for efforts.
Objective 1.18	Develop training modules for forensic interviewing, substance abuse identification and treatment, and determining IV-E eligibility for ward in case.
Response 1.18	**This objective is complete.** Forensic Interviewing Techniques & Working with Clients Challenges with Substance Use Disorders are part of the trainings provided regularly to field staff based on need. Training on IV-E eligibility is completed via a webinar through our contract provider, Maximus.
Objective 1.19	Classroom training available regarding the licensing of foster homes including all appropriate protocols, forms, and data entry required.
Response 1.19	**This objective is complete.** Comprehensive three-day trainings (including information on the Casey Foster Family Assessment, the licensure process, as well as effective strategies for recruitment and retention of foster parents) of the Regional Foster Care Specialists (RFCS) and

supervisors were held in January and February, 2010. In February 2011, the training was refined, with follow-up trainings occurring in March and May of 2011. Going forward, three (3) day trainings for new workers are offered at least once a year in the spring and training for all workers is offered at least once a year in late Summer/Fall. Additionally, monthly conference calls are held with RFCS Supervisors to reinforce or enhance learning.

Objective 1.20 — Development of a comprehensive training record information system to track all trainings attended and completed by DCS staff.

Response 1.20 — **This objective is complete.** DCS developed a comprehensive training record information system to track all trainings attended and completed by FCMs. DCS utilizes the Enterprise Learning Management System (ELM) for this purpose. Once a worker registers within ELM, the system tracks his/her training in-service training hours on the worker's Learning Transcript. Reports detailing all of the DCS trainings taken by a worker are available through the system, which include course name, completion dates and hours received from each course.

Objective 1.21 — Modify the Indiana Child Welfare Information System (ICWIS) in the next fiscal year to generate work daily to the new Centralized Eligibility Unit (CEU) and to allow work to be completed by the CEU staff with ticklers to FCMs when necessary.

Response 1.21 — **This objective is complete.** MaGIK provides Title IV-E and Emergency Assistance (EA) eligibility applications for both probation and CHINS cases. Beginning in July of 2012, CEU became responsible for all IV-E eligibility determinations in CHINS, Probation, and Emergency Assistance cases. FCMs enter income and personal information into MaGIK and upload supporting documents. MaGIK generates an eligibility application which is placed on the CEU assignment page. CEU staff perform their eligibility determinations and the results become visible in MaGIK.

Objective 1.22 — Expand the existing interface with the Public Assistance Agency (ICES) and Child Support (ISETS) to eliminate FCMs and the Centralized Eligibility Unit from having to search and update in ICWIS found information applicable to the child and family.

Response 1.22 — **This objective is complete.** The interface between ICES and ISETS became operational in July of 2012, when MaGIK was deployed. This eliminates the need for FCM's to complete searches and match data in ICES and ISETS. The ICES interface notifies ICES of children removed from the home or returned to the home. A recipient ID number for the child is returned and can be recorded on the child's health card in MaGIK.

GOAL #2: PROGRAMS AND SERVICES

ENSURE THAT INDIVIDUALIZED PROGRAMS AND SERVICES ARE DELIVERED TO FAMILIES AND CHILDREN IN ORDER TO ACHIEVE SAFETY, PERMANENCY, AND WELL-BEING OUTCOMES.

Objective 2.1 — DCS will offer an array of internal and external services to families based on identified needs. Regional Services Councils will select services significant to their respective region.

Response 2.1 — **This objective is complete.** DCS' has thirty-six (36) service standards that regulate a continuum of services offered through the agency i.e. adoption, Chafee IL services, family-centered programs, foster parenting, addictions, preventative care, probation services and foster parenting. In Quarter 2, these standards were updated to reflect TEAPI values and best

practices. Before August 31, 2010 Service specific review tools were developed and implemented by Regional Coordinators and Programs and Services staff to ensure services provided are in accordance with contract requirements and reflective of TEAPI values. The tool developed will be used by the Regional Child Welfare Coordinators, on a statistically valid random sample of providers and will be reviewed every two years.

DCS service standards will require that providers train their staff on substance abuse and domestic violence as a part of the contract requirements. RSC will develop new service standards by August 31, 2010 for transportation services to submit to central office.

During the Child and Family Services Review, a concern was noted that Indiana needed to improve the timeliness of service referrals. During Quarter 3, two features were migrated into ICWIS: the identified date (when a service need was determined) and a referral date (when a service referral was made). Field instructions were provided to alert staff of these new features and to reiterate the importance of meeting the service needs of families in a timely manner.

Additionally, Field Operations now utilizes an automated service referral form that will be housed in ICWIS and saves in the case plan. FCMs will be able to cross-reference this referral form to the state's payments/fiscal system, KidsTracks. The referral form will include a place to record the type of service, length of service and amount (unit) of service. This feature was available statewide July 2010.

DCS updated the referral process by implementing a Referral Wizard system which explains the service array to FCMs and assists them in making appropriate referrals for these services.

Objective 2.2 DCS will ensure that all wards are assigned a Medicaid Care Coordinator (Care Select) for the purpose that health benefits are coordinated and wards receive a comprehensive level of medical care.

Response 2.2 **This objective is complete.** DCS continues to collaborate with Indiana Office of Medicaid Planning and Policy (OMPP) to ensure that all DCS foster children and youth are covered by Medicaid. At the time that this goal was written *Care Select* was available to all eligible DCS foster children and youth. Indiana Medicaid administered by OMPP continues to evaluate and modify Medicaid health plan. Since the last APSR response, the Indiana Medicaid plans have been revised and *Care Select* is only available to individuals with certain medical conditions requiring medical care coordination. Therefore, some children are enrolled in the Indiana Medicaid Traditional plan. For more information regarding these plans please refer to the Health Care Oversight and Coordination Plan.

An MOU between DCS and OMPP was signed in early 2012 to begin work on integration between DCS and Medicaid to extract medical data and claims information. Preliminary planning sessions for this work are planned to begin soon.

Objective 2.3 DCS will explore additional funding to provide mental health assessments to children served in Informal Adjustments (IAs).

Response 2.3 **This objective is complete.** DCS and Community Mental Health Centers (CMHC) entered into an agreement whereby children with CANS behavioral health levels of 3 or higher are referred to

CMHC's for an assessment of the child's specific needs for behavioral health services. The Indiana Division of Mental Health and Addictions (DMHA) certifies CMHCs and participates in a work group with CMHCs and DCS to help maximize availability of Medicaid-funded mental health services on behalf of DCS foster children and youth. A Memorandum of Agreement was entered with Behavioral Health Management, Inc. (BHMI), on behalf of the CMHCs, to facilitate development of a provider network of CMHCs, which are the only entities authorized to provide the Medicaid Rehab Option (MRO) for mental health services. DCS' contracts with CMHCs include assessments for MRO as well as a full array of MRO services and companion services which may be necessary to complement the medically necessary mental health services.

Objective 2.4 DCS will enhance foster parents' preparation for placement to increase appropriate matching of homes to children and foster placement stability.

Response 2.4 **This objective is complete.** The CANS tool and the Casey Foster Family Assessment collectively address pre-placement issues. The CANS tool is currently utilized to determine the level of care or needs of a child prior to placement, and the Casey Foster Family Assessment tool is used by Regional Foster Care Specialists (RFCS) to identify the strengths and needs of foster parents before placements occur. RFCS currently utilize the Casey Foster Family Assessment tool in their evaluation of foster parents. RFCS also have access to a placement matching feature in MaGIK to assist in finding foster homes.

Objective 2.5 DCS will reduce factors that contribute to foster parent attrition during the licensing process.

Response 2.5 **This objective is complete.** In order to provide better support to foster parents and to expedite the licensing process, DCS has dedicated Regional Foster Care Specialists (RFCS's) and Supervisors. The RFCS's are tasked with providing comprehensive support to foster parents, including: assistance with licensure, completion of home visits to address issues and needs of the foster parents, providing timely responses to questions & concerns, identification of training needs and linkage to opportunities and resources, and facilitation of appropriate appreciation. See Response 2.7 for additional information.

A full-time curriculum writer rewrote pre-service training to better align with the vision, mission and values specific to the department. In addition, on-going training modules for foster parents were developed so that consistent and quality training can be offered regionally at convenient times and in convenient locations. Rules and policies relating to foster 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 Bloodborne Pathogens.

The training was reorganized and renamed Resource & Adoptive Parent Training (RAPT). Due to the frequency and variety of trainings offered, foster parents are able to complete training requirements for licensure much more quickly than in the past.

Objective 2.6 DCS will adopt a placement assessment tool that will evaluate the child's need for placement and level of care.

Response 2.6

This objective is complete. Indiana adopted the CANS (Child Adolescent Needs and Strengths) assessment as its placement and behavioral health assessment tool. All FCMs and FCM Supervisors are certified users of the CANS. DCS continues to provide training and education to ensure that all staff, including newly hired FCMs and FCM Supervisors, maintain their certification.

DCS is currently implementing modification and/or development of a Trauma Informed Care aspect to the CANS. This will provide additional information and support in referring for services and establishing a level of care.

Objective 2.7

DCS will create foster care specialization units statewide to focus efforts on recruitment, placement stability, foster care in-service trainings, respite care coordination, and after hour supports.

Response 2.7

This objective is complete. RFCS units have been created and are in operation statewide. The position of RFCS was fully developed and approximately 100 individuals were designated to complete these responsibilities along with approximately 20 supervisors. Prior to 2013, supervisors provided supervision to FCM's conducting assessments, ongoing case management, and foster care. In 2013, DCS is revising the supervisor structure so that the core responsibility of supervisors in the RGCS unit will be foster care.

A three (3) day training was developed and is delivered to these individuals yearly and is address in the DCS Training Plan below.

Accomplishments for the foster care unit in 2012 include:

1. RFCS and their Supervisors took part in a day long training which focused on the development of regional recruitment plans and regional support plans.
2. RFCSs assisted in training and supporting foster parents with the new foster care rate structure which took effect in January 2012.
3. Each region was given resources to facilitate at least one foster parent appreciation event regionally.
4. Foster parent in-service trainings expanded to include topics including cultural competence, educational advocacy, trauma-informed care, resource family self-care, and working with biological families.
5. Some regions were able to utilize a video-conferencing training option to allow more flexibility and timeliness in meeting the training needs of foster parents in smaller regions with less volume of foster parents.
6. Electronic invoicing was developed and piloted with traditional service providers and should be ready to roll-out to foster parents by summer/fall of 2013. This should reduce the time and potential frustrations associated with the invoicing process.
7. DCS just received an allocation of 30 statewide pilot positions designated to providing better support to relative caregivers when placement occurs. These Relative Support Specialists will work within the RFCS and will provide information and support to relative caregivers and assist them in making decisions about licensure. Referrals for licensure will now occur more timely and seamlessly for those wanting to pursue that avenue. Additionally, the RFCS' will be better able to focus on and support foster parents, while the Relative Support Specialists will be able to continue addressing the needs of

relatives who decide not to become licensed. Previously, RFCS tried to continue to meet the needs of unlicensed relatives, thus dividing their time commitments.

Objective 2.8 DCS will develop a list of mental health providers and dentists who accept Medicaid and provide information to FCMs and foster parents.

Response 2.8 **This objective is complete.** DCS located a website (http://provider.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx), operated and maintained by the Office of Medicaid and Policy Planning (OMPP) that showcases current mental health providers and dentists across the state. The website is updated annually and/or when Medicaid providers are added or deleted from the database. The information is generated from AIM (a data base system of active Medicaid providers). This information along with additional links has been shared with FCMs and added to the Foster Family Resource Guide given to prospective foster parents during RAPT training.

Objective 2.9 Statewide access to services for substance abuse, domestic violence and Spanish speaking families.

Response 2.9 **This objective is not complete.**

Objective 2.10 Statewide access for behavioral health services.

Response 2.10 **This objective is complete.** Through the DCS partnership with the Community Mental Health Centers, behavioral health service availability has been expanded and enhanced. CMHCs were provided a master contract to allow them to provide the full array of behavioral health care services to children throughout Indiana. This includes the provision of Medicaid Rehabilitation Option services. A protocol for referral to CMHCs was developed. The DCS Referral Wizard system explains the service array to FCMs and assists them in making appropriate referrals for these services.

GOAL #3: COOPERATION AND COMMUNICATION

ENSURE THAT SERVICES ARE DEVELOPED AND PLANNED IN PARTNERSHIP WITH FAMILIES AND COMMUNITIES TO PROTECT CHILDREN IN THEIR COMMUNITY THROUGH COOPERATION AND COMMUNICATION.

Objective 3.1 DCS will collaborate with community partners to develop domestic violence guidelines.

Response 3.1 **This objective is complete.** DCS continues to provide training for field staff to ensure that they are well informed and educated on Domestic Violence. DCS continues to work collaboratively with both state and local Domestic Violence programs.

Objective 3.2 DCS will partner with FSSA, OMPP and DFR to discuss issues of provider availability and develop strategies for service capacity expansion, accessibility, and availability including services geared toward prevention.

Response 3.2 **This objective is complete.** DCS continues to collaborate with FSSA, OMPP, and DFR to maximize the use of Medicaid funding and increase the accessibility of services to eligible youth and their families. These efforts are addressed in more detail in the Health Care Oversight and

Coordination Plan.

Objective 3.3 DCS will work with community partners to emphasize the importance of the involvement of non-custodial parents, absent parents, and other significant relatives.

Response 3.3 **This objective is complete.** DCS expanded father engagement initiatives to all regions in July 2011. DCS continues to have regular conference calls with contractors during which best practice approaches are shared.

Objective 3.4 DCS will collaborate with the Court Improvement Project (CIP) to address barriers to TPR filings and to actively pursue adoption as the permanency goal.

Response 3.4 **This objective is complete.** An Indiana Court of Appeals case, In Re Parmeter[1], was an insurmountable impediment to the timeliness of TPR filings in Indiana. The Indiana Court of Appeals, in Parmeter held that statutes requiring courts to hear a case in a timely matter were only directory and not mandatory, because Indiana statutes failed to provide adverse consequences for untimely filings. DCS successfully sought statutory changes in the 2012 legislature. Effective July 1, 2012, Indiana statutes now provide a party the option to file a motion to dismiss a CHINS case if the court fails to hold a hearing or act within the timelines specified by statute.

DCS representatives routinely attend 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, and DCS programs and services.

Objective 3.5 The DCS local office in Johnson County continues to collaborate with the Johnson County Circuit Court to manage CIP funded pre-hearing facilitation program.

Response 3.5 **This objective is complete.** The Johnson County Circuit Court initiated, implemented, and operated a pre-hearing CHINS Facilitation Project. Facilitation sessions are held on Monday afternoons, excluding public holidays and vacations. Facilitations are available at each dispositive or contested stage of CHINS and TPR proceedings. Parties are referred to facilitation either by the Court or by Party request. The weekly schedule allows facilitations to be held within days of the referral. The Facilitation Project has been a complete success.

All project goals have been satisfied. The number of contested court hearings has been reduced and the average length of time it takes a CHINS case to progress through the court has been reduced. This has allowed Johnson County courts to manage the large increase in CHINS cases without a corresponding increase in judicial officers or personnel time.

Objective 3.6 The DCS local office in Marion County continues to collaborate with the Marion County Juvenile Court on mediations funded through the CIP pre-hearing mediation program for CHINS cases.

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1 In Re RP, 949 N.E.2d 395 (Ind. App. 2011)

Response 3.6

This objective is complete. The Marion County Juvenile Court, Court Process Committee continues to meet monthly to discuss and resolve areas identified by stakeholders. Some of the issues discussed include ways to help families through the court process, how to decrease the amount of time spent waiting for hearing, and how to resolve recurring issues. Some of the resolutions include the addition of court dockets to help address wait time for hearings and increase the amount of time that can be allocated to each hearing.

The Marion County Juvenile Court Mediation program continues to prosper. There are typically four mediations scheduled every day, with the exception of one morning and one afternoon each week. Mediations are structured as a "facilitated settlement conference" and usually last around 90 minutes. Mediations are usually scheduled by Judges at the first pre-trial hearing when as many of the parties as possible are present. This is typically after public defenders are appointed for parents so they can be present for the scheduling of the mediation. Mediation numbers as of December 31, 2012, are as follows;

1,667	referrals have been made to the program
1, 280	(<77%) of those attended mediation
834	(50%) produced Full Agreements at close of the session
79	(4.75%) produced Partial Agreements
367	(22%) produced No Agreement
387	(23.25%) Failed to Appear or Canceled without Rescheduling

Of the 367 sessions which produced No Agreement, 273 cases were eventually resolved without Fact-Finding; 12 cases were still pending Fact-Finding; only 82 cases (<6.5%) of mediation sessions held actually went to contested Fact-Finding.

Median Time from Filing to Disposition is 76 days.
Median Time from Filing to Closure is 215 days.

Approximately 82% of all cases that went through the mediation process ended with children returned to the care of parents; and only 8.5% of cases ended in children adopted by non-parent relatives.

Objective 3.7

The DCS local office in Tippecanoe County continues to collaborate with Tippecanoe County Superior Court to manage CIP-funded court mediation and facilitation program.

Response 3.7

This objective is complete. The DCS local office in Tippecanoe County collaborated with the Tippecanoe County Superior Court on the CHINS Mediation and Facilitation Program. The program, funded through a federal grant by the U.S. Department of Health and Human Services for Court Improvement Programs, is authorized by the Indiana Supreme Court for a three year period from October 1, 2009, through September 30, 2012. Ninety five (95) mediation sessions were held in 2009, sixty (60) in 2010, sixty-two (62) in 2011, and forty-four (44) in 2012.

Objective 3.8

Positive outcomes reported from the CIP/DCS mediation and facilitation programs will be used to develop a statewide implementation plan.

Response 3.8

This objective is complete. The CIP facilitation and mediation grants continue with a new grant period from October 1, 2012, through September 20, 2013. Additional counties participating in CIP mediation and facilitation programs include Allen (271 Facilitations since 2012), Bartholomew (approved but not yet started), Clark, LaPorte, Putnam, and Sullivan counties. DCS

continues to collaborate with the CIP to identify additional counties that would benefit from these programs.

Objective 3.9

DCS will collaborate with the IDOE (Indiana Department of Education) on the development and implementation of education advocates for wards.

Response 3.9

This objective is complete. Education Liaisons provide FCM's, teachers, school administrators, foster parents, biological parents, relative caregivers and others the skills and knowledge necessary to identify educational strengths and ensure educational needs of DCS foster children and youth are met.

The education liaison program has been fully staffed throughout the state since the beginning of the 2012-13 school- year. On average, education liaisons receive between 100 and 125 new cases statewide each month. As of April 1, 2013, the education liaisons throughout the state have worked with over 1100 children and their education needs.

Along with working directly with case managers and schools in regards to specific children, the education liaisons work with school systems, foster parents, and other agencies by providing professional development.

Objective 3.10

Consistent with the Fostering Connections Act of 2008, DCS will ensure educational continuity of wards by implementing legislative changes that, in addition to current law, will facilitate greater access to transportation and transfer tuition, permit wards who are suspended and expelled from, or not thriving in, their current school environment, to seek an alternate education setting through open transfer in a public school or a private school chosen by the student and/or guardian.

Response 3.10

This objective is complete. IC 20-26-11-8 now authorizes school attendance by a child placed in a foster family home at a school determined by the foster family, the placing agency, and/or the juvenile court to best meet the child's needs, regardless of whether the school is in the child's legal settlement district (ordinarily the district in which the child's parent, guardian or custodian resides) or in the district where the foster home is located, without any requirement for transfer tuition payments between school corporations.

Indiana has also recently enacted sweeping school choice options that we hope can be used by Indiana foster children. DCS continues to work with IDOE on emergency rule language and policies to ensure that foster children who are eligible for vouchers are able to obtain them through private choice consistent with their case plan. Children in foster care may continue to attend a private school (which they attended prior to placement) under the voucher program. A child may also apply for a voucher while in foster care if attending a private school is approved through the child's case plan and he or she meets the voucher requirement, which is attending a public school for at least one year prior.

A new database is being created within MaGIK that will allow FCMs to access a foster child's educational data to improve the quality of the education portion of the child's case plan.

Education liaisons work closely with FCMs to address questions regarding school placement including options available through voucher programs for private and charter schools.

Due to changes regarding count day, which equates to school funding, it allows for more flexibility in placement of a child. School counts are more than one time a year for both the traditional student and the student which is in need of special services through an Individualized Education Plan. This flexibility allows for the case to be fully evaluated in order to meet the needs of a child.

Objective 3.11 — Mental Health Screenings for Informal Adjustments and In-home CHINS are consistently *completed in accordance with policy requirements.*

Response 3.11 — **This objective is complete.** In accordance with DCS policy, FCM's conduct a CANS assessment on all DCS foster children and youth who have open cases to assist in determining the appropriate level of behavioral health services for them. This includes Informal Adjustments (IA) & in-home CHINS. The CANS serves as the basis for planning individualized services for children based on their identified strengths and needs.

Objective 3.12 — DCS will collaborate with stakeholders to review disproportionality rates and identify underlined issues and needs.

Response 3.12 — **This objective is complete.** DCS has specialized staff whose sole responsibilities include recruiting, licensing, and supporting prospective and active foster parents. Having more of these specialized staff enhances the ability for targeted recruitment efforts to occur statewide.

Materials have been developed to provide practice guidance for staff in working with African-American foster, kinship, and adoptive families. Given the growing Hispanic population in Indiana, a current goal over this upcoming year is to develop recruitment materials in the Spanish language to better engage this population.

A culture and diversity training session is being developed for all staff.

Objective 3.13 — FCMs will understand the responsibilities of DCS relative to Juvenile Delinquent/Juvenile Services (JD/JS) cases.

Response 3.13 — **This objective is complete**. On November 1, 2011, the Court Improvement Program, Indiana Judicial Center, and DCS 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 FCMs, 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 FCMs 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.

DCS has a Central Office position and five (5) probation service consultants throughout the State that are the liaisons between DCS local offices/FCMs and probation departments.

Objective 3.14 Demonstrate increased support for the needs and efforts of foster parents.

Response 3.14 **This objective is complete**. Dedicated statewide Regional Foster Care Specialists (RFCS's) are fully trained and functioning in this role, as well as Supervisors providing guidance to them in these roles. RFCS's are tasked with providing comprehensive support to foster parents, including: assisting them in facilitation of the licensure process, completing home visits as necessary or appropriate to address issues/needs, providing timely responses to questions & concerns, helping identify training needs and linking with appropriate opportunities, obtaining necessary resources, and facilitating appropriate demonstration of appreciation for efforts.

GOAL #4: INFRASTRUCTURE

CREATE AN INFRASTRUCTURE THAT WILL SUPPORT AND SUSTAIN ALL COMPONENTS OF DELIVERY WITHIN THE CHILD WELFARE SYSTEM.

Objective 4.1 DCS will utilize an assessment tool to identify staff training needs.

Response 4.1 **This objective is complete**. DCS developed a policy which outlines annual training requirements for certain job classifications within the agency including FCMs, Supervisors, Local Office Directors and Regional Managers. This policy went into effect on February 1, 2010. The policy was revised in January 1, 2012 for all DCS staff.

DCS 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 October 12, 2009 (revised June 1, 2011).

DCS developed a comprehensive training record information system to track all trainings attended and completed by FCMs. DCS utilizes the Enterprise Learning Management System (ELM) for this purpose. Once a worker registers within ELM, the system tracks his/her training in-service training hours on the worker's Learning Transcript. Reports detailing all of the DCS trainings taken by a worker are available through the system, which include course name, completion dates and hours received from each course.

The Individual Training Needs Assessment tool was revised in 2011 to reflect current policies, procedures and best practices. It was completed by all FCMs 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
- Advanced Worker Safety
- Introduction to the Attachment Continuum

In November of 2012, a strategic planning session was held to review progress and further identify training needs based on the ITNA and additional survey and evaluation data. In addition to updating new worker training based on new policies/practices, the following trainings were identified as 2013 priorities:

- Understanding Culture and Embracing Diversity for All DCS Staff
- Servant Leadership
- Clinical Supervision and Advanced Clinical Supervision
- Engaging Challenging Clients
- Trauma Informed Care
- Presentation and Facilitation Skills Training

During this year, an Individual Training Needs Assessment for Supervisors has also been developed in Partnership with the Indiana University School of Social Work. This ITNA will be distributed in the summer of 2013 and will assist with developing additional management/supervisory trainings for DCS management staff.

The training schedule is available for all DCS staff on the intranet as well as in the ELM system.

Tracking reports reflect completed learning for an employee. These reports also list all DCS trainings taken by the participant. The trainings are described by course name and it includes new worker trainings, experienced worker trainings, supervisor trainings, and computer-based trainings. The completion dates and hours received from each course is also indicated in this report.

Objective 4.2 DCS will provide consistent quality foster parent training to new and ongoing foster parents.

Response 4.2 **This objective is complete**. Consistent with the steps outlined in the PIP, DCS began transitioning FAKT training from Programs and Services Department to the Staff Development Department in 2011. Fourteen staff positions, including two supervisory positions, 7 full-time trainer positions and 5 full-time coordinator positions were established to fulfill this task. A full-time curriculum writer rewrote 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.

The training was reorganized and renamed Resource & Adoptive Parent Training (RAPT). DCS Staff Development began training RAPT on July 1, 2011.

The entire pre-service training curriculum was reviewed and translated into Spanish by our Hispanic Initiatives Program Manager. When Staff Development is made aware that a potential

limited-English speaking foster parent is interested in the licensing process, the Hispanic Initiatives Program Manager contacts them to arrange a time that she can come to meet them and train them one on one. She then contacts the family's Regional Foster Care Specialist to advise that the required training for licensing was completed. This occurs on an as needed basis. For a potential limited-English speaking foster parent whose primary language is anything except Spanish, the Hispanic Initiatives Program Manager makes arrangements for them to have an interpreter in their native language.

Based on the identified need, this Division was expanded in 2013 to include an additional curriculum writer, a supervisor, and two additional trainers. Since July of 2013 through April of 2013, 750 classes for foster parents have been held reaching 3,350 individuals.

Objective 4.3 DCS will train foster parents, FCMs and FCMs supervisors on how to become educational surrogates.

Response 4.3 **This objective is complete.** DCS revised its Special Education Services Policy to incorporate additional information regarding educational surrogates. The revised policy was effective on February 1, 2010, and highlights DCS' responsibility to work with the Court and the Department of Education to secure an Educational Surrogate in appropriate circumstances. The policy includes related information about the role of an educational surrogate and when it is appropriate to request one.

Educational surrogate training is incorporated into RAPT training for foster parents. Computer Assisted Training has been developed for both general education students and special education students and this training has been shared with the educational community as well.

DCS created education specialist positions in 2012 which among other things, offers trainings on educational issues statewide to both foster parents and DCS staff in collaboration with Staff Development. By creating education champions in our foster parents, DCS is confident that our children will not have to face the challenges of the education process outside the classroom alone.

Objective 4.4 Enhance Practice Indicator review process to measure safety more effectively.

Response 4.4 **This objective is complete.** A more detailed Absence of Maltreatment Report was developed in 2012 to help local offices and regions identify specific cases in which a child is revictimized so that trends can be identified and strategies can be developed to meet the federal safety indicator. The DCS Ombudsman is also using this report to research all repeat maltreatment cases statewide in a sample month and will share the results with DCS when completed.

Objective 4.5 DCS will sustain clinical supervision supports by integrating the efforts into on-going staff training.

Response 4.5 **This objective is complete.** A clinical consultant position was filled 2009. This position no longer exists but has been replaced with other training support for supervisors.

Objective 4.6 Continued development of a Continuous Quality Improvement Process.

Response 4.6

This objective is complete. Quality Assurance Reviews (QAR) - The QAR Survey business requirements have been revised to ensure that it is a compliance based report. The development of data reports for the QAR is currently on the MaGIK priority task list. Once these have been designed they will be implemented into the field. The policy is currently under revision, due to the field having access to real time data once the QAR is re-implemented.

Hotline Quality Reviews - In February 2013, control over screen out review procedures was transferred to local community representatives and county directors to determine how to evaluate the appropriateness of screen outs. The local screen out review processes replaced the statewide Screen-Out Committee previously utilized. In March of 2013, a new process was implemented allowing the field to decide when intake reports are assigned or screened out. As of March 5, 2013 the Hotline receives all child abuse and neglect intake reports, makes a recommendation to assign or screen out each intake, and distributes those to the field. Data reports are currently under development and on the MaGIK priority task list that will measure screen outs. The reports will measure the percentage of screen outs, as well as, the difference between recommendations by the Hotline and the local level.

Customer satisfaction surveys were developed in 2012 for the Hotline. The first set of surveys was completed by DCS with Indiana University (IU) student volunteers in the fall of 2012. The second set of surveys was completed in the spring of 2013. Student volunteers were trained on the Hotline intake process and survey prior to taking surveys. After an intake with the Hotline is completed, the caller is asked if they would like to participate in a survey. Upon the caller's agreement, they are transferred to the volunteers to complete the survey.

Trained QAR reviewers completed a third party review of assigned intakes and their corresponding recording which began with the first pull in April 2011. Two hundred intakes continue to be reviewed each quarter to assess performance and adherence to best practice standards set forth in Hotline Protocols.

The Hotline is beginning to use this data for CQI and has established a CQI process that aligns with the CQI process for the Quality Service Review (QSR). The established CQI process begins with the Hotline Director presenting their plan to the Deputy Directors for feedback and assistance. Every six months the Hotline Director reports progress on their plan to the regional managers. The Hotline director receives a midyear and annual report to track their progress. The Hotline is also able to routinely track Hotline data. Development of system generated standardized reports for Hotline data is currently on the MaGIK priority task list.

In order to maintain a pool of trained QAR reviewers for intake reviews, 7 new reviewers were trained on the tool to assess intake calls and recordings in 2012 for inter-rater reliability purposes.

Institutional Child Protection Services (ICPS) - The QAR tool for ICPS has been developed to measure the compliance with policy. The business requirements have been completed and submitted to the Office of Data Management (ODM). The policy is currently under revision, due to the field having access to real time data once the QAR is re-implemented. This project is currently on the MaGIK priority task list for report development.

A specialized Reflective Practice Survey (RPS) tool has been developed for the ICPS Unit. The ICPS unit piloted the tool for revisions the first quarter of 2013. The tool is was rollout in the MaGIK on April 23, 2013.

Reflective Practice Survey (RPS) - In July 1, 2010, the RPS rolled out with training and initial implementation. The RPS is an instrument designed to assess both assessment and on-going cases using quality standards for best practice established in the Quality Service Review (QSR)

Protocol. The RPS is also used to assess the Family Case Manager's (FCM) skill levels in their work with children/youth and families during worker home visits. Trends found in both case outcomes and worker skill levels will be addressed by the Regional Managers and strategies to improve will be reported to Central Office.

Ongoing cases are randomly pulled and the tool has been deployed into DCS MaGIK as of January 2013. This has automated how the field is able to answer the RPS questions. A tool was specifically designed for assessments. The assessment tool rolled out to the field in April 2013. The assessment tool randomly selects assessments at the time of assignment each Tuesday. In counties where there are multiple CPS supervisors, half of the assessments are pulled on Tuesday and the other half is pulled on Wednesday to avoid all supervisors out of the office on the same day.

RPS data reports have been unavailable since MaGIK implementation. Reports are on the MaGIK task list for development.

A strategy to improve the RPS results is to have field management staff trained on the QSR. Training on the QSR will reinforce the scoring of outcomes instead of efforts for cases. At this time, many of our field management staff is trained or in the process of being trained on the QSR. Currently, the skills section of the RPS tool is in the process of being enhanced to develop a more detailed description of skill sets required within each indicator for accurate scoring of FCM's skills. Training for supervisors on the enhanced RPS is schedule for fall 2013.

Quality Service Reviews (QSR) – The QSRs are held per the predetermined schedule. The QSR process is currently a two day review. The number of cases pulled for the reviews has remained the same. The number of reviewers needed for each review has remained the same. It has continued to help reduce the time staff needs to be out of the office and continues to be more cost effective for the state.

Policy has been updated to reflect the following:

- Performance and Quality Improvement (PQI) staff will routinely conduct an inter-rater reliability review with qualified reviewers. Qualified reviewers will be asked to participate in inter-rater reliability process.
- Ad Hoc (Mini) reviews targeting specific indicators may be utilized to assist the Agency with tracking and adjusting strategic plans.
- Qualified reviewers are strongly recommended to attend at least one review per round to maintain reviewer skills.

The regional plans developed from the QSR are sent to the Deputy Directors and/or designees for comments and suggestions.

The Deputy Directors have also met several times to review statewide QSR trends and assigned a subgroup to determine next steps from the data trends. This subgroup collaborated with PQI, ODM, Human Resources, Staff Development, and Field Operations to develop strategies to address improvements in Team Formation and Functioning.

The subgroup has employed several strategies to improve Team Formation and Functioning. Underlying causes were researched and the following strategies were implemented:

- Significant understaffing issues were recognized and 75 new supervisor positions were hired as well as 156 new FCMs positions were hired.

- The PQI team did a deep case analysis on the QSR scores of two regions by reviewing the cases that scored in Refine Maintain 5/6 or Concerted Action 3/2/1. Those results were forwarded to Field Operations and Staff Development for training purposes.
- All Regions are required to focus on Team Formation and Functioning as part of the CQI plan.

There were 4 new reviewer trainings held in 2012 and 27 mentor trainings including 7 one-on-one mentor trainings. Currently there have been 3 new reviewer trainings held so far in 2013 with 5 more scheduled this year. PQI has also held 10 mentor trainings in 2013, with plans to hold more.

Additional planning around Continuous Quality Improvement will occur with the Director and Deputy Directors to develop the appropriate structure for Indiana's Continuous Quality Improvement efforts.

Objective 4.7 DCS will analyze how we may improve the current statutory framework regarding TPRs, and how it can be harmonized with Indiana case law and federal expectations.

Response 4.7 **This objective is complete**. As stated in Objective 3.4, this issue was resolved through a statutory amendment and there are no longer statutory gaps or needs for improvement regarding timeliness of hearings.

Objective 4.8 DCS will address judicial concerns and educate local judges regarding the need to proceed with permanency in a concurrent, not sequential, fashion in order to ensure that permanency is achieved within a minimal length of time in system.

Response 4.8 **This objective is complete**. During the 2011-12 legislative session, Judges on the Child Welfare and Juvenile Justice Improvement Committees collaborated with DCS to encourage continued improvement in making placements in less restrictive settings in CHINS and juvenile delinquency (JD) cases. In particular, the group agreed to the imposition of a penalty/sanction for improper emergency findings. IC 31-34-4-7, IC 31-34-19-6.1, IC 31-37-5-8, IC 31-37-17-4 and IC 31-37-18-9 were amended to require DCS to file a notice with the Indiana Judicial Center if inadequate written findings were made in emergency placements.

DCS also collaborated with these Judges during the 2011-12 legislative session to implement penalties for un-timeliness as addressed in Objective 3.4. In designing the penalty, DCS and the Judges sought to affirm the rights of the parties by creating the ability for a party to petition for a dismissal, without prejudice, of a case in the event the hearing does not take place within the required timeframe (the court must grant such a petition). See IC 31-34-10-2, IC 31-34-11-1, IC 31-34-19-1, IC 31-35-2-6, IC 31-35-3-7.

DCS hired eight practice development supervising attorneys (DG's) in 2012, who work with assigned local office attorneys to improve their courtroom skills, improve consistency in seeking expeditious permanency for children and to decrease delays in court processes that delay permanency for children. The PDG's and local office attorneys are required to complete 32 hours of training annually to increase their knowledge and understanding of child welfare practices and ways to keep cases moving through the courts.

Objective 4.9 A system will be developed to collect and report information on children who are adopted from other countries and who enter State custody as a result of the disruption of an adoptive placement, or the dissolution of an adoption. Such information will include the reasons for disruption or dissolution, the agencies who handled the placement or adoption, the plans for the child, and the number of children to whom this pertains. ICWIS to capture the number of children involved in the CHINS process that were adopted overseas.

Response 4.9 **This objective is not complete.** Due to the limited number of disrupted or dissolved international adoptions that come to the attention of DCS in Indiana, this information is collected manually. There were no disrupted or dissolved international adoptions from June 30, 2012 through June 30, 2013.

1. SERVICE DESCRIPTION

Describe the services to be provided in FY 2014, highlighting any changes or additions in services or program design and how the services will assist in achieving program purposes (45 CFR 1357.16(a)(4)). For each service provided report:
1. the population(s) to be served;
2. the geographic areas where the services will be available; and
3. the estimated number of individuals and families to be served.
This information may be provided in Part II of the CFS-101 form (Attachment B).

Identify and describe which populations are at the greatest risk of maltreatment, how the State identified these populations and how services are targeted to those populations (section 432(a)(10) of the Act).

DCS provides a continuum of services to families and children in Indiana. The range of services includes statewide child abuse and neglect prevention and intervention and treatment services including efforts to preserve the family or reunify the family. Services to prepare children and families for adoption are also provided.

As evidenced by the large number of young children in foster care in Indiana, clearly those at greatest risk are those under the age of 5. Indiana is targeting services to these children as indicated in the section on services for children under the age of 5. In addition, families struggling with substance abuse issues are very common within our system. Indiana is in the process of providing Motivational Interviewing and Relapse Prevention training to home based therapy and casework providers throughout the state. In addition, Indiana plans to offer training in evidence based practices related to substance abuse treatment and is currently reviewing the feasibility of the Matrix model. There is also an internal subgroup reviewing DCS policy and practice around assessing families with an abuse/neglect report involving drug use. The group has reviewed the UNCOPE as well as drug testing procedures. The goal is to develop a more uniform way of approaching families to best assess the risk for children in these homes.

Policy is being developed to guide FCMs on their approach to utilizing drug tests during assessments and ongoing cases.

Indiana has elected to change the percentages (see below on each category) allotted to each of the four programs named below. Since the development and implementation of home based services over the past twenty years, local office staff has become more comfortable in leaving children in their own home with intensive service providers working in the home with the family. These services are available in most of the counties at this time. Service provider contracts are state-wide which lessens the service gaps in specific geographic areas (most often rural areas where service is limited) upon approval of the Regional Services Councils. Because of these intensive services, fewer children are being removed. This coupled with the

progress being made through the Program Improvement Plan and the IV-E Waiver Demonstration Project, Indiana has been able to provide services to children and families, which has prevented many children from coming into care. Indiana has chosen to limit the funding in the time limited category and put the additional funds into family preservation to allow us to continue putting more funding toward preservation services to strengthen families. Indiana 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.

A. FAMILY PRESERVATION (35%)

This category is designed to provide services for children and families to help families (including 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: 1) intensive home-based casework; 2) homebased therapy; 3) individual/family counseling; 4) parent/ child/sibling visit facilitation; 5) counseling; 6) case management; 7) day care; 8) respite services; 9) homemaker/parent aid services; and 10) services designed to increase parenting skills, family budgeting, and coping with stress, health, and nutrition.

Target Population

Services must be 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.
4) All adopted children and adoptive families.

Desired Outcomes

1) Increase the number of families served in their own home that remain intact without removal of a child(ren).
2) Reduce the number of reports of substantiated child abuse and neglect in families served in their own homes.
3) Reduce the number of placements of children in substitute care.
4) Decrease the length of stay when substitute care is necessary.
5) Increase the number of children reunited with their families following substitute care placement.
6) Increase the number of permanent placements of children for whom reunification with their family is not possible (includes adoptive, relative, and guardian placements, as well as emancipation services.
7) Increase the number of children and families who receive post-placement adoptive services.
8) Increase the number of families served in their own home once the child is returned to reduce recidivism or abuse/neglect.

B. FAMILY SUPPORT (20%)

This category is designed to cover payment for community–based services which promote the well-being of children and families and is 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: 1) respite care for parents and other caregivers; 2) a range of center-based activities (informal interactions in drop-in centers, parent support groups); 3) services designed to increase parenting skills; 4) Community Partners for Child Safety and 5) counseling and home visiting activities. Client specific services are the identified priority for Family Support Services.

C. TIME LIMITED FAMILY REUNIFICATION (5%)

This category covers services and activities that are provided to a child that is 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 and activities that can be provided under this category include but are not limited to: 1) intensive home-based casework; 2) home-based therapy; 3) individual/ family counseling; 4) substance abuse treatment services; 5) parent/child/sibling visit facilitation; 6) assistance to address domestic violence; and 7) homemaker/parent aid services.

Target Population

Services must be 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.
4) All adopted children and adoptive families.

Desired Outcomes

1) Reduce the number of placements of children in substitute care.
2) Decrease the length of stay when substitute care is necessary.
3) Increase the number of children reunited with their families following substitute care placement.
4) Obtain reunification within the assigned time frame by ensuring a safe, stable environment for the child(ren).

D. 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 interest 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 with the goal of creating cross-system coordination and adoptive family centered care for service delivery. Services provided to families will 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. As of July 1st, 2011, contract awardees, SAFY, Children's Bureau, and The Villages will begin providing post-adoption services to families in the State of Indiana. These 3 agencies will provide Care Coordinators who will be 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, and other services and/or necessary items approved by DCS.

2. CHILD AND FAMILY SERVICES CONTINUUM

DCS provides a continuum of services to families and children in Indiana. The range of services includes statewide child abuse and neglect prevention and intervention and treatment services including efforts to preserve the family or reunify the family. Services to prepare children and families for adoption are also provided. This continuum is described below:

A. CHILD ABUSE AND NEGLECT PREVENTION

Indiana has a broad range of services to prevent child abuse and neglect. These services include Healthy Families Indiana, Community Partners for Child Safety, as well as primary prevention efforts through Prevent Child Abuse Indiana. Delinquency prevention is provided by Youth Service Bureau organizations. These prevention services are funded through various sources including TANF, SSBG (state and federal), CBCAP, Kids First Trust Fund, MIEC Home-visiting Grant, and the state's Youth Service Bureau Fund.

(1) HEALTHY FAMILIES INDIANA

Healthy Families is a community-based prevention program that serves all 92 counties in the State of Indiana and provides home visiting services to over 15,000 at-risk families each year. Local program sites deliver voluntary home visitation services to families prenatally, or from the birth of the target child, until the target child is three years of age. Home visitors provide parenting education, referral resources and access to health services. Families receive weekly, bi-weekly or monthly visits depending upon their circumstances and length of time in the program.

Healthy Families collaborates with First Steps, Head Start, the Department of Mental Health, the Indiana Department of Health, WIC, universities, hospitals, local Departments of Child Services and other local health and social service providers in program planning and coordination to offer a continuum of comprehensive services to at risk families.

Staff providing Healthy Families services are required to receive extensive, ongoing training. The program maintains a training contract through which new staff are required to receive 40 hours of Core Training as soon as possible after their hire date and complete training and competency testing online using 11 CD's within 12 months of their hire date. Staff may also attend service specific or advanced training by attending educational sessions at the semi-annual three day Institute for Strengthening Families sponsored by the Department of Child Services and Healthy Families Indiana in collaboration with the partners listed in the previous paragraph.

Healthy Families has a comprehensive program management system with the capacity to provide ongoing staff training, monitor program quality, capture data and generate reports required to be accountable to funding sources and to maintain program standards for Prevent Child Abuse America/Healthy Families America accreditation.

(2) KIDS FIRST TRUST FUND

The Children's Trust Fund (name changed to Kids First Trust Fund (KFTF) in 2003) was established in 1994 by the Indiana General Assembly. Legislation called for the design and issuance of a Children's Trust Fund license plate. "Kids First" license plates became available in January 1995 and proceeds from plate sales are used to fund grants to community organizations/programs to prevent child abuse and neglect. In 2006, proceeds from the sale of the KFTF plates shifted direction from funding individual community service providers to funding statewide, community-based, prevention focused programs. This approach provides a statewide, coordinated continuum of child abuse and neglect prevention programming. Each year since 2006, KFTF dollars have been awarded to two programs: The Villages/Prevent Child Abuse Indiana (primary prevention) and Community Partners for Child Safety (secondary prevention).

The KFTF is maintained by a 10 person volunteer board whose goal is to reduce the number of deaths due to abuse and neglect, reduce the total number of substantiated cases of abuse and neglect and to reduce the infant mortality rate in Indiana.

As competition among special recognition license plates in Indiana increases and the economy worsens, KFTF license plate sales are declining. In an effort to increase plate sales, the KFTF Board, in collaboration with the DCS Office of Communications, engaged in a media campaign with the BMV. This provided KFTF the opportunity to be shown on the BMV website in a moving billboard and to purchase posters to be displayed in local BMV locations around the state. Thank you cards were mailed out to individuals that purchased or renewed their KFTF plate. In July of 2011 the KFTF board designed a quarterly newsletter to be sent out to owners of the KFTF plate. This newsletter notifies them of the investments being made with KFTF funds towards prevention programs in Indiana. Through these efforts mentioned above KFTF has been able to keep plates sales even to 2010.

Also the KFTF Board and DCS will include in their strategic plan, increased communication and collaboration with legislators, other state agencies, child advocacy groups and service professionals, community stakeholders, the media, and the public.

(3) THE VILLAGES/PREVENT CHILD ABUSE INDIANA (PCAI)

PCAI provides parent education and public awareness statewide by:

- partnering with local councils, DCS, and other statewide and/or community-based networks to support child abuse and neglect prevention efforts
- building greater community support for policies that contribute to the prevention of child abuse and neglect

- developing procedures and tools for educating parents, caregivers, and the public
- identifying, creating and distributing printed prevention materials to assist parents and caregivers with parenting issues and promote available resources for support of children and families
- enhancing/expanding the annual Indiana Child Abuse and Neglect Prevention Awareness Month campaign each year (coincides with National Child Abuse and Neglect Prevention Awareness Month)

(4) COMMUNITY PARTNERS FOR CHILD SAFETY (CP)

In 2005, Indiana implemented a statewide response to service provision for those families whose children are at risk of abuse or neglect. The purpose of this program is to provide primary and secondary child abuse prevention services that can be delivered in every region in the state. This service builds community resources in order to have a collaborative prevention network throughout the region. The service is focused on those families that are identified by the Department of Child Services or through self-referral or other community agency referral. The service will provide home based case management services to connect families to resources to strengthen the family and prevent child abuse and neglect. The Community Partners for Child Safety Services will be divided into three components: the Service Component, the Community Component, and the Subcontracting Component.

Service Component

In summary, the Service Component requires the employment of a Project Manager, Neighborhood Liaisons, and Parent Partners. It also requires a home visitation program through which workers provide short term supportive services on a voluntary basis and development of family case plans that include no more than three (3) goals that the family identified. It also includes the development of classes and support groups for families and oncall staff availability for crisis intervention counseling and referral if needed.

Community Component

In summary, the Community Component requires participation with other agencies to develop a collaborative network of community resources that will support families. Community Partners for Child Safety must identify an advisory group for the Region(s) for which it has been selected to provide Community Partners Services that focuses on community development and participate in community events to build new relationships and support agency activities. They must also create opportunities to build a volunteer pool and develop opportunities for additional funding and financial support, including reporting its quarterly progress to the DCS' Central Office Consultant of additional funding sources committed to Community Partners agencies. They must also develop contacts and a presence throughout the entire Region(s) for which it has been selected to provide Community Partners Services by DCS and work with local community administrators, such as police departments, Mayor's offices, hospitals, and school districts. They must also partner with existing providers that offer child and family services in the Region(s) for which it is responsible.

Subcontracting Component

In summary, a percentage of the funding allocated for this Contract (not more than 40% of each Region's allocation) may be utilized for other prevention services which consist of both secondary and primary child abuse prevention services. This funding is allocated to be subcontracted for services that meet the secondary and primary child abuse prevention priority needs that are determined by DCS (based on any applicable recommendations of the Regional Services Council(s)) for each particular Region(s) that the Community Partners for Child Safety Agencies have been chosen to provide Community Partners Services. As part of this subcontracting component, the Contractor shall issue requests for proposals to identify the services that meet the secondary and primary child abuse prevention priority needs and select the providers to offer services that meet such secondary and primary child abuse prevention priority needs. They must also provide quarterly reports on outcomes to DCS and the Regional Services Council(s). Community resources include, but are not limited to:

schools, social services agencies, local DCS offices, Prevent Child Abuse Indiana Chapters, Youth Services Bureaus, Child Advocacy Centers, faith-based community, local school systems and Twelve Step Programs. In general, each community defines its own partnerships. The local office of the Department of Child Services is a critical partner. Child Protective Services Assessors frequently identify families that could benefit from services, but do not have a substantiated case of child abuse or neglect. These families are referred to Community Partners services.

(5) YOUTH SERVICE BUREAUS

There are 33 Youth Service Bureaus (YSB) serving 30 Indiana Counties. They are funded by the Youth Service Bureau Fund as outlined in Indiana Code (IC 12-14-24-3). Funds are allocated by the Indiana General Assembly and are wholly state funds.

Indiana law prescribes four core roles for funding to be applied:

- Referrals – Utilize service agencies that may benefit young people
- Community Education – inform citizens about the services available
- Advocacy – support, represent and protect the rights of young people
- Juvenile Delinquency Prevention – prevent adolescent misbehavior and diversion of young people from the justice system

Juvenile delinquency prevention is viewed as the key role with the other roles being supportive.

Service Description

Services are designed to prevent adolescent misbehavior and to divert young people from the justice system. These services can prevent youth from becoming involved in delinquent behavior; can intervene with youth who have become involved in delinquent behavior to prevent further progression in the juvenile justice system; and divert youth from the juvenile justice system through alternative programs.

These programs may include:

- Mentoring
- Diversion programs/Teen Court
- Skills programs
- Schools programs/retention
- Recreation programs
- Shelter programs
- Counseling programs
- Tutoring

Target Population

Youth under the age of 18 and their families (as defined by the family) who reside in the area served by the local YSB. Programs aim to serve youth and young people who are at risk of engagement in delinquent behavior and/or have committed delinquent behavior with the goal of preventing future delinquent acts.

Planning

Over the past year, DCS implemented unit rate contracts with YSB agencies. In addition, they all began tracking their outcomes with respect to delinquency prevention. This information, as well as all other data tracking for Indiana's prevention programs is coordinated by Datatude, Inc.

Youth Service Bureaus are part of the fabric of their communities as they collaborate with private and public agencies to provide services to their youth. Referrals can be received from the juvenile justice system, schools, hospitals as well as other social service agencies such as Healthy Families Indiana and Community Partners for Child Safety.

Youth Service Bureau staff receives select and varied training at quarterly meetings, arranged by their governing organization, the Indiana Youth Services Association (IYSA). Select staff also receives training from the company that administers the web based reporting tool that is being developed, so that outcomes and indicators are correctly reported.

Staff can receive on-going training and education at offerings such as The Institute for Strengthening Families, which occurs semi-annually.

DCS and IYSA have partnered to initiate an advisory board. This board is made up of DCS personnel, IYSA staff, and select YSB program managers and meets quarterly. This board has increased communication efforts between YSB programs and DCS. In the past year the advisory board has been successful in designing the upcoming contracting process.

In addition, DCS issued a Request for Proposals for an agency to coordinate funding and programming for the Youth Service Bureaus. The chosen agency, IYSA, will subcontract for services, provide program oversight and monitoring, and report outcomes for each of the services. This new contract will take effect July 1, 2013.

(6) CHILDREN'S MENTAL HEALTH WRAPAROUND SERVICES

A new prevention program was started in 2011 to address the needs of families with children who struggle with significant mental health issues. The families generally are trying to access services, but do not have the resources available to pay for the extensive services they need. These families do not qualify for Medicaid. Many have insurance, but the benefits do not cover wraparound services. In the past, these families have bounced from agency to agency trying to find assistance. At times, they have become involved with the child welfare system (through a CHINS 6) solely as a way to access services. They have also ended up in the juvenile probation system. Through a collaboration with the Division of Mental Health and Addictions (DMHA), DCS developed a program for these families. The program is currently active in eleven counties and will spread to the rest of the state by the end of the year.

DMHA and the Office of Medicaid Planning and Policy (OMPP) have recently applied for a Medicaid State Plan amendment under 1915(i) to expand the wraparound services to Medicaid clients. The DCS project mirrored the program and eligibility criteria of the proposed 1915i, in order for families to receive the same services regardless of their pay source.

Eligibility Criteria

1) Child or adolescent age 6 through the age of 17
2) Youth who is 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)
3) Not eligible for Bureau of Developmental Disability Services
4) Not eligible for Medicaid

Needs Based Criteria

1) *DSM-IV-TR Diagnosis*- Youth meets criteria for two (2) or more diagnoses.
2) *CANS* 4, 5, or 6
3) *Dysfunctional Behavior*- Youth is demonstrating patterns of behavior that place him/her at risk of institutional placement— & unresponsive to traditional outpatient and/or community-based therapy. Specifically:

Maladjustment to trauma, Psychosis, Debilitating anxiety, Conduct problems, Sexual aggression, and Fire-setting

4) *Family Functioning and Support*- Family/caregiver demonstrates significant need in one or more of the following areas: Mental health, Supervision issues, Family stress, and Substance abuse

Goals

The goals of the Children's Mental Health Wraparound Services Project are:

1) To allow families access to needed services so that children do not enter the child welfare or probation system for the sole purpose of assessing services.
2) To ensure that children are receiving services in the appropriate system.
3) To build community collaborations through examining current practices and cross-educating community stakeholders on available resources.

Service Availability

To ensure that the appropriate system mechanisms are in place prior to statewide rollout, the Children's Mental Health Wraparound Services Project was piloted in eleven counties of the State of Indiana. Division of Mental Health and Additions (DMHA) approved Access Sites which are considered the single point of service access and information for youth, families and providers who are in need of resources related to intensive, community-based family preservation services. The Access Sites serve as a means to disseminate information to the field about local, State, and Federal funded intensive behavioral health services available to assist in maintaining Seriously Emotionally Disturbed (SED) youth within their home and community; and also provides a means for families to explore their child's/youth's eligibility for those services.

Families will be sent to the Access Site for an assessment to determine eligibility for services

Pilot Area One Access Site: *One Community One Family of Community Mental Health Center* serving Ripley, Decatur, Dearborn, Ohio, Switzerland, and Franklin counties

Pilot Area Two Access Site: *Oaklawn* serving Elkhart and Saint Joseph Counties

Pilot Area Three Access Site: Aspire serving Boone, Hamilton and Madison Counties.

Services Access

Anyone can refer a family to an Access Site to determine eligibility for services. When a child is referred the family will be contacted to gather additional information. If the child is found ineligible for this program the Access Site will refer the family to services that may be appropriate including Community Partners for Child Safety.

B. INTERVENTION AND TREATMENT SERVICES

The State of Indiana provides Intervention and Treatment services to families and children through its Child Protection Services (CPS) workers and Children Services (CS) workers. The State is divided into 18 regions, which are supervised by the Regional Managers, and 92 counties which are overseen by the local office directors. Each county is staffed by workers who are classified as Family Case Managers (FCM). It is the primary responsibility of the FCM to ensure the safety and wellbeing of children for whom a report of suspected abuse or neglect is received and it is determined by management that the reports meet legal sufficiency to investigate.

Child Protection Services (CPS) workers protect Indiana's children from further maltreatment by assessing all reports of suspected abuse or neglect that are determined by a supervisor to meet legal sufficiency. Reports of suspected abuse or neglect are received by the Department of Child Services and the Child Protective Service (CPS) worker makes a determination of the safety of the child in the home. CPS is mandated to receive and initiate (staff has satisfactorily determined that a child who is the subject of a child abuse or neglect report is, and will continue to be, safe until the next step in the assessment process is taken) assessments of abuse and neglect on a 24-hour basis. Assessments of abuse or neglect can be determined to be substantiated (facts obtained during the investigation provide credible evidence that child abuse or neglect has occurred) or unsubstantiated (facts obtained during the investigation provide credible evidence that child abuse or neglect has not occurred). The safety of the child is the primary focus of every CPS assessment.

Families can receive further services/treatment based upon several factors:

- Families who do not have a substantiated finding of child abuse or neglect may receive services through Community Partners for Child Safety on a voluntary basis.
- Services are also provided to families and children after a substantiated finding of child abuse or neglect. Services are offered or ordered for the family and children based upon their assessed needs.

Direct family preservation and reunification services are provided through contract agreements with local providers. The Agency carries out these goals through the following interventions:

- Informal Adjustment (IA): a voluntary agreement collaboratively developed by the Family Case Manager (FCM), the parents, guardian or custodian of the child, attorney and other interested parties. An IA can be used when the family acknowledges that there are problems that need to be addressed and the child is at moderate risk in the home. An IA must be filed and approved by the juvenile court.
- Child in Need of Services (CHINS): families whose children are placed under the supervision of the court will be ordered to complete services to address the issue that brought them before the court. Services will be offered to the children and family to eliminate the need for removal or to reduce the length of time in out of home care.

Services are now available during the assessment phase. Services may be provided during the assessment phase (for up to 2 months) regardless of whether or not there is a substantiated finding or corresponding open case.

C. FOSTER CARE

The foster care program provides 24-hour care to children who can no longer remain safely in their home due to the substantiated occurrence of abuse or neglect or due to their own need for care and treatment for behaviors which constitute a danger to themselves or others. State policy dictates that workers place children in the least restrictive most homelike setting that can safely meet the needs of the child. Placements are to be in close proximity to the child's family, particularly when reunification is the case plan goal. Placement may be made with an approved relative, licensed foster home, group home or other child-caring institution, or other court approved facility or home. The child's placement provider is involved in the case planning process and the provision of services to the child and family. The scope of their involvement is determined during the collaborative case planning process.

D. RELATIVE CARE

There are many placement options available when out-of-home care is required for a child. A thorough assessment of the child's needs provides the foundation for determining what type of placement will be in the child's best interests.

Indiana statute requires a relative placement to be considered before considering any other placement for CHINS. Relative care offers the child a family-like living experience that most closely resembles the child's own home. Therefore, the DCS is to attempt to locate relatives as placement resources first. A relative placement may be considered appropriate when the

minimum sufficient level of care for the child is met and the relative can demonstrate that the best interest of the child is the primary focus.

Any child in substitute care is entitled to equal protection. Therefore, the approach to obtain approval or licensure for a relative home placement is to be the same as that for licensure of a foster home placement. That is, the basic procedures regarding evaluation, case documentation, training offered and required, supervision, and opportunities for receiving financial assistance are to be the same. Approved status or licensure is to be obtained in a timely manner.

E. PROGRAMS UNDER TITLE IV-B

Title IV-B is used to fund various standardized programs including but not limited to the following:

- Child Preparation
- Family Preparation
- Home-Based Family Centered Casework Services
- Home-Based Family Centered Therapy Services
- Homebuilders
- Homemaker/Parent Aid
- Resource Family Support Services
- Support Group Services for Resource Families
- Foster Home Studies/Updates/Re-Licensing Studies
- Care Network
- Child Advocacy Center
- CHINS Parent Support Services
- Counseling Individual/Family
- Cross-System Care Coordination
- Diagnostic and Evaluation Services
- Domestic Violence-Batterer Intervention
- Domestic Violence–Survivor and Child Intervention Services
- Father Engagement Programs
- Functional Family Therapy
- Parent Education
- Parenting/Family Functioning Assessment
- Quality Assurance for Children in Residential Placement
- Sex Offender treatment
- Transition from Restrictive Placement
- Tutoring/Literacy Classes
- Visitation Facilitation - Parent/Child/Sibling
- Drug Testing and Supplies
- Random Drug Testing
- Detoxification Services
- Residential Substance Use Treatment
- Substance Use Disorder Assessment
- Substance Use Outpatient Treatment
- Community Partners for Child Safety
- Day Reporting/Treatment
- Truancy Termination

(http://in.gov/dcs/3159.htm)

Indiana completed the updating of service standards and developing new standards for the Request for Proposal (RFP) that was launched in December of 2010. This process included the development a specialized workgroup consisting of Community Mental Health Center Staff, Medicaid Staff and Division of Mental Health and Addictions Staff. The goal of this group was to increase the use of Medicaid through the partnership with the local Community Mental Health Centers. The core group consisting of Community Mental Health Center Staff and the Department of Child Services Staff continue to meet on a bi-weekly basis. Staff from Medicaid and the Division of Mental Health and Addictions continue to give input into this workgroup.

DCS, beginning in 2013, is preparing to pilot two new services:

(1) SOBRIETY TREATMENT AND RECOVERY TEAMS (START)

With support from Casey Family Programs, DCS is preparing to pilot the START program in Monroe County. The program focuses on those families that become involved with the Department of Child Services and have substance use issues. Specifically, DCS plans to target those families with children under the age of 5. The family voluntarily enters the program and receives a START FCM, a family mentor, and a treatment coordinator. The family mentor is a person who has at least three years in recovery and has experience with the child welfare system. The family mentor could be a former client accused of abuse or neglect or a child who was the victim of abuse or neglect. The FCM and the mentor work with the family in collaboration with the substance abuse treatment provider to coordinate assessment and treatment options that are best for the family. Treatment options range anywhere from individual counseling to residential treatment. The focus is on keeping children safely in their homes with adults who use substances or reunifying the children with their families as quickly as possible. Both of these options are centered around ensuring the safety of the children. Child and family team meeting (CFTM) are held within 48 hours and the assessment is done within 48 hours of the CFTM. The client should begin the treatment plan immediately. Family mentors assist the family by providing essential support throughout the process. They transport adults to their first several treatment appointments. Communication between the FCM, family mentor, and substance use service provider is key to keeping the family engaged in treatment and keeping the children safely at home. The case remains open for a period of no less than six months. Parents must maintain abstinence from substances for at least 6 months before the case can be closed.

Aftercare Services are voluntary services that continue for up to six months after the DCS case has closed. These are primarily home based services that were in place during the open case. During the first two months after case closure, the family may choose to continue services at a low level of frequency. For the remaining 4 months, the family is able to contact the service provider as needed. This program is being piloted in DCS Region 18.

(2) COMPREHENSIVE HOME BASED SERVICES

In addition, DCS is currently in the process of contracting for Comprehensive Home Based Services. Comprehensive Home Based Services is a family-centered approach that offers short and long term behavioral health care to the entire family. Comprehensive Home Based Services focuses on the reduction of child maltreatment through services that improve caretaking skills, family resilience, health relationship building, and the child's physical, mental, emotional, and educational well-being. This holistic approach utilizes current evidence-based models to help families overcome complex challenges surrounding child maltreatment.

Examples of evidence-based models used by Comprehensive Home Based service providers include:

- Alternatives for Families Cognitive Behavioral Therapy,
- Trauma Focused Cognitive Behavioral Therapy
- Cognitive Behavioral Therapy,

- Functional Family Therapy,
- Multi Systemic Therapy,
- Family Centered Treatment,
- Motivational Interviewing,
- Brief Strategic Family Therapy
- Child Parent Psychotherapy, OR
- Other DCS approved treatment models

Comprehensive Home Based Services are delivered using a trauma informed, strengths-based, and inclusive service model. Providers engage clients and families in a way that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Services are delivered in a way that focuses on the strengths of the family, ensuring the family feels respected, informed, connected, and hopeful regarding their own future.

DCS is planning to provide training, QA and consultation for those providers contracted for Family Centered Treatment. FamiliFirst will be under contract to ensure these providers are properly trained and implementing the model with Fidelity. In addition, DCS plans to provide training for TF-CBT and Motivational Interviewing providers. In fact, many providers were trained in MI during 2012. A partnership between the Indiana Department of Child Services (DCS) and the Institute for Family Development (IFD) was created from November 2012 through December 2012 to support Motivational Interviewing (MI) training. This partnership was designed to offer MI training to all home-based family-centered providers contracted to work with families involved in child maltreatment cases. IFD offers contracted providers a 2 day workshop which introduces the concepts of MI and establishes a conceptual foundation for utilizing MI with DCS clients.

Motivational Interviewing is a technique for engaging the intrinsic motivation of a client in order to change a behavior. It is a client-centered model designed to help clients articulate and become aware of the underlying issues that can cause resistance to change. MI uses Prochaska's and DiClemente's Six Stages of Change as a framework to identify strategies practitioners and clients can use to help resolve ambivalence and/or resistance. MI has been shown to be an effective tool in facilitating behavioral changes with parents and adolescents.

F. INDEPENDENT LIVING

The Independent Living Program provides direct services for youth in foster care and for those individuals who have aged out of foster care up to age 21. Services offered vary depending upon the age of the youth and are described in detail in under *Chafee Foster Care Independence and Education and Training Vouchers.*

G. OTHER PLANNED PERMANENT LIVING ARRANGEMENTS

Guardianship with relatives and/or other appropriate adults involved in the child's life is an option available to the DCS as they determine permanency for children in care. Adoptive parents are sought out for children whose parental rights have been terminated. Other options include housing arrangements with case management services through the Bureau of Development Disability Services when eligibility is established and the youth has not been adopted or placed in a guardianship.

3. DECISION MAKING PROCESS

A. BIENNIAL REGIONAL SERVICES STRATEGIC PLAN

In 2008, legislation was passed that added the requirement for a Biennial Regional Services Strategic Plan (the Plan) that would be tailored toward the provision of services for children in need of services or delinquent children. The Regional

Services Council (RSC) is the structure responsible for the development and approval of the Plan. The Plan incorporates the Early Intervention Plan, the Child Protection Plan and the Regional Services Plan as well as new requirements. The Early Intervention Plan focuses 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. The Regional Services Plan outlined the array of services available within the region. These three plans were combined to form the Biennial Regional Services Strategic Plan. The most recent Regional Plans are available at: http://www.in.gov/dcs/2829.htm.

B. REGIONAL SERVICES COUNCIL

The State of Indiana is responsible to provide programs, services and placement for Indiana's most vulnerable and needy children and families. On January 1, 2009, the State began paying for those programs, services and placements. It was recognized that local involvement in the evaluations, contracting and implementation of the service delivery systems was critical.

Because of the importance for service capacity delivery to children and families in neighborhoods, communities, counties and state, the coordination of service availability and delivery is critical to protecting children and families. This process of service availability and delivery is best done at the local level. For example, rural communities often do not have the demand for, or the capacity to, deliver a wide variety of services. This is made more complicated since each individual case may present difficult and expensive needs or a changing variety of issues.

In order to address these issues, including the need for coordination in wider geographic and geopolitical boundaries, the Regional Services Councils were created. The Regional Services Councils include staff from the Department of Child Services as well as foster parents, CASA/GAL, judges, probation departments and others. For a full description of these Councils and each region's Biennial Regional Services Strategic Plan, see: http://www.in.gov/dcs/2829.htm

C. REQUEST FOR PROPOSAL PROCESS

The Request for Proposal (RFP) was distributed through the Department of Child Services website. Proposals were submitted electronically for the first time in December, 2010. The provider could choose the service standards they wished to propose for and the region/county they wanted to serve. Scoring of the submitted proposals was completed by State staff, recommendation were made to the Regional Services Council in each region. Each Regional Services Council gave approval recommendation of the services/providers for their region.

Another major change in this process in 2010 was in the Regional Child Welfare Services Coordinators. This position had been a contracted position since 1984. In 2010 these positions became state employees. Six people were hired to take on the coordination of services for Indiana. These six staff members are scattered throughout the state and each serves 2 and 4 regions. These staff member are instrumental in getting services in place, being the liaison between the providers and the region/state and the overall service maintenance.

4. COLLABORATION

A. ACTIVITIES IN ONGOING PROCESS OF COLLABORATION EFFORTS ACROSS SERVICES SPECTRUM

Describe activities in the ongoing process of coordination and collaboration efforts conducted across the entire spectrum of the child and family service delivery system. This section should also describe stakeholder or partner

involvement in the review of progress made in the past fiscal year and expected updates for the coming year (45 CFR 1357.15(l)).

Through our Healthy Families Indiana and Community Partners for Child Safety prevention initiatives we work with community-based public and private providers statewide. A continuum of services is offered to families who participate voluntarily beginning prenatally through 18 years of age. Local service providers formalize agreements with HFI and CPCS to assure family access to needed services.

To enhance these services, coordination of training across systems has resulted in establishing a training institute to offer skill building sessions for DCS staff, service providers and families. Priority training needs are identified particularly to address domestic violence, mental health & infant mental health, substance abuse, and child abuse and neglect.

Our Institute partners include, DCS, Child Care, Head Start, Purdue and Indiana Universities, Mental Health and Infant Mental Health Associations, First Steps, Department of Health, Maternal and Child Health, Prevent Child Abuse Indiana, Cooperative Extension, Indiana Institute on Disability. The Institute is held twice a year. In addition to these efforts, the service provider community was very active in Indiana's PIP process.

Indiana continues to work with its partner agencies to evaluate progress and identify areas for continued improvement. In the coming year, DCS will continue to engage service provider partners through continued meetings and workgroups. For example, DCS will continue its ongoing work and regular meetings with the Community Mental Health Centers, as well as with the Home-based Community Service Providers. DCS will also continue to elicit feedback from the Indiana Family-Based Services Coalition regarding service standards and service improvement.

In the area of Prevention Services, DCS regularly meets with providers on various workgroups including the Healthy Families Think Tank, Funding Workgroup, Evaluation Workgroup, as well as the Youth Services Bureau Advisory Group. In 2012, the Indiana Youth Services Association became a partner in the Strengthening Families Training Institute. During 2013, DCS and the Indiana State Department of Health started the Indiana Home Visiting Advisory Board (INHVAB). The focus of the INHVAB is to ensure proper coordination of home visiting programs and to monitor the Continuous Quality Improvement efforts of those home visiting programs funded through the Maternal Infant and Early Childhood Home Visiting program (MIECHV).

Another new area of collaboration includes the first Children's Justice Act 2012 Conference. The inaugural CJA Conference was held on Friday, October 26, 2012. The conference brought together members of the multi-disciplinary teams that included representatives from law enforcement, the judicial system, medical practitioners, CAC forensic interviewers, and staff from DCS. The CJA Task Force focused the inaugural CJA Conference on identifying and developing strategies that will help multi-disciplinary teams increase their capacity to work collaboratively. This goal was achieved by presenting topics that helped multi-disciplinary team members gain greater awareness of the different roles and responsibilities of each member.

Presentations at the CJA Conference included a Keynote address from the Honorable Steven H. David, Indiana State Supreme Court, discussing the prosecution of persons charged with child maltreatment. A Lunch Keynote was given by Brad Russ, Director of the National Criminal Justice Training Center, describing the efforts taken by New Hampshire to improve communication and collaboration among multi-disciplinary team members. A Closing Plenary Address was given by Brian K. Homgren, JD, Assistant District Attorney General, 20th Judicial District, Nashville, TN, discussing how the US Supreme Court evaluated the expert testimony presented at the criminal trial of a defendant convicted of Shaken Baby Syndrome.

B. COLLABORATION WITH THE COURTS

Provide an update on how the State has demonstrated substantial, ongoing, and meaningful collaboration between the child welfare agency and the courts, with regard to the development and implementation of the APSR and any CFSR or title IV-E PIPs (section 422(b)(13) of the Act). Meaningful, ongoing collaboration means that the State agency and the court will identify and work toward shared goals and activities, assess outcomes, and develop strategic plans to increase the safety, permanency, and well-being of children in the child welfare system.

Individuals from the DCS Legal Department and Staff Development Division continue to collaborate with the Indiana Judicial Center to provide training to CASA's, Judges, Magistrates, Commissioners, and Court personnel on child welfare issues as explained in the "Updates to Training Plan" section below. For example, individuals from the DCS Legal Department work with the Indiana Judicial Center to provide training on the need for specific IV-E required findings in initial court orders for removal of a child from their home. As a result of the MaGIK implementation in July, 2012, the Central Eligibility Unit (CEU) now completes all IV-E eligibility determinations for Children in Need of Services (CHINS) and Juvenile Delinquent/Juvenile Status (JD/JS) cases. As part of the eligibility determination, CEU reviews the Court's initial removal order to assure that it includes required Title IV-E findings. If the required language is not in the Court Order, a copy of the order is sent to the DCS Legal Department. The DCS Legal Department, in collaboration with the Indiana Judicial Center, works with judges to assure that they understand the need for the required findings in their initial court orders.

A representative from DCS will be presenting at the Annual Meeting of Juvenile Court Officers on June 13 and 14, 2013.

DCS continues to work with Probation staff and the Indiana Judicial Center on the DCS/Probation interface, to share information about the services available and services needed for children involved in the probation system. They are also working together to roll out the residential placement committee (IC 31-9-2-109.5) and the permanency roundtable process for juvenile delinquency cases.

DCS representatives attend 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 c are, statutory timelines in CHNS and TPR cases, and DCS programs and services.

5. PROGRAM SUPPORT

A. UPDATES TO TRAINING PLAN

(1) 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 DCS 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.

A comprehensive Training Records Tracking System called Enterprise Learning Management (ELM) was developed. It allows staff to register for training on-line and some training can also be completed on-line. A permanent training record is established which can be used to track and verify an employee's training 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.

Training for newly hired FCMs, "The Institute" is 12 weeks in length, includes 29 classroom days, 21 transfer of learning days, and 10 on the job reinforcement days. A summary of this program is included as ATTACHMENT 1.

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 the training. New cohorts begin every 2 to 3 weeks. 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 FCMs 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 FCMs 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. Due to increased staffing, three additional positions and a supervisor have been added and will be hired in the next few months. There are no other procedural changes that are anticipated.

During pre-service training, all FCMs are 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.

(2) ONGOING TRAINING FOR FAMILY CASE MANAGERS

In January of 2010, Indiana established required yearly training hours for FCMs, Supervisors and Field Management Staff. This consisted of 24 annual hours (12 of which could be on-line) for FCMs and 32 hours (16 of which could be on-line) for Supervisors and other Field Management Staff. This policy was updated on November 1, 2011 (see http://www.in.gov/dcs/files/Internal_Training.pdf) to establish required training hours for all DCS personnel. 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. An External Training policy, effective June 1, 2011, outlines the procedures staff must follow to participate in

external trainings and requires approval of an External Training Review Committee .(see http://www.in.gov/dcs/files/External_Training.pdf).

The Individual Training Needs Assessment tool was revised to reflect current policies, procedures and best practices and was completed by all FCMs with their supervisors in the summer of 2011. Following a 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
- Advanced Worker Safety
- Introduction to the Attachment Continuum

Advanced Developmental Disabilities, Experienced Worker Safety, Protective Factors, and Understand Culture and Embracing Diversity have been developed and are available to be trained regionally upon request. A Strategic Planning meeting, held in November, 2012, identified the following curricula to be developed in 2013 based on ITNA results:

- Servant Leadership
- Clinical Supervision and Advanced Clinical Supervision
- Engaging Challenging Clients
- Trauma Informed Care
- Presentation and Facilitations Skills Training

Understanding Culture and Embracing Diversity and Trauma Informed Care will be offered Regionally Statewide to the majority of 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.

An Individual Training Needs for Supervisors is currently in development and will be conducted during the summer of 2013 with a report available for development of curriculum for 2014 related to supervisors.

(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. Beginning in January of 2012, Peer Coach Consultants have provided 3 hour specialized, regionally based trainings to enhance Practice Skills. During 2012, the focus was on "Start of the Team Formation," "Advanced Team and Teaming Transitions," "Team Maintenance and Stability," and "Preparing for Case Closure". During the 1st quarter of 2013, the emphasis was on enhancing the skills of the Peer Coaches described above with a workshop entitled "Permanency Round Table for Peer Coaches. " Additional workshops scheduled for 2013 include "Basics of Prep Meeting to Get to the Underlying Need," "Advanced Engagement Skills for Supervisors," and "Advanced Engagement Skills for FCMs."

A Workshop for all Peer Coaches was held in July of 2012, including a presentation by the DCS Director and workshops on providing Constructive Feedback/Debriefing and Public Speaking. A similar workshop for all Peer Coaches is in the development phase and will be held in July of 2013.

(4) MANAGEMENT GATEWAY FOR INDIANA'S KIDS (MAGIK)

A statewide training of MaGIK, DCS' new computer information system, was held anticipating its release on July 5, 2012. Manuals and various materials are posted to a common SharePoint that can easily be accessed by all and scenarios have been developed to assist individuals with the transfer of learning component from the classroom to their daily tasks. The MaGIK Coordinators are in the process of developing scripts for additional Computer Assisted Trainings that will be implemented in the next fiscal year so that there is easy accessibility to all staff.

(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. 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 appropriate DCS staff as well as stakeholders. In addition, one day training on enhancing facilitation is conducted for those individuals designated to provide facilitation services for these meetings. Trainings were provided by Casey Family Program staff in 2011 and early 2012 with DCS Staff providing assistance and assuming a greater role in the process. DCS developed materials and began completing the trainings in July of 2012, and developed a 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. 9 trainings are planned for 2014.

(6) SUPERVISORY AND MANAGEMENT TRAINING

New supervisors receive a comprehensive 5 month training, including modules on Orientation, Clinical Supervision, Servant Leadership, and Leadership Behaviors. The curriculum as implemented with the assistance of experienced trainers from the Butler Institute for Families working with Indiana trainers to develop competency in delivering the curriculum. 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.

A Supervisor Mentor program was 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. 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 is 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. To further assist with providing supervisors with skills and tools necessary to provide for Staff Retention and Better Outcomes in Child and Family Services, DCS 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. 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.

Beginning in the summer of 2009, Indiana worked closely 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 program was modified for the 2011/2012 academic year. The selection process was narrowed further for the 2012/2013 class which started in January of 2013. 22 individuals are participating at this time and have developed the Personal Learning Plan and Change Initiative. One webinar was conducted to review the overall course and explain expectations. All other training is classroom based with 5 modules that focus on leadership enhancement. 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. Graduation is slated for August, 2013. Indiana continues to provide consultation and assistance to other states through the National Child Welfare Workforce Institute (NCWWI) regarding a statewide implementation plan for this training, including participating in a national webinar with over 800 individuals registered.

Five designated individuals participated in the classroom based Leadership Academy for Middle Managers (LAMM) facilitated by NCWWI. That brings a total of fourteen DCS leaders who have completed this training and have continued to be involved with follow-up webinars.

(7) MANAGEMENT TRAININGS

A "leadership training program" for executive staff and local office directors was initiated and completed in 2009, including a two day workshop in January of 2009, and 5 additional half day workshops which focusing on leadership/management skills in staff development and 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 occurred.

DCS developed the "Management Innovations Institute", in collaboration with the Indian University School of Social Work, School of Public and Environmental Affairs (SPEA) Executive Education Program. Learning opportunities were 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. 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.

(8) 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 residential treatment service providers in Indiana on contract compliance audits and monthly critical incident reporting. DCS first began auditing residential provider contracts in 2013.

During Fiscal Year 2014, DCS will provide training to Probation Officers focusing on transitioning the functionality of the MaGIK Probation Application to KidTraks. There are 12 sessions scheduled and the training will focus on how Probation Officers access cases, enter and edit data and create referrals.

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 were provided last year providing cross training in permanency to court personnel, probation officers, Guardian ad Litem/Court Appointed Special Advocates and other stakeholders. Specifically, DCS partnered with the State Court Appointed Special Advocate (CASA) program to provide training to CASA's/GALS through 4 regionally based trainings which occurred in Lafayette, Warsaw, Evansville and Indianapolis. Topics covered in this training included: Legal Requirements for the Identification of Child Abuse and Neglect, The Role of an Attorney Guardian ad Litem in Juvenile Court, Developmental Considerations in Working with Abused and Neglected Children and Adolescents, Treatment of Child Abuse and Neglect: Trauma Informed Care and Ethics. There has been ongoing collaboration on the development/re-design of the DCS and Probation interface and DCS and the Judicial Center hosted a webinar to train Probation staff on the new referral and ICPR process.

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.

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 DCS 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 DCS FCMs, 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 DCS staff who work with children involved or at risk of being involved in both systems.

(9) STATEWIDE CONFERENCE HELD "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, DCS 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.

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.

(10) 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 FCM 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. Once complete, training will include this section so that appropriate referrals can be made based on the results of the cans assessment.

(11) SPECIALIZED MEDICAL TRAINING FOR INDIANA PHYSICIANS AND OTHER RELEVANT PARTIES

In 2012, DCS amended an existing contract with Indiana University to provide program development, implementation and training on child abuse and neglect identification and/or reporting and related topics 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. 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.

(12) 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 Care 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.

(13) 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.

(14) 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 been identified to receive this training beginning in the fall of 2013.

(15) 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.

(16) EDUCATIONAL LIAISONS

"Educational Liaisons have developed training which they regularly 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.

(17) 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 ATTACHMENT 2.

(18) 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 FCM, 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.

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.

(19) 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 has hundreds of hours of footage from developing documentaries with unprecedented access to Juvenile Courts. Several staff have been interviewed to provide a realistic review of their position. This video has been incorporated into the recruitment process including the funded BSW students so that all potential FCMs 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

For a list of essential learning course names and descriptions, **see ATTACHMENT 3.**

6. CONSULTATION AND COORDINATION BETWEEN TRIBES AND STATES

DCS is committed to improving the safety, permanency and well-being of Indian children and families receiving child welfare services in the state of Indiana.

The Pokagon Band of Potawatomi Indians (hereinafter Pokagon Tribe) is the only federally-recognized tribe located in the state of Indiana. Members of this Pokagon Tribe have lived in the lower Great Lakes area for hundreds of years. Today, the Pokagon Tribe's homeland covers six northern Indiana counties including LaPorte, St. Joseph, Elkhart, Starke, Marshall and Kosciusko and the four southwest Michigan counties including Berrien, Cass, Van Buren and Allegan. The Pokagon Tribe and the tribal court are located in Dowagiac, Michigan.

DCS has an excellent collaborative and cooperative interagency relationship with the Pokagon Tribe and their tribal services director, Mark Pompey. David Judkins, DCS' current Deputy Director of Field Operations, and other local office directors in northern Indiana, have met with Mark Pompey as tribal issues have arisen over the years. This occurred even before ICWA requirements became law. DCS expanded that relationship in recent years to assure that ICWA requirements are met, including the assignment of Tatiana Alvarez, DCS' International and Cultural Affairs Liaison as Indiana's ICWA Coordinator. That role was recently transferred to Sheryl Alyea, who recently joined the International and Cultural Affairs (ICA) team.

In 2012, the "Pokagon Small Group Team," was formed consisting of two DCS Regional Managers in DCS' northern regions, Local Office Directors in these regions, members of the ICA division, a DCS local office attorney with knowledge and background of ICWA matters, a DCS FCM who is a member of the Pokagon Tribe, and the Federal Compliance Manager. The Pokagon Small Group Team meets quarterly to discuss matters specific to the Pokagon Band. As an example, the Pokagon Small Group Team held a meeting on June 4, 2013. A team member notified the group that DCS' computer system, MaGIK, has Potawatomi Indians listed for the state of Michigan because the tribal headquarters are in Dowagiac, MI. This has caused some concern that FCMs may be looking for the Pokagon Band and not just Potawatomi Indians and they might be looking for Indiana when trying to locate and enter a child or individual's Tribe identification. Members of the group suggested that the Pokagon Band of Potawatomi Indians (MI and IN) be added to the list of Tribes provided for selection. The ICWA Coordinator contacted DCS MaGIK program developers after the meeting to explore solutions and the issue will be addressed in the interim by publishing an update in the MaGIK Times, a MaGIK news update that is sent via email to all staff.

DCS also has another ICWA group, the "ICWA Policy Team," comprised of policy, legal, and ICA members which meets monthly to discuss and update the DCS ICWA policy.

In January of 2013, the ICA Liaison and a member of the Pokagon Small Group Team met with the Pokagon Tribe's Director of Social Services and a Prosecutor for the tribal court. Tribal participants indicated that they would like to see better identification of Indian children on the ICWA forms received by the tribe. Participants concluded that DCS would develop a form to expedite the verification of Indian children identification. The tribal participants explained eligibility requirements for tribal membership including the levels of descendants and blood quantum requirements. The tribal participants also indicated that they prefer to receive referrals on, not only formal proceedings, but also on all informal proceedings and that they will intervene in all cases involving their members. As a result of that meeting, the following strategies have been implemented:

1. A 'Request for Verification of Child's Indian Status' form will be sent prior to the ICWA Notification Form which will assist with identification of a child's Indian status and therefore expedite notification of DCS involvement to the appropriate tribe. This form will also assist in maintaining confidentiality for the child and their family.
2. DCS is in the process of transferring responsibility for ICWA transactions from the ICA Liaison to the attorneys in each DCS local office to assure that the attorney becomes involved at the earliest possible time and can begin working with the tribe immediately upon identification. The local office will have the authority to begin the verification process immediately upon learning of the child's Indian status, membership or eligibility for membership. The local attorneys will have direct contact with the identified Indian Tribe and therefore have the opportunity to begin building a working relationship much earlier in the case. This will also assist local office attorneys in tracking proof of service of court proceedings sent to the tribe and will expedite tribal intervention in court actions. The DCS Deputy General Counsel visited the Pokagon Tribe on May 17th and met with Mark Pompey and others to discuss his new involvement with the tribe.
3. DCS ICWA Policy is currently being updated to include these new forms and procedures and is expected to be completed by fall, 2013.
4. The Family Functional Assessment Tool is also being updated to include additional questions regarding Indian heritage at the initial stages of DCS involvement and throughout the life of the case. The Family Functional Assessment Tool is a guide which FCMs use when assessing a family. It is hopeful that including questions on Indian heritage throughout the case will help identify Indian heritage.
5. An Indian Child Desk Guide is being developed for use by DCS employees in the local offices. This desk guide will be a tool to assist employees in understanding the Indian culture, to know the correct questions to ask, and to help them comply with ICWA requirements.
6. A new ICA staff member was added in March of 2013. She will assume responsibility for ICWA and will be referred to as Indiana's "ICWA Coordinator".

Additional Supportive Measures

Training – Cultural Competency Training for experienced DCS workers is still being developed and is now being discussed as a CAT (Computer Assisted Training) for all FCMs in the field.

DCS is hopeful that the Pokagon Tribe, Director of Social Services, will be able to provide a presentation on their tribe and culture issues at the DCS annual training for attorneys in June 2013.

The Pokagon Tribe Director was invited to present at the DCS Supervisors' annual training on June 27th and 28th, 2013, but was unable to attend due to another engagement. Therefore, DCS ICA staff will provide a presentation at this annual training on the Indian culture and the importance of complying with ICWA and maintaining Indian heritage and placements for children.

The Prosecutor and Presenting Officer from the Pokagon Tribe will present an overview of ICWA at a workshop on June 7, 2013, in LaPorte, IN. The DCS ICWA Coordinator will attend this workshop. The Pokagon Tribe Director has suggested that the presentation be taped for use in future training of DCS staff. Plans for the Pokagon Director of Social Services to speak at future field trainings, such as the DCS Directors' Workshop in January of 2014 have been initiated.

The DCS Deputy Director of the Child Abuse Hotline will be traveling to Dowagiac, MI to provide training specific to Indiana's procedures for reporting suspected child abuse and/or neglect. The Intake Specialist/Case Manager for the Pokagon Band of Potawatomi Indians Health Department requested the training for her staff on August 16, 2013.

DCS Field Worker Support Tools – Accurate data collection and statistics still present a challenge. DCS' information system, MaGIK, should be able to track Indian Children identification, as well as, their families, and possibly more, in the near future and is currently under development.

Development of an ICA referral form and process for field staff through the DCS ICA Share Site has begun. The DCS ICA Share Site will also provide access to ICWA program materials, forms, and resource information. A tracking system is also in the development phase. Additional forms are also in the development stages including a checklist, referral form, and a parent signature form to be signed during the assessment phase of DCS involvement. Tentative dates for completion of these improvements are projected for fall, 2013.

Culture Cards, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the American Indian/Alaskan Native Professionals and Families Advocates, will be distributed to DCS field staff and supervisors. It is a convenient pocket size guide to cultural awareness specific to the American Indian and Alaska Native Indians.

Outreach

June 2012, ICA Liaison attended the Miami Nation of Indians All Nations Gathering.

ICA Liaison attended the 2012 MCWIC Gathering.

January 2013, the ICA Liaison and an FCM from the Pokagon Small Group committee met with the Director of Social Services and the Prosecutor of the Pokagon Band of the Potawatomi Indians.

The Indiana Safe Sleep Project reported for January 2013 – March 2013 that five cribs were provided for American Indian children.

On May 17, 2013, the DCS Deputy General Counsel, Practice Development and Appeals, traveled to Dowagiac, MI and met with the Pokagon Director of Social Services and other staff.

June 7, 2013, the DCS ICWA Coordinator is scheduled to attend the 'Indian Child Welfare Act' workshop in LaPorte, Indiana. The Prosecutor and Presenting Officer for the Pokagon Band of Potawatomi Indians will be the presenters.

June 19 and 20, 2013, the ICA Liaison and the ICWA Coordinator for ICA will be attending the MCWIC Regional Tribal Child Welfare Gathering in Sault Ste Marie, Michigan. The DCS Deputy General Counsel, Practice Development and Appeals, will also be attending.

7. HEALTH CARE SERVICES

The Health Care Oversight and Coordination Plan developed in coordination with the State Medicaid agency, pediatricians and other experts in health care, and experts in and recipients of child welfare services must 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.

DCS joined forces with the Indiana Family and Social Services Administration (FSSA), the agency that administers Medicaid in Indiana, and collaborated with pediatricians and other health care experts in Indiana to develop Indiana's 2013 Health Care Oversight and Coordination Plan which is attached as ATTACHMENT 4.

8. DISASTER PLAN

The Disaster Plan should describe how a State would:
Identify, locate, and continue availability of services for children under State care or supervision who are displaced or adversely affected by a disaster;

- *Respond, as appropriate, to new child welfare cases in areas adversely affected by a disaster, and provide services in those cases;*
- *Remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster;*
- *Preserve essential program records; and*
- *Coordinate services and share information with other States.*

States are required to review their previously submitted disaster plan to determine if changes are needed. If the State determines changes are necessary, describe in the APSR the changes the State is making or include an updated disaster plan. If the State determines that no changes are necessary, note this fact in the APSR. Specify whether the State was affected by a disaster since the last APSR, and, if so, describe how the plan was used and assess its effectiveness.

The DCS Disaster Plan was last updated on December 1, 2011. The Disaster Planhas been converted to DCS Policy so that it can be updated when necessary. The DCS Disaster Plan spells out the Agency's responsibility to ensure the safety and security of all children in the agency's care, to provide on-going services and to provide for administration of new cases in the event of an emergency or disaster. The plan outlines communication protocol, procedures for locating all children in care, responsibilities of service providers, licensed providers and resource parents, handling of new child welfare cases, provision of ongoing services, records preservation and management procedures during a government shut down or temporary weather emergency. Revisions in the 2011 release of the Disaster Plan included: (1) modifications to the Hotline; and (2) inclusion of information regarding maintaining Child Support Bureau operations in the event of a disaster. The revised plan is available on the DCS website at http://www.in.gov/dcs/3037.htm or http://www.in.gov/dcs/files/Disaster_Plan.pdf. There has been no need to use the Disaster Plan since submission of the last APSR.

9. FOSTER AND ADOPTIVE PARENT RECRUITMENT ACTIVITIES

Section 422(b)(7) of the Act requires that the State's CFSP provide for the diligent recruitment of foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed. In the APSR, describe the State's progress and accomplishments made since the last APSR, citing any relevant data, and describe planned activities for recruiting foster and adoptive families in FY 2014. States are encouraged to utilize the resources and information developed by or available through AdoptUSKids located at: http://www.adoptuskids.org/.

(1) ADOPTION

DCS began using a new contractor, the Children's Bureau (CB), on July 1, 2011, for recruitment and retention of adoptive families. For more than 30 years, CB has focused on recruiting minority families to adopt minority children through their Homes for Black Children initiative. This model of actively recruiting minority families will be implemented throughout the regions. Collaboration with local diverse neighborhoods, faith-based organizations, and minority leaders will be sought in order to recruit appropriate minority families. CB will also handle local recruitment through adoption champions, prepare the monthly *Opening Hearts Changing Lives* adoption picture book, and assist in the hosting of matching events. The Heart Gallery began using a new provider, Transform Consulting Group (aka, JCL & Company), on December 1, 2012.

In addition to efforts of CB and Transform Consulting Group, SNAP Specialists continue to walk potential adoptive parents through the adoption process and they serves as a liaison for post-adoption service referrals. The SNAP Specialist works on behalf of the potential adoptive family and children waiting to be adopted by pre-matching families with children.

(2) FOSTER CARE REORGANIZATION, RECRUITMENT, AND RETENTION

The DCS Regional Foster Care Specialist (RFCS) program is now fully staffed with 21 Supervisors and 98 Regional Foster Care Specialists. With approximately two years at a fully staffed capacity, the procedures have been well-defined and the program is running well. The newest initiative for the program has been the development of regional foster parent recruitment and retention plans. In November of 2012, DCS held a training session for all Regional Foster Care staff, which provided enhanced information related to targeted recruitment. Each region reviewed their own data regarding children coming into care and their current foster parent population and developed initial plans. DCS also recently submitted an annual Communication Plan to the state's Office of Management and Budget that is pending approval. This plan is designed to provide increased financial resources to aid in recruitment and retention of foster parents. Last year's plan resulted in the procurement of new foster parent recruitment brochures, promotional items, and funding for regional foster parent appreciation events. Once the approved resources are known from this year's pending Communication Plan, each region will have a follow up planning meeting with the Central Office Foster Care and Communications Divisions to finalize a Targeted Recruitment plan for the upcoming state fiscal year.

As of April 2013, each region has an active full-time Foster Care Supervisor whose primary job responsibility is to provide supervision to foster care staff and enhance the regional program. Until very recently, with the exception of three regions, the supervision for the Foster Care Specialists was provided by a regional staff person who had additional, full-time job duties supervising other field staff. Having specialized supervision will allow for enhanced focus on the use of the Practice Model skills with DCS foster parents and the development and use of data measures to monitor regional foster care and placement trends.

Regional Relative Support Specialist (RRSS) positions were also created within the foster care unit. DCS recently received approval to allocate 30 positions statewide to make contact and do initial education and work with relatives at the onset of

placements. This specialized position is designed not only to allow for more prompt attention to the needs of relative caregivers, but also to assist the Foster Care Specialists in focusing more attention to the licensing and support of traditional foster parents and their unique needs.

The development and growth of DCS training for foster parents has provided additional supports and resources for foster parents. Recent additions to the in-service curriculum include courses on cultural competency, educational advocacy, trauma-informed care, resource family self-care, and working with biological families. These are topics which touch upon some of the most relevant and frequent stressors experienced by foster parents, so additional training will aid them in developing skills and self-awareness regarding these issues.

DCS has worked to streamline the invoicing process to allow for a less cumbersome, more user-friendly process for submitting claims. In addition to enhancing the package of additional reimbursements available to foster parents in 2012, DCS is now in the pilot stage of providing an e-invoicing option for foster parents that will allow for a much easier online submission, communication and monitoring of foster parent invoices. E-invoicing will allow for a more user-friendly and responsive customer service experience and in turn reduce another large stressor for many DCS foster parents.

10. MONTHLY CASEWORKER VISITS

For FYs 2013 and 2014, States are required to ensure that the total number of monthly caseworker visits to children in foster care is not less than 90 percent of the total visits that would be made if each child were visited once per month. In FY 2015 and thereafter, States are required to ensure the total number of monthly casework visits is not less than 95 percent of the total visits that would be made if each child were visited once per month. In addition, at least 50 percent of the total number of monthly visits made by caseworkers to children in foster care must occur in the child's residence. 12
In the APSR, States must describe their use of the Monthly Caseworker Visit Grant and their continued action steps to ensure that these standards are met. See ACYF-CB-PI-12-01, issued January 6, 2012, for more information on monthly caseworker visit performance standards and data requirements.
Also refer to information in Section F of this PI, "Statistical and Supporting Information," for instructions on submitting FY 2013 caseworker visit data.

STRATEGIES FOR IMPROVEMENT

DCS has far exceeded the benchmarks below for improvement originally submitted in the APSR.

- 2007- 23%
- 2008 - 50%
- 2009 - 70%
- 2010 - 85%
- 2011 - 90%

In the final year, the standard was 90%. Indiana DCS exceeded 90% in the most recent data submission to ACF and it was confirmed that for FFY 2011/2012, Indiana DCS successfully completed 92.88% of the required caseworker monthly visits.

Because the federal measurement essentially fails the case for an entire year once a visit is missed at any point during the year, any strategy to improve missed visits must be proactive. Recognition of a missed visit (while helpful in developing strategies to avoid this problem in the future) does little for the particular case in which the visit was missed as this error cannot be corrected. The average for FFY 2012/2013 as of May, 2013, indicates Indiana DCS is completing the required visits at a rate of 91.97%. In an effort to remain above any future compliance range, DCS implemented the following strategies:

1. DCS has redesigned its reports to mirror the federal measure;
2. DCS posts these measures monthly on a SharePoint for all management staff to review;
3. Multiple systemic reminders were sent to line staff prior to the month of February advising staff that visits must be accomplished during the month of February. This was done because Indiana's policy requires a visit every 30 days as opposed to the federal measure of monthly visits;
4. DCS changed its policy to mirror the federal monthly requirement effective July 1, 2011.
5. The importance of completing monthly visits is an important part of Indiana's practice model and is a frequent agenda item on the monthly regional manager meeting agenda;
6. A new report was created to identify incomplete visits as of the 20th day of each month. This allows management staff and workers to prevent a visit from being overdue.

Updated information, since the last APSR, is included in the FFY Monthly Caseworker Visits Reports below:

FFY 2011/2012 Monthly Caseworker Visits Report (Oct 1, 2011 to September 30, 2012)							
	Children with Contacts				Children w/ Contacts in Home Setting		
Month	Contacted Children	Total Children	Percent		Contacted Children	Total Children	Percent
October 2011	8133	8411	96.69%		6891	8411	81.93%
November 2011	8055	8345	96.52%		6783	8345	81.28%
December 2011	7831	8107	96.60%		6679	8107	82.39%
January 2012	7381	7624	96.81%		6216	7624	81.53%
February 2012	7461	7774	95.97%		6225	7774	80.07%
March 2012	7597	7953	95.52%		6395	7953	80.41%
April 2012	7813	8194	95.35%		6518	8194	79.55%
May 2012	7906	8286	95.41%		6618	8286	79.87%
June 2012	7883	8214	95.97%		6860	8214	83.52%
July 2012	6637	8121	81.73%		5707	8121	70.27%
August 2012	6730	8187	82.20%		5639	8187	68.88%
September 2012	7410	8583	86.33%		6050	8583	70.49%
Average for FFY 2011/2012	**90837**	**97799**	**92.88%**		**76581**	**97799**	**78.30%**

FFY 2012/2013 Monthly Caseworker Visits Report (Oct 1, 2012 to September 30, 2013)							
	Children with Contacts				Children w/ Contacts in Home Setting		
Month	Contacted Children	Total Children	Percent		Contacted Children	Total Children	Percent
October 2012	7762	8803	88.17%		6498	8803	73.82%
November 2012	7929	9098	87.15%		6314	9098	69.40%
December 2012	8242	9027	91.30%		6792	9027	75.24%
January 2013	8145	8582	94.91%		6751	8582	78.66%
February 2013	8394	8935	93.95%		6897	8935	77.19%
March 2013	8529	9060	94.14%		7177	9060	79.22%
April 2013	8712	9278	93.90%		7113	9278	76.67%
May 2013	8441	9149	92.26%		6865	9149	75.04%
June 2013							
July 2013							
August 2013							
September 2013							
Average YTD FFY 2012/2013	**66154**	**71932**	**91.97%**		**54407**	**71932**	**75.64%**

11. ADOPTION INCENTIVE PAYMENTS

In the APSR, report on how Adoption Incentive funds received during FY 2012 were or will be spent and describe any changes to how the State plans to use such funds should they receive Adoption Incentive funds in the coming fiscal year. Address any issues or challenges the State has encountered in expending funds in a timely manner.

Adoption incentive payments are being used to provide a wide spectrum of services and supports to adoptive families and children. A majority of the 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.

Indiana 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 and their families. The current statewide contract 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, is being renewed through June of 2014. 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.

DCS also purchased adoption recruitment billboards aimed at recruiting adoptive/foster parents. Billboards were purchased statewide in August of 2012 with rural, urban, and suburban exposure and a concentration in the south where we are in need of new adoptive/foster parents.

The Indiana Heart Gallery was also implemented through adoption incentive payments. This program expands the exposure of children eligible for adoptive homes to a wide range of individuals outside of the DCS website and the" Opening Heart, Changing Lives" adoption book publication. The gallery pictures are professionally done and capture the child's unique personality. The Indiana Heart Gallery exhibits travel to different events, including two major heart galleries, and many minor galleries. These galleries are placed across the state in churches, libraries, and businesses. The recent addition of video vignettes allows the audience to hearing from a child on their individual interests and dreams, as well as, their wants in an adoptive family. The traveling Indiana Heart Gallery is also used in conjunction with educational and public relation events about adoption. Contracting with AdoptUSKids for online recruiting activities continues.

12. CHILD WELFARE WAIVER DEMONSTRATION ACTIVITIES

If the State has an approved child welfare waiver demonstration project under section 1130 of the Act, it must provide a description of its coordination efforts to integrate the activities under the demonstration with the goals and objectives of the CFSP. In particular, the State must discuss how Title IV-B monies are used to maximize the use of flexible Title IV-E dollars in the demonstration.

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 the Indiana Child Welfare Demonstration Project for an extension of the State's waiver demonstration project. Indiana DCS accepted the Terms and Conditions on September 27, 2012. The demonstration period is five years which began July 1, 2012.

Indiana's 2012 waiver extension will allow DCS to address issues uncovered in the prior waiver period. It will also enable a broadened service array and increase the target population to all children served by DCS. It will again provide statewide

coverage but will not impose caps and increases the range of services eligible for funding under the Waiver. The demonstration supports and enhances service and program offerings that are consistent with Indiana's Safely Home, Families First initiative.

The Indiana Waiver Demonstration 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. Specifically, the target population served will include 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 Informal Adjustment (IA) or Child in Need of Services (CHINS) status.
2. Children and their families which have IA or the children have the status of CHINS or Juvenile Delinquency Juvenile Status Offense (JD/JS).
3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

The flexibility of the waiver program will better align the State's system of care with desired outcomes and DCS' overall initiative of "Safely Home, Families First" which emphasizes concerted efforts directed at enabling children to remain safely in the home, and when that is not possible, seeking supportive relatives to provide care and nurture with a goal of permanency. The waiver allows the State to invest in an improved array of in-home and community-based family preservation, reunification and adoption services and expand existing services.

Indiana 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:

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

13. QUALITY ASSURANCE SYSTEM

In the APSR, assess the State's current QA/CQI system based upon the information shared in IM-12-07 and any improvements elected or planned. In the IM, CB advised States to focus on the following:
* *Foundational administrative structure;*
* *Quality data collection;*
* *Case record review data and process;*
* *Analysis and dissemination of quality data; and*
* *Feedback to stakeholders and decision makers and adjustment of programs and process.*

The APSR should also include any training or technical assistance the State anticipates needing from CB resources or other partners.
In addition, in the APSR, provide an update on QA/CQI results and data that have been used to update goals, objectives, planned strategies or use of funds in the APSR. Also describe any specific practice or systems improvements the State has made since the last APSR based on QA/CQI findings.

DCS continues to offer an array of internal and external services to families based on identified needs. Service standards, reflecting the DCS vision, values and Practice Model (TEAPI), regulate the continuum of services offered through provider

agencies based on identified needs (i.e. adoption, Chafee IL services, family-centered programs, resource family centered services, addictions, preventative care, and probation services).

Foundational and Administrative Structure

- Single agency oversight
- Written and consistent CQI standards and requirements
- Approved training process for CQI staff
- Written policies, procedures and practices for CQI staff including any contractor and stakeholder conducting CQI activities
- Evidence of capacity and resources to sustain an ongoing CQI process, including designated CQI staff or CQI contractor staff

Indiana Department of Child Services (DCS) has been working to improve its quality improvement processes. Currently, the Performance and Quality Improvement (PQI) unit has a formalized CQI process as part of the Quality Service Review (QSR). The QSR uses a thorough case review method and practice appraisal process to assess:

1. How the children and their families are benefitting from services received; and
2. How well locally coordinated services are working for children and families.

QSR is an evidence-based method to evaluate results in a specific service area at a given point in time. The review of each child and family served is an evaluation of the service system. A random sample of children's cases are reviewed to determine child and parent/caregiver status, recent progress, related system practice, and performance results for 22 indicators and they are as follows:

Child Status indicators

1. Safety
2. Behavioral Risk to Self/Others
3. Stability
4. Permanency
5. Appropriate Living Arrangements
6. Physical Health
7. Emotional Status
8. Learning & Development
9. Pathway to Independence

Parent/Caregiver Status indicators

Parenting/Caregiving Capacities

Informal Supports

System Performance indicators

1. Role & Voice of Family Members
2. Team Formation & Functioning
3. Cultural Recognition
4. Assessing & Understanding
5. Long-Term View
6. Child and Family Planning Process
7. Planning Transitions & Life Adjustments
8. Intervention Adequacy
9. Resource Availability
10. Maintaining Quality Family Relationships
11. Tracking & Adjusting

Note: As related to the Indiana Practice Model "TEAPI" – Teaming, Engaging, Assessing, Planning and Intervening

The PQI staff is responsible for the management of the QSR processes, Reflective Practice Survey (RPS), the Quality Assurance Review (QAR), Hotline Quality Review processes, Institutional Child Protective Services Quality Review, and Continuous Quality Improvement, as well as all related training.

Reflective Practice Survey

The Reflective Practice Survey process provides an analysis of case management services by identifying the strengths and needs of the family, as well as those of the Family Case Manager (FCM). The RPS tool uses field observation and a FCM interview by supervisors to review assessments and cases in order to evaluate the FCM's practice skills.

Each quarter randomly selected RPS assessments or cases are reviewed for quality standards established through the Quality Service Review (QSR) Protocol and best practice standards set forth through Teaming, Engaging, Assessing, Planning and Intervening (TEAPI) training.

Quality Assurance Review

Quality Assurance Review (QAR) provides an objective analysis of the Indiana Child Welfare System. The QAR evaluates systemic factors in each DCS local office by identifying strengths and needs through data reports to ensure compliance with:

1. Federal and state laws (i.e., statutes);
2. Regulations; and
3. Policies.

Hotline Quality Review

The Hotline Quality Review processes are designed to measure the consistency and uniformity of practice, improve responsiveness to community stakeholders and professional providers, and improve tracking capabilities. DCS developed a matrix to identify the desired outcomes, performance targets, and methodology for reaching the outcomes. The Hotline Review consists of the following:

- Intakes
- Screen Outs
- Matrix data compliance
- Customer Satisfaction Surveys

Institutional Child Protection Services Quality Review

The Institutional Child Protection (ICPS) Quality Review evaluates assessments completed by assigned Central Office institutional investigators. Assessments will be reviewed through QAR data reports and field observation of FCM's practice skills by supervisors. A RPS tool designed specifically for ICPS assessments was created by a subgroup to develop quality standards for ICPS staff which are similar to the QSR indicators for field assessments. The tool was implemented into DCS MaGIK on 4-11-13.

Continuous Quality Improvement

At this time, the PQI unit directs and oversees CQI planned initiatives and proposed outcomes for field operations. PQI has provided oversight from Central Office for CQI at the local level using the data from the QSR, QAR, RPS, and Practice Indicator reports to assist the Regional Managers (RMs) and local offices in decision making and planning purposes for improvement. The RMs develop a plan for improvement and report their progress on their plan through the STrategic Action Report (STAR) and through updates to peers and PQI during RM meetings. DCS has decided to convene a meeting of executive management staff to discuss the implementation of a new statewide CQI process which may include the use of the BRSSP (Biannual Regional Strategic Services Action Plan) in conjunction with the STAR reports as the guiding CQI plan for the regions. Due to projected changes in the CQI process and current changes in the DCS Director, executive staff plans to begin discussions in the following areas:

1. CQI process design, expectations, implementation, oversight
2. Regional support to the field by Central Office
3. Use of quantitative and qualitative data to measure improvement
4. Setting uniformed agency goals for improvement
5. Creating action steps to achieve established goals

6. Establishing a format for reporting progress on goals
7. Monitoring progress on set goals, etc

Currently, Indiana has a formalized QSR policy as part of DCS written policies and procedures. PQI is developing a manual to formally document PQI, QSR, and Hotline procedures. In addition, DCS will begin requiring contracted providers to have formalized and documented CQI policies and procedures as required through the RFP (Request for Proposal) process. PQI has standardized procedures and processes as well as CQI processes in place for the QSR, RPS, QAR, Hotline Quality Review, and ICPS Quality Review. Policies are in place for the QSR, RPS, and QAR; however, the QAR policy needs updated based on current process changes to the field QAR process, Hotline Quality process, and ICPS QAR process which are impacted by MaGIK rollout. In addition, a formal statewide CQI policy needs developed.

A plan to redesign roles, duties, and responsibilities as well as reassign staff in order to support and sustain a regional CQI team is part of current discussions with DCS Executive staff. The PQI staff and Service Coordinators will be part of a regional CQI team who will help to facilitate a comprehensive CQI approach. Additional team members have not been determined to date. All regional CQI team staff will need formalized and directive training on CQI, as well as data analysis training either through internal resources and/or Children's Bureau technical assistance. The Executive Team will also need technical assistance in formalizing a statewide CQI process and data analysis. DCS has been in discussions with Casey Family Programs to obtain additional assistance.

Quality Data Collection

- Data needs to be consistent, accurate, complete, timely
- Clear process used to extract and collect accurate quantitative and qualitative data, and the process is consistently and properly implemented across the entire state. Collection and extracting processes are documented and an audit mechanism is in place to verify that the process is being followed
- Process used to identify and resolve data quality issues and informs Children's Bureau, as necessary, regarding quality data issues
- Process for the collection of quantitative and qualitative data that addresses key issues important to the state and demonstrates how the state is functioning on systemic factors, such as training staff and resource parents, functioning of the case review system and service array
- State monitors existing federal requirements or guidelines and uses appropriate quality utilities and tools to ensure data is accurate, including but not limited to: most recent AFCARS review, most recent NCANDS data, NYTD data, meetings

Indiana continues to work with the MaGIK Development Team to improve the quality and accuracy of the data for both operational reports and federal reporting purposes. The Office of Data Management (ODM) is developing several reports to help workers improve the data they input into the system. There are also reports designed to remind workers to complete certain activities in a timely fashion. Also a governance committee and governance process has been established to help with future development and prioritization.

DCS monitors existing federal requirements or guidelines and uses appropriate quality utilities and tools to ensure data is accurate, including but not limited to the most recent AFCARS review, the most recent NCANDS data, and NYTD data. DCS has expanded its team which monitors federal requirements and reporting. The team now includes a staff person who focuses primarily on the requirements and monitoring of the data. In addition, a second staff person assists with pulling data and planning cleanup efforts. Both coordinate with the MaGIK team to develop appropriate mechanism and checklists to ensure data is being properly documented within the system. With the change to a new system, it was critical to add additional resources to this effort.

Qualitative data is collected through the Quality Service Review and Reflective Practice Survey processes. The QSR and RPS both have established forms and procedures for collecting the data. The QSR data is monitored for accuracy by the PQI team through mini rounds where teams report out the results of their review as well as workbook reviews from each QSR. Teams are required to complete workbooks for each case reviewed and justify their scores in the workbook for each indicator. The workbooks are reviewed by PQI staff to develop trends for the regional report to the RM. Data from the QSR is housed in a database accessed only by PQI staff. The RMs can review the workbooks for trends or if they are concerned the trends are not accurate. PQI staff can also review any case where there are questions from field staff on the results. The QSR process identifies overall systemic issues, practice trends, training issues, and service array trends. Trends are compiled at the middle and end of each full review round (review of all regions) for strategic planning purposes.

The RPS process for ongoing cases was in place and paused for MaGIK implementation. The ongoing case review process was implemented into MaGIK as of January, 2013. Previous data reports indicated staff needed additional training to ensure understanding of case scoring as the results were not consistent with the QSR results. The RPS measures two parts; case outcomes and worker's skills. Indiana has begun a three step strategy to improve management's understanding of the RPS. The first strategy is to increase the number of QSR trainings offered during 2013. Currently 69% of field supervisory staff are trained in the QSR and are going through the qualified reviewer training. In the new QSR policy, field supervisory staff are strongly encouraged to become qualified QSR reviewers. RMs must report reasons why field supervisory staff are not participating in this process.

The second strategy to improve the RPS results is to enhance the RPS skills section in order to give more explicit direction on necessary skills associated with each indicator. A subcommittee was formed to expand the skills definitions and scoring guidance for skills. The subcommittee has completed a draft of a RPS tool for both ongoing and assessments.

The third strategy is to train all management staff on the new RPS tools for Fall 2013. QSR training, in addition to the complimentary RPS training on the enhanced RPS tools, should result in more accurate scoring and alignment of scores with the QSR.

RPS report design is slated to begin the third quarter of 2013. Statewide data reports were designed previously; however, additional reports which enable field managers to drill down to individual case listings for accuracy and underlying needs assessments still need developed.

Case Record Review and Data Process

- Policies, written manuals, and instructions exist to assist in standardizing completion of the instruments and the implementation of the case review process.
- State reviews cases of children based on a sampling universe of children statewide who are/were recently in foster care and children who are/were served in their own homes.
- Must include IV-B and Sample is stratified to include different age groups, permanency goals, and other considerations such as varying geographic areas of the state IV-E eligible children (Indian tribes, juvenile justice, and mental health)
- State conducts case reviews on a schedule and takes into consideration representation of populations served, including the largest metropolitan areas
- Case reviews collect specific-level data that provides context and addresses agency performance
- Case reviews are able to detect quality of services for children and families served and therefore focus on assessment and monitoring of how child and family functioning is progressing in relation to services provided
- Case reviews include the completion of interviews specific to each case
- Case reviews are conducted by staff who go through uniform and consistent training process and whom the state determines are qualified to conduct reviews

- Process prevents reviewer conflict of interest and promotes third-party unbiased review of cases Inter-rater reliability procedures are implemented to ensure consistency of case ratings among reviewers.
- There is a process for conducting ad hoc/special reviews targeting specific domains when analysis and other data warrant such reviews.

Indiana has been conducting Quality Service Reviews since 2007. Indiana was first to use data from the QSR for the Program Improvement Plan (PIP) in Region 5 last CSFR round. The QSR was assessed by the federal government and determined to have the necessary components required. Cases are pulled through a randomize sample through the Office of Data Management (ODM). The sample may include any child assigned a case type (IA, CHINS, Probation, Adoption) or has been part of an assessment. The randomized sample is based upon four components and determined by each region's universe of cases in the following areas:

- age of child
- placement type
- case type
- time in care

Each region has a predetermined number of cases pulled based on the number of cases and the pull is statistically valid statewide. Marion and Lake Counties have 60 cases and 12 assessments pulled. Allen County has 30 cases and 6 assessments pulled, and all other counties have 20 cases and 4 assessments pulled for review.

The QSR process involves in-depth interviews with the child, parent, both formal and informal child/family supports, and key stakeholders in the case by a team of qualified reviewers. Each child's case is assessed based on 22 QSR Protocol indicators based on established quality standards for best practice, the Practice Model, safety, permanency, and well-being of children. The QSR Protocol includes indicators to measure Child Status, Parental/Caregiver Status, and System Performance.

Qualified reviewers are used to conduct the QSRs. Qualified reviewers attend New Reviewer training, Mentor Training, and are mentored through a shadow, two lead, and a mentor case review experience by a Mentor Qualified Reviewer prior to becoming qualified reviewers. Once reviewers are qualified, they are required to review a case once a round to maintain their reviewer skills. In 2013, PQI staff will routinely distribute indicators for scoring to all qualified reviewers to ensure inter-rater reliability. Results will be tracked and those reviewers who score outside the acceptable range will be contacted by PQI staff to discuss discrepancies in scoring ideology. In addition, PQI staff has developed an Advanced QSR reviewer training for qualified reviewers. Reviewers who have not reviewed in the current round and evidence scoring inconsistencies are specifically encouraged to attend the Advanced Reviewer training to obtain additional understanding of the QSR Protocol. The majority of the reviewer pool consists of DCS staff.

The new RFP for Comprehensive Home Based Services for providers require 1 representative from each organization to become a qualified QSR reviewer. This strategy was implemented to assist providers in the following areas:

- increase their understanding of the Practice Model
- educate their representatives on the quality standards established through the QSR Protocol
- increase provider involvement into the QSR process
- increase feedback and involvement in planning for CQI within the regions and statewide

Providers who are qualified reviewers will also be required to review one time per round to maintain their skills.

During each QSR, cases and scores are reviewed through the mini round process facilitated by PQI staff. PQI staff and other teams of reviewers listen to case report- outs by assigned teams. During mini rounds, teams ask questions and review scores which seem inconsistent with justifications made by the assigned review team as part of the inter-rater reliability process. PQI staff review each workbook for inconsistencies while compiling the data and identifying trends for regional reports. When issues are found with individual review team members, PQI staff speak to review team members. PQI staff ensure those team members are paired with a strong mentor for their next experience.

During the fall 2013, Collaborative Care (CC) cases will be pulled for review to establish a baseline and begin measuring the effectiveness of this new program. The number of cases reviewed will be based on a statewide statistically valid pull. The random sample will determine the number of cases for review in an assigned region. Data from the review will be kept separate from other QSR data. Reports will be produced the midway point and end of each round for Collaborative Care CQI purposes.

Although approved standardized training curricula exist for the New Reviewer training, the RPS, the Mentor training, and Advanced Reviewer training, an existing manual is in the development process. DCS policies exist for the QSR, RPS, Hotline Reviews, and QAR. The QSR policy has been updated and directs the staff on the scoring guide. Both the RPS and QAR policies are in the revision process due to changes in MaGIK implementation and tool enhancements.

Currently, local management staff meets with PQI staff to review the data from the review and discuss regional strengths and areas needing improvement. The management team determines which indicators the region will target for improvement over the following 18 months. The Regional Manager presents the QSR data results at the Regional Service Council (RSC) meeting for feedback and input for regional plans for improvement. Currently, RMs develop plans for improvement which are reviewed by the Deputy Directors for input and assistance. RMs provides updates on progress toward CQI plans to their peers and PQI every 6 months.

DCS Executives are discussing enhancements to this process to improve regional planning through the Biannual Regional Strategic Services Action Plan (BRSSP). Currently, the Services and Outcomes staff is in progress of restructuring in order to provide comprehensive support to the regions for CQI purposes. Service Coordinators and PQI staff will be assigned to specific regions as part of a CQI team to facilitate the team's review of data trends, exploring underlying needs behind data, aiding in regional goal setting, as well as, the development of measurable action steps for improvement. The improvement plan will be developed with input from stakeholders, youth, parents, and other system partners through the RSC. The Regional Management Team and Regional Service Council, in conjunction with the Service Coordinators and PQI, will develop the BRSSP. The BRSSP plan will incorporate the CQI process from the QSR and RPS, the child protection plan, early intervention plan, identified gaps in services, and focus on strategies to improve the quality of services and service array. Statewide quantitative and qualitative data, ad hoc reviews, and improvement planning outcomes will be used to assess regional progress on their plans.

Analysis and Dissemination of Quality Data

- The State has consistent mechanisms in place for gathering, organizing, and tracking information and results over time regarding safety, permanency, well-being outcomes and services (at the child, caseworker, office, regional and state level, as appropriate)
- The State has a defined process in place for analyzing data (both quantitative and qualitative), and the State provides training to staff and determines that they are qualified to conduct such analyses.
- The State aggregates Statewide and local data and makes it available to stakeholders for analysis.
- Agency decision makers, courts, tribes, and other stakeholders are involved in analyzing and understanding the data and in providing feedback on analysis and conclusions.
- The State translates results (trends, comparisons and findings) for use by courts, tribes, and a broad range of stakeholders, and the State disseminates results through understandable or reader-friendly reports, websites, etc.

In July of 2012, Indiana implemented a new data collection system. As with any new complex system, conversion of existing data was closely monitored to ensure accuracy. Also business transformations of adjusting to a new system also impact the data and reporting from a new system. Indiana is continuing this process of monitoring the data for accuracy and has developed several reports to help maintain the accuracy of the data during the transition period.

Several of the key business questions are monitored in the Practice Indicators Reports series. These reports were targeted for conversion first to allow for consistency during the transition of the new systems. Completely vetting these reports for accuracy was a priority prior to making these reports available to the public. This process is continuing for some other reports that the general public and our stakeholders find useful. ODM is also working with staff at all levels to develop reports needed to answer new business questions that have come from the business transformation from the new system and new state legislation.

All other projects and report development must go through the committee to determine the agency's priorities. The committee is comprised of the DCS Director, DCS Deputies and their designees as well as MaGIK development staff. This committee will review all the projects on the priority list to determine the order of project completion.

Indiana has historically made reports and used data from the system to share with stakeholders. Often data is pulled and repackaged into different formats to meet the needs of the audience and project goals. This reformatting and condensing of relevant data assists groups in their decision-making processes. Data has been and will continue to be used with different stakeholders, Citizen Review Board, courts, media, Regional Service Councils, Fatality Review Board, etc., to achieve strategic plans.

Currently Regional Service Council meetings are used at a local level to encourage stakeholder involvement in developing service plans. Indiana intends to expand the purpose of this planning group as a vehicle for CQI using qualitative and quantitative data, in addition to services data, to improve the system's functioning and service array. Although the RSC currently uses data reports for service array, the stakeholders will need to be instructed on the use of other data reports available for the region.

Indiana has several projects designed to enhance our analysis of quantitative and qualitative data. As an example, DCS is working with Chapin Hall to develop additional analysis skills and to better use tools such as the Chapin Hall Multi-State Database. This project has two parts. DCS is working with Chapin Hall's data team to incorporate service data into Chapin Hall's database by way of creating an agency file. This will allow DCS to analyze provider and service data at a program level to see trends and areas of improvement.

In the second part of the project Chapin Hall is working with DCS staff to begin to analyze Indiana longitudinal data. Chapin Hall's Multi-State database is being used to assist in this process. DCS has created a multi-departmental group which meets regularly to discuss this analysis and how to improve on the process.

The third project is the IV-E Waiver Demonstration Project. DCS is partnering with Indiana University to define and measure child well-being through the use of quantitative data points and qualitative data obtained through the QSR process. This project will start with the analysis of data and trends beginning with the QSR baseline data through 2015. In addition, the evaluation will monitor the effectiveness of the new Evidence Based Programming provided through the Comprehensive Home Based Services contracts.

These projects, along with the creation the Outcomes Unit, will enhance and develop the skills needed to improve the analysis of Indiana's data. Another element of this improvement is the creation of a reporting data warehouse and the format of our reports. The DCS reporting data warehouse will facilitate the handling of the data from the various areas of DCS. It allows for improved handling of monthly snapshots of key data elements as well and making easier to incorporate

all of DCS data for use for analysis. DCS is also working on improving the format of reporting to increase user at all level access to data and ease of use. During this process user feedback and input is consistently being used to improve reports.

A Data Governance Committee was established by DCS in 2012. This committee is comprised of representatives from ODM, Research and Evaluation (R and E), PQI, Field Operations, Services, Placement, Practice Support, Finance, Communications, MaGIK, Constituent Services, Legal, and Kids Track. The committee was developed for the following purposes:

- To ensure released data was consistent with existing data reports that reference or measure the same outcome
- To develop data reports which are easily understood by anyone unfamiliar with DCS data reports
- Provide additional information to reports or coversheets for reports to provide clarity for each data point in reports

With the exception of standardized data such as Practice Indicator reports, all other data released for public consumption must be reviewed and approved for release by the Data Governance Committee. Data requests are sent to the Research and Evaluation Director. The R and E Director will ensure the data graphs and accompanying data explanation coversheets, are reviewed by committee members. The committee members ask for clarifications and ask other data source experts in related topics to review the data. The committee will make certain suggested changes to documents prior to release.

Statutory and Regulatory Requirement for Quality Assurance and Improvement

The title IV-E agency is required to monitor and conduct periodic evaluations of its title IV-E programs. The operation of a Statewide QA is one acceptable method for complying with 471(a)(7) of Act.

- A specific requirement that the title IV-E agency implement standards to ensure that children in foster care receive quality health and safety services. It is important to consider the full array of statutory and regulatory requirements relevant to quality health and safety services for children in foster care, including those related to screening, assessments, and provision of mental health and early intervention services.
- Title IV-B regulations require State agencies to utilize QA to regularly asses the quality of services under the CFSP and assure there will be measures to address identified problems, A description of this system must be a part of the State's CFSP
- QA system is: (1) identifiable; (2) in place in all jurisdictions covered by the CFSP; (3) able to evaluate the adequacy and quality of services; (4)able to provide reports to administrators on the evaluated services and needs for improvements, and (5) able to evaluate measures used to address identified problems.

Indiana has had existing policies and procedures in place requiring health, mental health, dental, and hearing screenings at removal or soon after placement, after placement changes, for routine check-ups, and as deemed necessary. Indiana's Health Care Oversight Plan outlines the mechanisms by which this is accomplished.

In addition, timely Child and Needs Assessment (CANS) must also be completed during substantiated assessments and throughout the life of a case to ensure children are in appropriate placements and services. The CANS assessments are also required at critical case junctures. In addition, placement and service appropriateness, child emotional health status, physical health status, intervention adequacy, and resource availability is measured through the Quality Service Review process as a means of ensuring children are provided appropriate interventions. Each region reports the results of their QSR to enable the members and attendees at the RSC to give input on next steps for improvement.

At this time, the quality standards for Service Standard Assessment Review (SSARS) is in the process of redesigned. While DCS routinely evaluates services based on compliance with service standards and contract requirements through its audit team, the SSARS focuses on the quality of the service being provided by external contracted service providers. The SSARS review will be completed in conjunction with the QSR in order to complete a comprehensive review of each region. The

SSARS review is designed to measure the effectiveness of services through an in-depth review of each services standard, the manner in which the service is delivered, timeliness of service interventions, and the outcomes related to safety, permanency and well being the service produced for children and families receiving the service. The region will use the results of the comprehensive review to create a strategic plan which will address the quality of practice and services through the Biennial Regional Services Strategic Planning process. The reviews will be completed on predetermined review cycle and well begin in September 2013 with the new round of QSR reviews. Each region will have a report on the outcome of the review, and assistance from the Services Coordinator and PQI staff in incorporation the results of the review in their BRSSP.

14. SERVICES FOR CHILDREN UNDER FIVE

P.L. 112-34 part E" (section 422(b)(18) of the Act).
In the APSR, States must report on their efforts to provide developmentally appropriate services to this population. Services must recognize the distinct developmental needs of infants, toddlers, and children and the need to promote well-being, assess for developmental delays, and promote and expedite the permanency of these children. This information must include:
The number of children under the age of five projected to be in foster care in FY 2014, compared to the number of such children in FY 2013;
The method the State uses to identify and follow these children to ensure oversight of age-appropriate services (e.g. specialized data reports, staff assignments to these cases, and other oversight mechanisms);
The demographics and characteristics of the identified children;
Changes or updates to the targeted services provided to these children to find a permanent family and how they address the developmental needs of infants, toddlers, and children;
Changes or updates to the approach that have been developed for working with this group of infants, toddlers, and children (e.g. priorities for safety assessments, service delivery for reunification, and standards regarding the foster parent-to-child ratio); and
Changes or updates to how the State addresses the training and supervision of caseworkers, foster parents, and other providers with respect to this population.

DCS continuously strives to reduce the time children who have not attained 5 years of age are without a permanent family. See ATTACHMENT 26 for the number of children under 5 in foster care as well as projections for 2014.

Trauma Informed Care

DCS' strategic plan includes steps toward making improvements in our system and developing a more comprehensive trauma-informed system. To that end, DCS is improving its utilization of the CANS and increasing the capacity of its service providers to focus on moving these children to permanency quickly by meeting the child and family's service needs through Evidence Based Practices provided by well trained competent staff.

Screening and Assessment of children Birth to 5:

CANS

DCS utilizes the comprehensive Birth to Age 5 CANS screening tool to identify the unique needs and strengths of children in this age group and to make appropriate service referrals based on the specific needs of each child. The adjustment to trauma items on the CANS were recently revised in order to better identify children entering the system who have experienced adverse reactions to abuse or neglect. It is our intent to identify those children who can best benefit from evidenced based services which focus on trauma (e.g., Child Parent Psychotherapy).

Assessments

For those young children who need a full trauma assessment or attachment assessment, DCS has enhanced the service array to allow for these services. The Diagnostic Evaluation service standard was expanded to outline the procedures and expectations for these assessments.

EPSDT

For every child in out-of-home care the Indiana Department of Child Services (DCS) will ensure that a general health exam is scheduled within 10 business days of placement. The general health exam must include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, known in Indiana as HealthWatch. The general health exam by the child's pediatrician, family doctor, or general practitioner will include screens for physical, dental, visual, auditory, and developmental health.

Training and Services for Children from Birth to Age 5

First Steps

All children who have a substantiated assessment for abuse or neglect and are under the age of 3 are referred to First Steps. First Steps is an early intervention program designed specifically to assess and meet the developmental needs of children in this age group. The program focuses on infant/toddler development and ways to promote healthy development. This includes designing learning environments and activities to promote development across all domains: cognitive; physical; communication; social/emotional; and adaptive.[1] Services provided by First Steps includes occupational therapy, physical therapy, speech therapy, psychological services involving a child's social or emotional development, developmental therapy (DT)/early childhood education, audiological services including signed and cued language services, nutrition services and service coordination.

Indiana Association for Infant and Toddler Mental Health

DCS partnered with the Indiana Division of Mental Health and Addiction, the Indiana Head Start Collaboration and the Indiana Department of Health's Sunny Start Project to establish the Indiana Association for Infant and Toddler Mental Health (IAITMH). IAITMH developed a professional endorsement with four levels corresponding to education, skills, and experience. The endorsement was designed to establish a set of professional competencies that will assure that professionals provide culturally sensitive, relationship-based, services which promote infant and toddler mental health, and recognize the importance of continuing education and training. These training opportunities have been in place in Indiana for more than 10 years and have been critical to enhancing the abilities of those working with young children who have experienced the complex trauma associated with maltreatment. See Attachment 14.

RILEY PEDS Contract

DCS partners with Riley Hospital to obtain medical consultation from a team of specially trained pediatricians. This partnership allows DCS staff to request medical consultations and review s of cases involving head trauma and physical other injuries. This service, while not limited to this age bracket, is particularly helpful with young children and babies due to their difficulties in communicating the cause of their injuries. These highly qualified pediatricians, with significant training and knowledge of child abuse and neglect, are able to medically diagnose and identify the source of injuries to

[1] http://www.indianafirststeps.org/for-families/program-information

assist in determining if the injuries are accidental or the result of abuse or neglect. They often consult with other doctors across the state, in addition to DCS, to ensure appropriate safety decisions are being made for these children and their families. This program helps to ensure that children are removed when necessary and are not removed unnecessarily.

Enhanced Services

DCS has been working with Casey Family Programs to enhance the utilization of Evidence Based Practices in Indiana. Specifically, the Homebuilders program is often utilized for children in this age bracket. The intense services are especially appropriate for young children when risk factors are high, but with appropriate service levels, children can maintain safely at home. In addition, DCS continues to work with Casey Family Programs to expand the service array to include Child Parent Psychotherapy. This is specifically targeted to the Community Mental Health Centers. This program will service children under the age of 5 who have experienced trauma (as identified by the CANS). These services help to keep children at home and allow DCS to move toward permanency more quickly.

Safe Sleep

Family case managers work with community partners to ensure homes of young children are equipped with appropriate bedding, food, and supplies for infants and toddlers. Important Crib Information is posted on the DCS website alerting parents of new safety standards including recommendations to discontinue use of crib rails and bumper pads. Information regarding Safe Sleep was added to DCS Assessment Policy 4-13 in October of 2012. In addition, DCS partners with Riley Hospital to provide cribs to families.

Adoption Efforts

Indiana has several programs to enhance the possibility of adoption for children under five. The Indiana Heart Gallery, the Adoption Picture Book, and the Special Needs Adoption Program are all available resources for these families.

Visitation Plans

DCS policy requires increased visitation between young children and their parents. Per policy, face-to-face contact with the parent, guardian, or custodian will occur at least once per week and at least twice per week if the child is an infant (age 0-1) or toddler (age 1-2) unless the court has ordered otherwise.

15. CHILD MALTREATMENT DEATHS

Describe all sources of information relating to child maltreatment fatalities that DCS currently uses to report data to NCANDS;
If the State does not use information from the State's vital statistics department, child death review teams, law enforcement agencies and medical examiners' offices when reporting child maltreatment fatality data to NCANDS, explain why any of these sources are excluded; and
If not currently using all sources of child maltreatment fatality data listed in the previous bullet, describe the steps the agency will take to expand the sources of information used to compile this information.
To ensure that information in the APSR is consistent with related information reported directly to NCANDS, each State's contact for NCANDS should be consulted in developing this response in the APSR.

The Indiana Department of Child Services (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. In addition, DCS assesses all fatalities of children under the age of one. 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 mandates that the county coroner file an immediate report with DCS on all suspicious, unexpected, or unexplained child deaths. State law also considers all Indiana residents to be "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 FCM gathers relevant data from a variety of sources, including, but not limited to, law enforcement, hospitals, pathologists, primary care physicians, schools, the state's vital statistics department and coroners (Indiana does not have medical examiners). 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. 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. Data gathered by the Family Case Manger during the child fatality assessment is entered into MaGIK. Indiana pulls the data from MaGIK on all substantiated child fatalities to submit for the NCANDS child maltreatment fatality measure.

DCS has implemented and provided training for child fatality review teams in each of its 18 regions. Indiana law was recently revised, effective July 1, 2013, to add I.C. 16-49 which moves the responsibility for local and statewide child fatality review teams from DCS to the Indiana State Department of Health. The law requires prosecutors in each county to convene a committee of statutorily mandated representatives (law enforcement, coroner, hospital, etc) in the county in which they serve. The committees will then decide if their local child fatality review team will function as a county team, or collaborate with other local team(s) to operate as a regional team. This committee will also select statutorily mandated representatives for local child fatality review teams. Once the teams have been assembled, they will select the team's chairperson. The scope of cases reviewed did not change and teams will still review sudden, unexpected, and unexplained, cases that are assessed by DCS, and cases that are deemed by the Coroner to be a result of homicide, suicide, or accident. A DCS representative is a mandated member of each county child fatality review team.

D. CHILD ABUSE PREVENTION AND TREATMENT ACT STATE PLAN REQUIREMENTS

1. Describe substantive changes, if any, to State law or regulations, including laws and regulations relating to the prevention of child abuse and neglect, that could affect the State's eligibility for the CAPTA State grant (section 106(b)(1)(C)(i)). The State must also include an explanation from the State Attorney General as to why the change would, or would not, affect eligibility. Note: States do not have to notify ACF of statutory changes or submit them for review if they are not substantive and would not affect eligibility.

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.

2. Describe 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 (section 106(b)(1)(C)(ii)).

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.

3. Describe how CAPTA State grant funds were used, alone or in combination with other Federal funds, in support of the State's approved CAPTA plan to meet the purposes of the program since the submission of the last APSR (section 108(e) of CAPTA).

The CAPTA State Grant funds continue to be used to support programs within the fourteen eligible program areas. The CAPTA State grant funding, received by DCS beginning in 2008, is primarily used to support FCMs and legal staff as described below. The State of Indiana has also used the funds to contribute to the Indiana Supreme Court programs and the Indiana CASA/GAL program.

(a). improving legal preparation and representation, including— procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; and provisions for the appointment of an individual appointed to represent a child in judicial proceedings;

Indiana DCS continues to use CAPTA grant funding to support 3 Administrative Law Judges (ALJ) and 1 ALJ Supervisor who conduct administrative appeals hearings relating to DCS substantiations and licensing.

The position provides for a due process review of decisions for individuals negatively affected by administrative decisions of the agency. ALJs conduct administrative appeals hearings relating to DCS substantiations in accordance with the time frames set out in statutes, rules, and/or DCS policies governing the relevant administrative appeal process and licensing requirements. Upon receipt of a request for administrative appeal hearing, the ALJ conducts a procedural review to determine whether the case is ripe for administrative appeal. The ALJ reviews motions submitted by the parties and issues orders as appropriate. Hearings are held in various regional locations based upon the residence of the appellant and/or DCS policy. Decisions are rendered timely as set out in DCS policy. Decisions demonstrate a rational connection between the basic facts found by the ALJ and the ALJ's ultimate decision. The ALJ's decision also cites relevant laws upon which the ultimate decision is based, and relates the facts to the law.

(b).Case management- case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families;

DCS was statutorily created in July 2005 and immediately began its work to protect the children of Indiana from abuse and neglect by partnering with families and communities to provide safe, nurturing, and stable homes. The greatest barrier the Agency faced was a lack of FCMs to effectively manage the caseloads of the Department. The General Assembly recognized this need and responded by authorizing the hiring of 800 new FCMs over the course of the biennium ending SFY 2008.

Pursuant to IC 31-25-2-5, enacted in the spring of 2007, DCS is statutorily required to ensure that FCM 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.

In order to maintain caseload levels, the majority of CAPTA grant funds go to hire and support FCMs. Indiana tracks its outcomes through a series of practice indicators. These indicators demonstrate significant improvement in positive outcomes for children. These significant improvements in outcomes are largely linked to the amount of time FCMs are able to devote to working with families as a result of these caseload standards.

Examples of the types of improved outcomes for youth in Indiana resulting from the investment in case management staff include:

- 92.26% of children received a monthly visit by an FCM in May of 2013, compared to only 10.4% in 2005.
- In 2006, only 18.1% of CHINS were placed in relative care compared to 41% in April, 2013.
- When children have to be removed from the home, DCS places them with their siblings at a greater rate. In April, DCS placed 70.40% of siblings together, compared with only 62.23% in March 2007.

Practice Indicator reports are updated monthly and can be viewed at: http://www.in.gov/dcs/2811.htm

(c). Information on Child Protective Service Workforce

Information on the Child Protective Service Workforce is available as ATTACHMENT 15. Update to Training Plan for Workforce Information hereinabove.

4. Submit a copy of the annual report(s) from the citizen review panels and a copy of the State agency's most recent response(s) to the panels and State and local child protective services agencies, as required by section 106(c)(6).

The Lake County Citizen Review Panel Annual Report from June, 2012, is attached as ATTACHMENT 5. The DCS response in December of 2012 is attached as ATTACHMENT 8. The Lake County Citizen Review Panel Annual Report, due June 30, 2013, has not yet been received but will be forwarded to you as ATTACHMENT 11, as soon as it is received.

The Marion County Citizen Review Panel Annual Report from June, 2012, is attached as ATTACHMENT 6. The DCS response in December of 2012 is attached as ATTACHMENT 9. The Marion County Citizen Review Panel Annual Report, due June 30, 2013, has not yet been received but will be forwarded to you as ATTACHMENT 12, as soon as it is received.

The Wayne County Citizen Review Panel Annual Report from June, 2012, is attached as ATTACHMENT 7. The DCS response in December of 2012 is attached as ATTACHMENT 10. The Wayne County Citizen Review Panel Annual Report from June, 2013, is attached as ATTACHMENT 13.

Please note that Citizen Review Panel Annual Reports are due on June 30th each year. As such, the corresponding responses are not due until December, 2013. They will be included in next year's APSR.

5. CAPTA Fatality and Near Fatality Public Disclosure Policy
In September 2012, CB issued revised policy regarding the requirements for States to disclose to the public information about child fatalities and near fatalities that are a result of child abuse or neglect. (See Child Welfare Policy Manual Section 2.1A.4
http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=68)

Previously, States were required to have procedures to release available facts about a case of child abuse or neglect that resulted in a fatality or near fatality to the public, but there was no requirement about the specific minimum information the State was required to release to the public. When disclosing information to the public, States are now required to provide the following minimum information:
The cause and circumstances regarding the child fatality or near fatality

- *The age and gender of the child.*
- *Information describing any previous reports of child abuse or neglect that are pertinent to the abuse or neglect that led to the child fatality or near fatality.*
- *Information describing any previous investigations pertinent to the abuse or neglect that led to the child fatality or near fatality.*
- *The result of any such investigations.*
- *The services provided by the State and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the child fatality or near fatality.*

The State's public disclosure procedures must adhere to the updated guidance in section 2.1A.4 of the Child Welfare Policy Manual regarding section 106(b)(2)(B)(x) of CAPTA. If the State's procedures do not, the State must describe in the CAPTA section of the APSR the actions the State will take to meet the assurance, such as

necessary changes to law or policies and the timeframe required, and resubmit the assurance when the actions are completed.

Indiana's public disclosure procedures adhere to Section 106(b)(2)(B)(x) of CAPTA and Child Welfare Policy Manual Section 2.1A.4. Disclosure of these records to the public is specifically addressed in Indiana Code 31-33-18-1.5, which sets out the specific procedures that must be followed for release of this information in the event of a the death or near fatality of a child which may have been the result of abuse, abandonment, or neglect.

6. To facilitate ongoing communication between CB and States on issues relating to CAPTA and child abuse and neglect, please submit the name, address, and email for the State CAPTA coordinator (also known as the State Liaison Officer) or where this information can be found on the State's website.

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E. CHAFEE FOSTER CARE INDEPENDENCE AND EDUCATION AND TRAINING VOUCHERS

a. Indiana's specific accomplishments in the seven purpose areas

1. HELP YOUTH TRANSITION TO SELF-SUFFICIENCY

DCS continues to focus on transition planning for all youth (except those who are close to achieving permanency) starting at age 15.5 by utilizing and building upon a teaming approach. New this year under this topic, is the enhanced focus on older youth transitioning out of foster care via the Collaborative Care program. All youth, at the age of 17.5, transition to a specialized Collaborative Care Case Manager (3CM). 3CMs have undergone specialized training to work specifically with older youth in and transitioning out of foster care and 3CMs only have youth age 17.5 and older on their caseloads.

At age 17, a member of the Older Youth Services Team (Collaborative Care or Independent Living staff) is invited to the youth's Child and Family Team Meeting (CFTM) to discuss NYTD and Collaborative Care options and to give the youth the NYTD survey to complete, if applicable.

Building social capital and relational permanency are two of the foundational pillars for which Collaborative Care was built. All 3CMs have had training in these areas and assist youth in focusing on building their social capital and identifying lifelong connections. Focus is placed on assisting the youth with building their team/supports beyond DCS and service providers. This helps the youth transition away from being dependent upon the foster care system and helps them develop healthy lifelong interdependent relationships with a team of people who will continue to support them as they become self-sufficient adults. DCS continues to provide Independent Living skills education (see #5 below). The policies and associated services focusing on transition will continue in 2014. DCS will also gather feedback from youth, providers, and other stakeholders, on the service provision of Older Youth Services which will be used to inform and adjust future service provisions.

2. HELP YOUTH RECEIVE THE EDUCATION, TRAINING, AND SERVICES NECESSARY TO OBTAIN EMPLOYMENT

Education and employment preparation for older youth in foster care continues to be a focus now and in 2014. Services in this area have not changed. Service providers and case managers continue to ensure that youth are referred to WorkOne, through Indiana Department of Workforce Development (DWD) for employment related coaching, GED classes, and testing.

Older youth who are receiving IL 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.

These services and the partnership between DCS and DWD will continue in 2014.

3. 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 and training as well as associated funding. In addition to their other duties, DCS Educational Liaisons train and educate FCMs and youth on educational opportunities. As explained in the ETV section below, DCS contracts with a vendor to provide Education and Training Vouchers (ETV) to eligible youth. This will continue in 2014.

4. PROVIDE PERSONAL AND EMOTIONAL SUPPORT TO YOUTH AGING OUT OF FOSTER CARE THROUGH MENTORS AND THE PROMOTION OF INTERACTIONS WITH DEDICATED ADULTS

DCS' Collaborative Care program continues to focus efforts in this area. Indiana Older Youth Services address this in supporting authentic youth-adult partnerships, relational permanency and supporting building positive social networks. These areas are addressed in the Older Youth Services Service Standards, see page 8-10. Youth with assistance from their 3CM focus on building their CFT with people who are committed to the youth beyond DCS and service provider staff.

In addition, Indiana's Youth Connections Program continues to focus on assisting youth make lifelong connections. This program has grown in the last year and will continue in 2014.

5. 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 EFFORTS 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 services in this area have not changed and will continue in 2014. Chafee Voluntary Services, including Room and Board funding, continue to be available to all eligible youth ages 18-21.

Under the Collaborative Care Program, youth who turned 18 in foster care, left DCS' care, and are in need of support, can re-enter foster care. Youth sign a Voluntary Collaborative Care Agreement wherein the youth agrees to be under the supervision of the Juvenile Court, to maintain eligibility for the program, to meet with their assigned 3CM at least once per month, and to actively participate with an OYS provider. As of March 2013, a total of 142 youth have re-entered foster care through Collaborative Care.

6. MAKE AVAILABLE VOUCHERS FOR EDUCATION AND TRAINING, INCLUDING POSTSECONDARY 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 and training goals. See Education and Training Voucher section below for additional details.

7. PROVIDE SERVICES TO YOUTH WHO, AFTER ATTAINING 16 YEARS OF AGE, HAVE LEFT FOSTER CARE FOR KINSHIP GUARDIANSHIP OR ADOPTION.

DCS continues to offer Older Youth Services to youth who transitioned from foster care to an adoption or kinship-guardianship program on or after age 16. This will continue in 2014.

b. Report activities performed since the last APSR and planned for FY 2014 to coordinate services with other Federal and State programs for youth (especially transitional living programs funded under Part B of the Juvenile Justice and Delinquency Prevention Act of 1974, abstinence programs, local housing programs, programs for disabled youth (especially sheltered workshops), and school-to-work programs offered by high schools or local workforce agencies in accordance with section 477(b)(3)(F) of the Act.

DCS continues to connect youth to services offered through other Federal and State programs. Since the last reporting period, DCS has strengthened its partnership with the Indiana Housing and Community Development Association (IHCDA). DCS continues to be supportive of housing funded by IHCDA and the Corporation for Supportive Housing (CSH) which has focused on former foster youth. The Willard Park project was the first such project in Indiana. DCS and IHCDA collaborated with Willard Park property owners to keep the Willard Park project focused on current and/or former foster youth. DCS, IHCDA, and the Willard Park property owners are exploring how Willard Park housing can be reserved for youth aging out of the foster care system with long term Mental and Physical Health needs. DCS plans to continue to collaborate with IHCDA and Willard Park property owners in 2014 to locate long term funding for the supportive housing project. DCS will explore how Willard Park can benefit youth in the Collaborative Care program. In addition, DCS will engage the local CMHC's to plan for long term adult services for youth living in Willard Park Housing.

c. Provide information on specific training that was conducted since the last APSR and planned for FY 2014 in support of the goals and objectives of the States' CFCIP and to help foster parents, relative guardians, adoptive parents, workers in group homes, and case managers understand and address the issues confronting adolescents preparing for independent living, consistent with section 477(b)(3)(D) of the Act. Such training should be incorporated into the APSR training plan, but identified as pertaining to CFCIP, with costs allocated appropriately.

DCS continues to engage foster parents, relative guardians, adoptive parents, case managers, and staff at group homes, residential facilities and at Licensed Child Care Placing Agencies (LCPAs). With the release of Collaborative Care, the Older Youth Services team hosted several presentations to these individuals and to Juvenile Court Judges and Probation Officers. 3CMs and Older Youth Services providers received specialized training on working with older youth in foster care, specifically in areas on how to recognize and act upon teachable moments and on the Broker of Resources Matrix outlined in the OYS Service Standards.

Presentation to various audiences about Older Youth Services and the Collaborative Care program will continue into 2014.

d. For States that choose to establish a trust fund program for youth receiving independent living services or transition assistance.

Indiana does not use Chafee funds in this way.

e. Describe any activities undertaken to involve youth (up through age 20) in State agency efforts such as the CFSR/PIP process and the agency improvement planning efforts.

Indiana DCS does not have a PIP. DCS continues to ask youth for feedback on relevant policies, procedures and programming. The Indiana Youth Advisory Board (YAB) provides consistent feedback and is involved in planning efforts. In 2014, Indiana YAB leadership will focus on building regional youth boards that will feed information to the state YAB.

f. Medicaid Expansion: Describe, if applicable, how the State utilizes, or plans to utilize, the option to expand Medicaid to provide services to youth ages 18 through 20 years old who have aged out of foster care.

Coverage for individuals age 18-21 is available through a number of categories including the provision for Foster Care Independence which extends Medicaid eligibility to individuals who were in foster care at the age of 18 years. 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.

To ensure Medicaid enrollment of all eligible DCS foster children and youth, when a child is not IV-E eligible or looses IV-E eligibility for any reason, 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. 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. MEU intervenes if a child's eligibility has not been determined timely, there are questions, or there is negative result.

g. TRIBAL CONSULTATION REGARDING CFCIP:

1. DESCRIBE HOW EACH INDIAN TRIBE IN THE STATE HAS BEEN CONSULTED ABOUT THE PROGRAMS TO BE CARRIED OUT UNDER THE CFCIP.

The Pokagon Band of Potawatomi Indians (Pokagon Tribe) is Indiana's only federally-recognized tribe. When the Pokagon Tribe intervenes in an Indiana DCS case and assumes jurisdiction, they request that all IV-E benefits be terminated. The Pokagon Tribe provides income and services for the family and youth as part of their tribal benefits and does 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 Tribe is aware that Indiana DCS will assist them if this changes in the future and Indiana DCS continues to inform them of new benefits and programs during meetings.

2. DESCRIBE THE EFFORTS TO COORDINATE THE PROGRAMS WITH SUCH TRIBES.

As discussed above, the Pokagon Tribe does not wish to participate in IV-E programs or benefits.

3. DISCUSS HOW THE STATE ENSURES THAT BENEFITS AND SERVICES UNDER THE PROGRAMS ARE MADE AVAILABLE TO INDIAN CHILDREN IN THE STATE ON THE SAME BASIS AS TO OTHER CHILDREN IN THE STATE.

As discussed above, the Pokagon Tribe does not wish to participate in IV-E programs or benefits.

4. REPORT THE CFCIP BENEFITS AND SERVICES CURRENTLY AVAILABLE AND PROVIDED FOR INDIAN CHILDREN AND YOUTH IN FULFILLMENT OF THIS SECTION AND THE PURPOSES OF THE LAW.

As discussed above, the Pokagon Tribe does not wish to participate in IV-E programs or benefits.

5. DESCRIBE WHETHER AND HOW THE STATE HAS NEGOTIATED, IN GOOD FAITH, WITH ANY TRIBE THAT REQUESTED TO DEVELOP AN AGREEMENT TO ADMINISTER OR SUPERVISE THE CFCIP OR AN ETV PROGRAM WITH RESPECT TO ELIGIBLE INDIAN CHILDREN AND TO RECEIVE AN APPROPRIATE PORTION OF THE STATE'S ALLOTMENT FOR SUCH ADMINISTRATION OR SUPERVISION. DESCRIBE THE OUTCOME OF THAT NEGOTIATION.

As discussed above, the Pokagon Tribe does not wish to participate in IV-E programs or benefits.

Mr. Pompey and the Pokagon Band of Potawatomi Indians are not interested in becoming an IV-E Agency. Indiana DCS has an excellent working relationship with the tribe. The need for MOU's or agreements has been discussed, but has been determined to be unnecessary due to the excellent working relationship and minimal number of children involved.

F. EDUCATION AND TRAINING VOUCHER PROGRAM:

Collaboration and Program Support

DCS continues to administer the ETV program via the same dedicated vendor as last reporting period. The program eligibility requirements and supports have not changed.

Expansion of postsecondary education assistance program: Describe the specific accomplishments and progress to establish, expand, or strengthen the State's postsecondary educational assistance program to achieve the purpose of the ETV program.

Indiana has focused efforts on lending support to Connected by 25 to expand its work across the state. Post-secondary support is a component of Connected by 25's program model. This partnership has proved to be the most successful effort in this area thus far.

All 3CMs received specific training on how to assist youth in pursuing their post-secondary education/training goals. In addition, the DCS Educational Liaisons have held several trainings for multiple audiences on post-secondary education/training options for students.

How is ETV Administered: Indicate how the ETV program is administered, whether by the State child welfare agency in collaboration with another State agency or another contracted ETV provider, if changed.

The Indiana ETV program is administered by an outside vendor. Selection of this vendor was the result of a Request for Proposal that went through the Indiana IDOA process. Connected by 25 was the selected vendor for the state. The vendor is responsible for creating a funding matrix to fund ETV recipients, distributing funds, creating and maintaining a website for students to apply and submit application materials and for continued support of students.

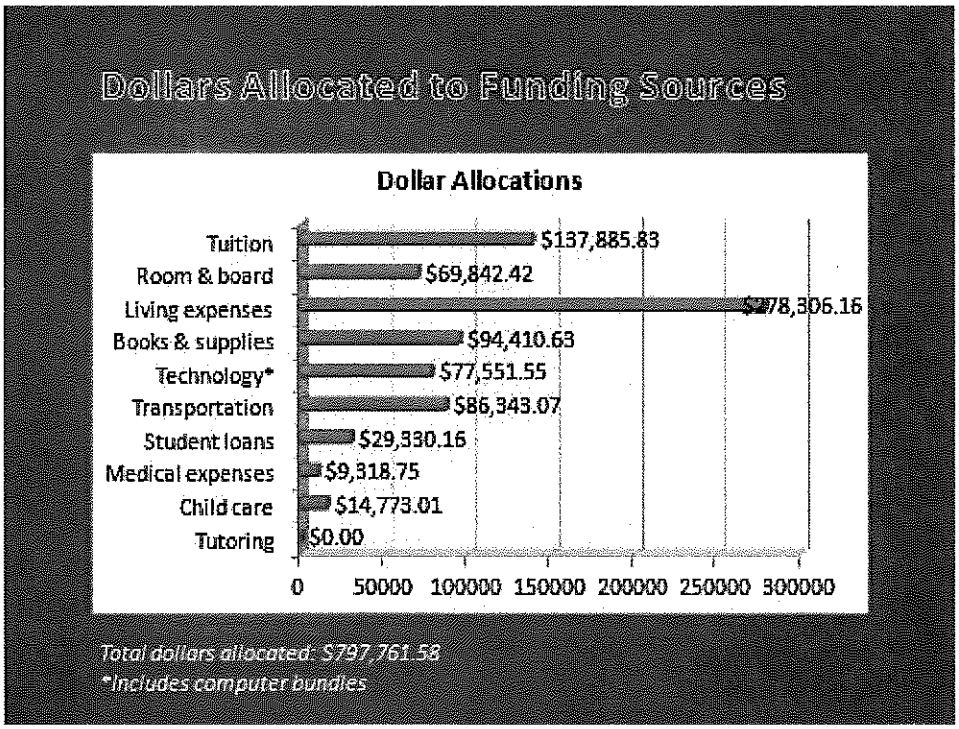
Eligible students can be awarded up to $5,000 per academic year and must initially apply before their 21st birthday. The funds may be renewed until the student's 23rd birthday as long as they were already receiving ETV and CONTINUE TO MEET THE QUALIFICATION REQUIREMENTS.

G. STATISTICAL AND SUPPORTING INFORMATION

1. EDUCATION AND TRAINING VOUCHERS:

Identify the number of youth who received ETV awards from July 1, 2011 through June 30, 2012 (the 2011-2012 School Year) and July 1, 2012 through June 30, 2013 (the 2012-2013 School Year). States may estimate a total if they do not have the total number for the 2012-2013 School Year.
Report the number of youth who were new voucher recipients in each of the school years. To facilitate more consistent reporting, please use Attachment E for a format to report information on the ETVs awarded.

In the 2011-2012 academic year, 421 students were funded by the ETV program across the state of Indiana and $797,761.58 was disbursed to those students. Below is a chart of the total number of expenses and the specific use of the funding by the students.



ETV Student Highlight

Crystal Prescott graduated from Purdue University in May 2012 with her Bachelors of Science in Film Studies. She originally planned to pursue veterinary science, but her love for movies, interest in production, and desire to travel and help others led Crystal to change her major. She is excited about the opportunities to produce documentaries and looks forward to a future special project involving foster care.

Crystal, a recipient of ETV funds said, "the extra funding through ETV puts your mind at ease and you don't have to work long hours for extra money. You can study, participate in other campus activities and enjoy the college experience. People underestimate the power of money. The lack of finances can deter you from applying at certain schools, especially the better universities and colleges."

She is quick to acknowledge that many people helped her to reach a personal goal-a college degree. "Make the better choice to be the exception and not the rule," Crystal said.

National Youth in Transition Database

Indiana is participating in the National Youth in Transition Database and successfully submitted the required reports/data for all report periods. In FFY 2011, Indiana had a total of 665 youth turn 17 while placed in a foster care setting. These youth were asked to complete their survey by their FCM or probation officer. Youth had the option of completing the survey by themselves or with another adult or trusted person. The youth could complete the survey through a web portal with a username and password that is randomly assigned to them; or, they could complete the survey by hand and mail the completed survey to Indiana's NYTD helpdesk. FFY 2013 marks the first report period in which the state is collecting outcome results for youth surveyed in 2010. The follow-up population consists of 232 youth whom were selected through random sample by the Administration for Children and Families (ACF).

The state exceeded all outcome requirement thresholds for the Cohort 1, 2013A report period. Results are pending for 2013B as the report period is ongoing as this report is being written.

To gather data regarding the served population, service providers are asked to submit a monthly report through a web portal for all youth who are over the age of 16 and received IL services from the agency submitting the report. At the time that the providers submit the report they are to select any data elements (as defined by the federal government) that describe the services that were provided to the youth in question.

Guidance and support for FCMs, probation officers and service providers are given via email, and by telephone. There is a DCS NYTD helpdesk email box and Indiana's NYTD and Special Projects Coordinator is available to answer emails and phone calls regarding the program.

The largest barrier that DCS has encountered in implementing NYTD is meeting the participation rate requirements for the out-of-care follow up population. Indiana was able to contact and invite all but 15 youth in the out-of-care follow-up population but most of these youth declined to participate. Due to the high number of youth that declined, Indiana was marked to receive a .5% penalty upon submission of the 2013A data in May of 2013, even though over 85% of the out-of-care follow up population was contacted and asked to participate.

In the future, Indiana hopes to build the NYTD program through the following actions:

- Increase engagement and training efforts regarding the NYTD reporting requirements statewide.
- Work towards improving the accuracy and consistency of the reporting process for the served population.
- Further engaging youth in the development and implementation of Indiana's NYTD program.

2. INTER-COUNTRY ADOPTIONS

Report the number of children who were adopted from other countries and who entered into State custody in FY 2012 as a result of the disruption of a placement for adoption or the dissolution of an adoption, the agencies who handled the placement or the adoption, the plans for the child, and the reasons for the disruption or dissolution. (See section 422(b)(12) of the Act.)

There have been no parental rights terminations of children adopted internationally since July 1, 2012.

3. CAPTA ANNUAL STATE DATA REPORT ITEMS

Information on Child Protective Service Workforce: Information on the education, qualifications and training requirements established by the State for child protective service professionals, including requirements for entry and advancement in the profession, including advancement to supervisory positions

FCM Minimum Qualifications: Bachelor's degree from an accredited college/university is required with 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.

FCM Supervisor Qualifications: 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. Also requires:

- 2 years full-time professional experience in the provision of education or social services to children and/or families. At least 1 year of the required experience must be in an administrative, managerial, or supervisory capacity.

  - or -

- Master's degree in Social Work from an accredited university/college. Substitution: Accredited graduate training in any one of the following areas may substitute for the required experience on a year for year basis: Child Development, Criminology, Criminal Justice, Education, Healthcare, Home Economics, Psychology, Guidance and Counseling, Social Work, or Sociology.

Local Office Director Qualifications:

- 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.

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.

- 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. Since 2006, 168 individuals have received IV-E supported BSW degrees with another 36 scheduled to begin their Senior Year August of 2012. From 2001 to May of 2013, 218 DCS staff has obtained Title IV-E supported MSW degrees with additional spots slated for the semester starting in the fall of 2013. 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. The Institute for newly hired FCMs is 12 weeks in length including 29 classroom days, 21 transfer of learning days and 10 on the job reinforcement days. Curriculum is based on established child welfare competencies. Please see the Updates to the Training Plan section for additional detail related to new worker training.
- Demographic Information of Current Staff and Recent Hires: Please see ATTACHMENT 15, 16, and 17, for information about the age, gender, race/ethnicity by position type for DCS workers.
- 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, DCS is required to ensure that FCM 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. This is referred to as 12/17. 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. In general, DCS has experienced an increase in child abuse and neglect reports made statewide. This trend resulted in an overall increase in caseload numbers in regions throughout the state. Periodic shifts in caseloads and turnover also impact 12/17. As of the end of April 2013, only 3 of 18 DCS's Regions were in compliance with the caseload averages of 12 and 17. During state fiscal year 2012, there were two key factors that resulted in our inability to effectively staff to 12 and 17. DCS continued to experience increased assessments since rollout our centralized Hotline. Last year also proved challenging with respect to staffing as agency turnover trended upwards throughout the year. To address agency concerns over the increase in cases, the agency requested and received approval for the creation of 120 additional FCM positions. Moreover, the agency focused recruitment efforts on a broader array of strategies to increase the pool of viable candidates for FCM positions. This effort has proven effective, as the agency has hired more than 250 new FCMs since January 1st of this year. Additionally, the agency has identified strategies to improve employee retention in an effort to curb FCM turnover. One of the strategies, increased compensation, appears to have made an initial impact, as negative turnover has steadily declined over the last 6 months from 20.6% in November 2012 to 17.9% as of May 31, 2013.

Juvenile Justice Transfers: Report the number of children under the care of the State child protection system who were transferred into the custody of the State juvenile justice system in Federal FY 2012 (specify if another time period is used). Provide contextual information about the source of this information and how the State defines the reporting population (section 106(d) (14) of CAPTA).

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/2493.htm. Below is the data for 2011 juvenile justice transfers. This specific report can be found at http://www.in.gov/judiciary/admin/files/rpts-prob-2011-probation3-juvenile.pdf. The 2012 juvenile justice transfer data is not yet available.

2011

Indiana Probation Report

Juvenile Probation

4. MONTHLY CASEWORKER VISIT DATA

The Federal Monthly Caseworker Visits report reflects timely monthly contacts (based upon the federal definition for timely contacts). For purposes of this report, if a placement ends because a child runs away, DCS continues to count the child until case status type is closed or a subsequent placement ends. Information from the 2012 Report and the October 1, 2012 to May, 2013 reports are included below.

FFY 2011/2012 Monthly Caseworker Visits Report (Oct 1, 2011 to September 30, 2012)							
	Children with Contacts				Children w/ Contacts in Home Setting		
Month	Contacted Children	Total Children	Percent		Contacted Children	Total Children	Percent
October 2011	8133	8411	96.69%		6891	8411	81.93%
November 2011	8055	8345	96.52%		6783	8345	81.28%
December 2011	7831	8107	96.60%		6679	8107	82.39%
January 2012	7381	7624	96.81%		6216	7624	81.53%
February 2012	7461	7774	95.97%		6225	7774	80.07%
March 2012	7597	7953	95.52%		6395	7953	80.41%
April 2012	7813	8194	95.35%		6518	8194	79.55%
May 2012	7906	8286	95.41%		6618	8286	79.87%
June 2012	7883	8214	95.97%		6860	8214	83.52%
July 2012	6637	8121	81.73%		5707	8121	70.27%
August 2012	6730	8187	82.20%		5639	8187	68.88%
September 2012	7410	8583	86.33%		6050	8583	70.49%
Average for FFY 2011/2012	**90837**	**97799**	**92.88%**		**76581**	**97799**	**78.30%**

FFY 2012/2013 Monthly Caseworker Visits Report (Oct 1, 2012 to September 30, 2013)							
	Children with Contacts				Children w/ Contacts in Home Setting		
Month	Contacted Children	Total Children	Percent		Contacted Children	Total Children	Percent
October 2012	7762	8803	88.17%		6498	8803	73.82%
November 2012	7929	9098	87.15%		6314	9098	69.40%
December 2012	8242	9027	91.30%		6792	9027	75.24%
January 2013	8145	8582	94.91%		6751	8582	78.66%
February 2013	8394	8935	93.95%		6897	8935	77.19%
March 2013	8529	9060	94.14%		7177	9060	79.22%
April 2013	8712	9278	93.90%		7113	9278	76.67%
May 2013	8441	9149	92.26%		6865	9149	75.04%
June 2013							
July 2013							
August 2013							
September 2013							
Average YTD FFY 2012/2013	**66154**	**71932**	**91.97%**		**54407**	**71932**	**75.64%**

H. FINANCIAL INFORMATION

See Attachments 18-23

I. ATTACHMENTS

1. DCS Training Institute
2. Child Welfare Training and Cost Allocation Methods
3. Essential Learning Course Names and Descriptions
4. Indiana Health Care Oversight and Coordination and Services Plan
   A. Indiana Psychotropic Medication Advisor Committee (IPMAC) Membership List
   B. MOU between DCS and FSSA Office of Medicaid Policy and Planning (OMPP)
   C. Riley PEDS Contract
5. 2012 Lake County Foster Care Citizen Review Panel Annual Report
6. 2012 Marion County Foster Care Citizen Review Panel Annual Report
7. 2012 Wayne County Foster Care Citizen Review Panel Annual Report
8. DCS 2012 Response to Lake County CRP Report
9. DCS 2012 Response to Marion County CRP Report
10. DCS 2012 Response to Wayne County CRP Report
11. 2013 Lake County Foster Care Citizen Review Panel Annual Report
12. 2013 Marion County Foster Care Citizen Review Panel Annual Report
13. 2013 Wayne County Foster Care Citizen Review Panel Annual Report
14. IAITMH: A Path to Professional Endorsement
15. Information on CPS Workforce
16. CPS Demographics – Age
17. 2013 Affirmative Action Plan - Job Group Analysis
18. CFS-101 Part I: Annual Budget Request FY 2014
19. CFS-101 Part I: Annual Budget Request FY 2013 Revised
20. CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services
21. CFS-101 Part III: Annual Expenditures FY 2011 for Title IV-B, Subparts 1 and 2, CFCIP and ETV
22. CFS-101 Part I: Annual Budget Request FY 2012 Revised
23. Section G
24. Training Financial Report with ER Added Allocation and Costs
25. APSR ETV Report
26. Children Under 5 Report

ATTACHMENTS

Training Overview
THE INSTITUTE
(Training for newly hired FCMs)

"The Institute" is 12 weeks in length, includes 29 classroom days, 21 transfer of learning days, and 10 on the job reinforcement days. A summary of this program is as follows:

Total 60 days – 12 weeks
29 Classroom, 21 County Based Transfer of Learning Days, &
10 County Based On the Job Reinforcement Days

Module I: Orientation and Introduction to Child Welfare: 19 days – 9 Classroom & 10 Local Office

- 1 Day – **Orientation in Central Office-HR presentation** (ID, Finger Printing, Swearing-in, info on location of training, parking, etc.)
- 2 Days – **Getting to Know DCS** (introduction to agency mission and values, agency structure, position roles and responsibilities, and essential processes at DCS)
- 1 Day – **Introduction to Laptop & MaGIK** (laptop distribution and set–up, introduction to MaGIK, and on-line policy manual)
- 1 Day – **Transfer of Learning: DCS Hotline** (Overview of functions and responsibilities of the DCS Hotline)
- 5 Days – **Orientation in County Office & Transfer of Learning in County Office** (Introduction to field office supervisor, director, and FCMs, completion of initial new hire paperwork, etc.)
- 2 Days – **Culture & Diversity** (cultural learning continuum, self-assessment, and norms, as well as cultural aspects of Indiana and working with diverse families throughout state)
- 1 Day – **Legal Overview** (introduction to legal aspects of the job)
- 2 Days – **Worker Safety** (introduction to risk management & safety awareness, cycle of escalation, universal precautions, substance identification, and car seat installation)
- 4 Days – **Transfer of Learning in County Office**

Module II: Assessing for Safety: 15 days – 9 Classroom & 6 Local Office

- 2 Days – **Engagement** (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.)
- 2 Days – **Teaming** (introduction to the child and family team meeting process, preparation of parents, identification of team members, discussion of formal and informal supports, etc.)
- 1 Day – **Transfer of Learning in County Office**
- 5 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)
- 5 Days – **Transfer of Learning in County Office**

Module III: Planning for Stability and Permanency: 10 days – 5 Classroom & 5 Local Office

- 3 Days – **Case Planning & Intervening** (introduces participants 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.)
- 2 Days – **Legal Roles & Responsibilities** (introduces the FCM to the legal roles and responsibilities of the position including knowledge of CHINS statutes, timelines, legal reports, etc.)
- 5 Day – **Transfer of Learning in County Office**

Module IV: Tracking and Monitoring Well–Being: 16 days – 6 Classroom & 10 Local Office

- 1 Days – **Introduction to MaGIK** (introduces the FCM to the states child welfare data management system and 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)
- 2 Days – **Effects of Abuse, Neglect, and Separation on Child Development** (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)
- 1 Day – **Permanency Planning Outcomes for Children & Families** (introduces participants to permanency options & programs, importance of achieving permanency, ways to assess & ensure permanency within legal timeframes)
- 1 Day – **Time Management** (introduces importance of time management, planning, prioritizing, and maintaining a positive work / life balance)
- 10 Days – **On the Job Skill Reinforcement in County Office**
- 1 Day – **Cohort Graduation** (half the day is spent on posttest, collection of training feedback, and recommendations, other half is focused on graduation ceremony)
- ceremony)

Child Welfare Training and Cost Allocation Methods

I. IV-E Eligible (with IV-E at 75% rate).

Any courses or trainings developed by DCS Staff Development or contractor and offered to DCS staff related to the following topics are eligible to IV-E without applying a penetration rate, with a 75% match rate. Related IV-E indirect costs are at 50% rate. Appropriate documentation to support the level of effort for curriculum development, preparation and training presentation is maintained.

- IV-E Eligibility Training
- IV-E Rate Setting
- Other course meeting 45 CFR 1356.60 criteria and only relate to IV-E

II. Child Welfare (Apply Combined Eligibility Ratio with IV-E portion at 75% rate)

Any courses or training developed and taught by DCS Staff Development or contractor related to the following topics are allocated to IV-E using the combined foster care and adoption eligibility ratio with IV-E portion at 75% rate. Related IV-E indirect costs are at 50% rate. Appropriate documentation to support the level of effort for curriculum development, preparation and training presentation is maintained.

Initial In-Service Training Program for new or reassigned employees:

Module I: Orientation and Introduction to Child Welfare	19 days
Module II: Assessing for Safety	15 days
Module III: Planning for Stability and Permanency	10 days
Module IV: Tracking and Monitoring Well-Being	16 days

Courses for experienced workers:

- Peer Coach Training 4 – 6 weeks
- Field Mentor Skill Assessment Training 1 day
- Legal Training Including Court Testimony ½ day
- Making Visits Matter 2 days
- Concurrent Case Planning ½ day
- Facilitation for Child and Family Team Meetings 2 – 4 weeks
- Introduction to Developmental Disabilities 1 day
- Adoption Services 1.5 days
- Positive Youth Development 1 day
- The Role of Foster Parent Specialists 2 days
- Casey Foster Family Assessments Training 1 day
- Engaging and Working with Challenging Clients 1 day
- Engaging Parents with Mental Illnesses 1 day
- Advanced Disabilities 1 day
- Service Standards – What are They and How do I Use Them? 1 day
- Advanced Domestic Violence: Critical Dynamics in Child Welfare 1 day

- Working with Clients Challenges with Substance Use Disorders — 1 day
- Homebuilders Training For DCS Staff: An Overview — ½ day
- Effective and Appropriate Customer Service — ½ day
- Introduction to the Attachment Continuum — 1 day
- Teaming in the First 30 Days — 1 day
- Trauma Informed Care — 1 day
- Protective Factors — ½ day
- Advanced Cultural Competence — 1 day
- MaGIK Power User Training — 1 day
- MaGIK Training — 1 day
- Licensing Foster Parents — 1 day
- DV: Facilitating a CFTM when Domestic Violence is present — 1 day
- Time Management — ½ day

MSW Program for selected DCS employees

BSW Program designed for identifying future DCS employees

Resource and Adoptive Parent Training (RAPT) Topics include:

- RAPT I – Introduction to DCS — 3 hours
- RAPT II – Effects of Abuse & Neglect of Child Development — 4 hours
- RAPT III – Overview of Attachment, Discipline and Effects of Care-giving on the Family — 3 hours
- RAPT IV – Adoption — 6 hours
- Educational Advocacy for Resource Parents — 2 hours
- Understanding the CFTM Process — 4 hours
- Understanding Sexual Abuse for Resource Parents — 3 hours
- Understanding Children who Have Attachment Challenges — 4 hours
- The Nuts and Bolts of Resource Parenting — 2 hours
- Fostering Older Youth — 6 hours
- Cultural Competence Series:
  - Race/Ethnicity Discussions — 1 day
  - The Culture of Poverty — 1 day
  - The Culture of Substance Abuse — 1 day
  - The Culture of Power — 1 day

III. Child Welfare Administration (Apply Combined Eligibility Ratio with IV-E portion at 50%)

Any courses or training developed and taught related to the following topics are allocated to IV-E using the combined foster care and adoption eligibility ratio with IV-E portion at 50% rate. Appropriate documentation to support the level of effort for curriculum development, preparation and training presentation is maintained.

Courses for experienced workers:

- Advanced Fatherhood Training — 1 day
- Boot Camp of Trainers and Those Who Present — 3 days
- Forensic Interviewing Techniques — 3 days
- Advanced Worker Safety — ½ day
- Secondary Trauma and Work/Life Balance — 1 day

Courses for Supervisors:

- Supervisor Training Program
  - Module I: Orientation — 2 days
  - Module II: Administration — 3 days
  - Module III: Personnel and Technical — 3 days
  - Module IV: Educational Supervision — 3 days
  - Module V: Supportive Supervision — 3 days
- Coaching For Successful Practice — 2 days
- Management Trainings for Executive Staff and Local Office Directors: Leadership From Within — 4 days
- Annual Workshop For Supervisors — 2 days
- Annual Workshop for Local Office Directors — 2 days
- Supervisor Mentor Training — 1 day
- Leadership Academy for Supervisors — 7 days
- Quarterly Supervisor Workbook Series — ½ day

IV. P.L. 110-351 Training for DCS partners (Apply Combined Eligibility Ratio with IV-E portion at designated rate starting at 55% and going to 75% with indirect at 50%)

Any courses or training developed and taught for DCS partners are allocated to IV-E using the combined foster care and adoption eligibility ratio with IV-E portion at designated rate in law. Appropriate documentation to support the level of effort for curriculum development, preparation, and training presentation is maintained.

- Court Appointed Special Advocate/Guardian Ad Litem Training — ½ day
- Training with Indiana Judicial Center — 1 day
- Homebuilders: Core Curriculum — 4 days
- Homebuilders: Client Documentation (Assessment, Goal Setting Service Planning and Service Summary — 1 day
- Homebuilders: Motivational Interviewing — 2 days
- Homebuilders: Implementing Cognitive and Behavioral Interventions — 2 days
- Homebuilders: Teaching Skills to Families — 1 day
- Homebuilders: Supervisor/Manager Training — 3 days
- Other contracted service provider/stakeholder trainings to be developed

V. Computer Assisted Training (CAT)

CAT courses are developed for DCS staff training to convey information to assist in providing effective services. As a new course is added, development and implementation costs are allocated by an appropriate allocation methodology. Documentation to support the level of effort for curriculum development, preparation and training presentation is maintained. Examples of allocation methodologies for SFY 2010/2011 CAT courses developed, disseminated and maintained include:

- Combined foster care and adoption eligibility ratio with IV-E portion at 75% rate
  - GenoPro
- IV-B
  - PEDS Module 1 – Physical Injuries in Infants
  - PEDS Module 2 – Abusive Head Trauma
  - PEDS Module 3 – Pediatric Evaluation and Diagnostic Services Overview

Several additional courses were developed during SFY2011 and continue to be offered.

Release Date	Due Date	Title
4/18/2011	4/29/2011	Safety, Risk, Reunification, and Strengths and Needs Assessments
2/6/2011	Ongoing	Field Mentor TOL Module
2/1/2011	2/14/2011	Educational Advocacy for FCMs Module 1 - General Education
2/1/2011	2/25/2011	Educational Advocacy for FCMs Module 2 - Special Education
1/3/2011	1/31/2011	Safe Sleep Practices and Reducing the Risk of SIDS
7/26/2010	8/13/2010	DCS Disaster Plan
7/12/2010	7/23/2010	DCS Code of Conduct

Computer Assisted Trainings and Webinars developed in FY2012 include::

5/3/2012	Ongoing	Supervisor Mentor for New Supervisors Manual
11/28/2011	12/15/2011	DCS Rate Changes Information and Procedures
10/11/2011	12/15/2011	Field Operations My Share Reports

Computer Assisted Trainings and Webinars developed in FY 2013 include:

TBD	TBD	Personal and Clothing Allowances CAT
7/31/2012	Ongoing	Training on DCS Guidelines for using Psychological Testing
7/31/2012	Ongoing	Overview of Practice Model for Non-Field Staff CAT
1/7/2013	2/1/2013	DCS Abuse and Neglect Hotline CAT

VI. Online Webinars Developed/Presented in SFY12

- Provider Referral Form (Wizard) Training
- Individual Child Placement Referral & DCS Rate Changes
- Leadership Academy for Supervisors
  - Module 1 – Introductory
  - Module 3 – Leading in Context
  - Module 4 – Leading People
    - Module 5 – Leading for Results
  - Permanency Roundtable Scribe Training

VII. NE (Not Eligible for IV-E Reimbursement, Eligible for other Program funding (such as IV-B, SSBG, TANF, XIX or State)

Courses may be developed that pertain to non-IV-E eligible activities.

Footnote:

Day = 7.5 hours for initial training for new workers
Day = 6.0 hours for all other training
½ Day = 3.0 hours for all other training

CHILD WELFARE TRAINING COURSE DESCRIPTIONS

INITIAL IN-SERVICE TRAINING PROGRAM:

This 60 day program for new or reassigned employees is described by Module and day in the Training section of the Plan. The program covers 12 weeks with 29 classroom days, 21 county based transfer of learning days, and 10 county based on the job reinforcement days. The Modules are Orientation and Introduction to Child Welfare, Assessing for Safety, Planning for Stability and Permanency and Tracking and Monitoring Well-Being.

PEER COACH TRAINING

This course prepares a staff member to be a Peer Coach through a one on one learning experience. A Peer Coach Consultant (staff member) models the development of Family Case Managers (FCMs) by demonstrating this facilitation process with another FCM. The worker who is being trained as a Peer Coach will be coached in the areas of preparing the Family for and conducting a Child and Family Team Meeting. After training the FCM will be able to coach another worker and also provide written and verbal feedback. The Peer Coach Training is a 4 to 6 week process.

FIELD MENTOR SKILL ASSESSMENT TRAINING

This training prepares experienced FCMs to work with staff participating in new worker training to assess the development of the worker as he/she journeys through the classroom, Transfer of Learning and on-the-job training experience. Field mentors are taught how to interact with the new worker and how to document the new worker's progress.

LEGAL TRAINING

This course covers the general legal process, the use of court forms and appropriate preparation for testifying in court. Updates on legislative changes impacting court proceedings and forms will be covered.

MAKING VISITS MATTER

This course focuses on the critical role of the FCM visits and the relationship visits have in improving the safety of children and supporting the effective case planning and assessment process. It will assist workers on tracking and adjusting case plan, as necessary, and will provide a high level of engagement and interviewing skills to be used while in the field. This class is provided for a staff member who has 6 or more months of field experience.

CONCURRENT CASE PLANNING

This class provides information regarding the use of concurrent case planning with Indiana's practice model. Specific attention is given to discussing the concurrent plan with parents and foster parents.

FACILITATION FOR CHILD AND FAMILY TEAM MEETINGS

This process is a one on one learning experience where a staff member works with a peer coach on the facilitation of Child and Family Team meetings. A peer coach models a Preparation Meeting and Child and Family Team Meeting for the staff member. After this process a Peer Coach observes the staff member demonstrate the preparation meeting and Child and Family

Team Meeting. During this process the Peer Coach provides coaching and feedback to the staff member. This process takes approximate 2 to 4 weeks.

ADVANCED FATHERHOOD TRAINING
This course provides a manual on skill-building for practitioners and is based on a three-year research project on engaging and involving fathers in their children's lives. Specific examples are provided on how to engage fathers. Information is provided for administrators including recommended agency policies and competency levels for engaging fathers.

BOOT CAMP OF TRAINERS & THOSE WHO PRESENT
This course focuses on platform skills, preparation of materials and use of training equipment. Intensive, hands on practice is provided and each student will present to the group.

FORENSIC INTERVIEWING TECHNIQUES
This class introduces those workers who want to learn more about forensic interviewing to the Step Wise model. Research information will be reviewed in the classroom and resources will be provided to participants. Workers will be given the opportunity to view videos of interviews for discussion. Legal implications for forensic interviewing will be addressed by an attorney. Workers will be provided with opportunities to share information.

SUPERVISOR TRAINING PROGRAM
This 14 day program for new DCS Supervisors has the following five (5) modules:

MODULE I: Orientation
This course provides new supervisors with an orientation to DCS and field work in the Practice Model. Administrative leadership specific to Indiana is covered as well as an introduction to the concepts of Servant Leadership.

MODULE II: Administrative Supervision
In this course participants will review the importance of communicating the agency mission, vision and philosophy while furthering development of an awareness of their own attitudes, needs and behaviors and their effect on relationships within the agency. The new supervisor will practice applying organizational and management approaches and philosophies to self and agency for maximum effectiveness. The learner will understand how to successfully transition from peer to supervisor and how to creatively and effectively advocate for clients and staff within and outside the agency. Participants will apply a system for ensuring accountability to stakeholders for agency performance and appropriately use data for decision-making and planning to ensure the proper focus on outcomes.

MODULE III: Personnel and Technical
This course introduces the new supervisor to personnel requirements and supervisor computer tracking obligations.

MODULE IV: Educational Supervision
In this course participants will develop the ability to convey the following:

- Understanding and valuing diversity and different styles of perceiving, learning, communicating and operating

- Knowing the components of the state's training program for new FCMs
- Understanding the value of a developmental approach to supervision and adapting supervision style to the worker stage of development
- Knowing how to improve the transfer of learning from the classroom to the field
- Understanding the value and components of a mentoring program
- Knowing, showing and teaching necessary elements of statutes, rules, policies, assessment, decision making, case planning and outcomes
- Understanding and explaining the outcomes of safety, permanency and well-being
- Providing constructive feedback
- Applying coaching techniques to supervision situations
- Knowing and recognizing when an FCM's emotional responses and/or judgment interfere with the casework process and can empower the FCM to identify and examine these issues
- Understanding the value and components of proactive, structured supervision

MODULE V: Supportive Supervision

In this course new supervisors will be introduced to the value of supportive supervision and how to motivate staff. They will be taught how to recognize secondary trauma in self and others and how to implement strategies to address the issues. They will be taught how to recognize burnout and utilize interventions. They will be able to assess and improve team functioning and to identity and facilitate successful resolution of conflict. Participants will apply strategies to increase the job satisfaction of workers and to improve retention.

SUPERVISOR MENTOR TRAINING

Experienced Supervisors are paired with newly appointed Supervisors and are provided the guidance to mentor and document their progress.

COACHING FOR SUCCESSFUL PRACTICE

This course is for supervisors to explore their role within the Indiana Department of Child Services. The workers will be able to identify and emphasize key outcomes in Child Welfare which shape supervisor guidance for staff. During the course supervisors will use cases to show how to apply the Performance Leadership Cycle in each phase of the TEAPI (Teaming, Engaging, Assessing, Planning and Intervening) practice model to improve engagement and outcomes for children and families and ensure that permanency of children is met in a timely manner. Staff will be able to analyze reports and assessments to ensure that plans developed for a family are addressing underlying needs and family dynamics.

QUARTERLY SUPERVISOR WORKSHOP SERIES

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.

ANNUAL WORKSHOP FOR SUPERVISORS

This workshop held in June for all DCS Supervisors of each year will cover topics identified by a State Supervisor Committee and include things such as Concurrent Planning, data on Safely Home, Families First, the Child and Family Team Meeting Training Video and a Breakthrough Series Collaborative Initiative.

ANNUAL WORKSHOP FOR LOCAL OFFICE DIRECTORS

Workshop held in the winter of each year for all Local Office Directors will cover several topics identified by a committee of Local Office Directors. Topics include Domestic Violence, Developmental Disabilities, Finance, Human Resources, Data Review and Understanding and the Statewide Abuse and Neglect Hotline.

LEADERSHIP ACADEMY FOR SUPERVISORS

Indiana has been closely worked 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.

CHILD & ADOLESCENT NEEDS & STRENGTHS (CANS) Super User Booster

All CANS Certified FCM Supervisors must attend an annual Booster session to keep their certification current. Updated policy and best practice are reviewed.

CHILD & ADOLESCENT NEEDS & STRENGTHS (CANS) Super User 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.

HOMEBUILDERS: Core Curriculum (4 Days) and Client Documentation (1 Day)

This workshop is designed to introduce participants to the program philosophy, program structure and the treatment practice that are fundamental to delivering high quality Homebuilders Family Preservation and Reunification services. Includes focus on safety planning, structuring for safety, engagement skills, use of cognitive/behavioral interventions, teaching skills to families, and skills practice of the key strategies and intervention skills. Includes methods for documentation of all of the above.

HOMEBUILDERS: Implementing Cognitive and Behavioral Interventions and Teaching Skills to Families

This workshop provides more in depth instruction and practice of key cognitive and behavioral intervention strategies. The goal of the training is to help practitioners develop individually tailored and effective cognitive and behavioral interventions that go beyond behavior and chore charts. Participants will practice using Rational Emotive Behavioral Therapy (REBT), reframing and other cognitive strategies and learn to identify common cognitive distortions and how to address these in their work with families. Behavioral strategies addressed and practices during the workshop include conducting a Functional Behavioral Analysis and developing interventions based on the analysis. Participants will learn to use Positive Behavior Support strategies and to develop both antecedent and consequence based interventions. Participants will learn and practice using the teaching interaction" to role play and practice a number of skills to teach parents and children (e.g. praise, following instructions etc).

HOMEBUILDERS: Motivational Interviewing

This workshop introduces the strategies of Motivational Interviewing, based on the internationally recognized work on Dr. William Miller. Originally developed to motivate clients with addictive behaviors, Motivational Interviewing has been effective in facilitating many other types of behavior change, including non-compliance and running away of teens and discipline practices of parents. Motivational Interviewing is a directive, client-centered counseling approach to help clients/families clarify and resolve their ambivalence about change. Using Prochaska and DiClemente's Six Stages of Change as a framework, Motivational Interviewing identifies strategies for practitioners including related tasks for the clients within each stage of change to minimize and overcome resistance.

HOMEBUILDERS: Supervisor/Manager Training

This course is designed for a broad range of supervisors and managers and focuses on the primary roles of the supervisor in implementing processes for providing ongoing feedback to staff, improving staff performance and strategies for handling and solving employee work problems and for facilitating and improving team coordination and performance. Participants will receive the "S3", a computerized staff satisfaction tool for providing feedback to supervisors and managers.

HOMEBUILDERS: ODM TRAINING

This course is a one day training on the Homebuilders Online Data Management System. Showing users how to log in and enter required data for Homebuilders referrals, it also showed users how to pull reports on cases served by their agency.

HOMEBUILDERS: TEACHING SKILLS TO FAMILIES

This workshop will focus on the key strategies of teaching skills to family members, which will focus on achieving the behavioral and other changes that need to occur to decrease risk and strengthen and increase family stability and functioning. Through demonstration and practice and feedback, training participants will learn and practice a number of effective parenting skills and a direct teaching strategy.

MANAGEMENT TRAINING FOR EXECUTIVE STAFF & LOCAL OFFICE DIRECTORS: LEADERSHIP FROM WITHIN

This series of workshops emphasizes the link between personal and organizational transformation by introducing leadership concepts and anchoring them in an ongoing, real-life task. The mini sessions bring groups together for discussion and sharing. This checking in at intervals maintains the momentum of agency's vital work.

SECONDARY TRAUMA AND WORK/LIFE BALANCE

This is a one day training that addresses the effects of secondary trauma and time management on job related stress. Participants will learn to recognize risk factors for child welfare workers in experiencing secondary trauma and develop strategies to build resilience. Participants will develop time management skills including effective decision making, planning, goal-setting and organization.

CASEY FOSTER FAMILY ASSESSMENTS TRAINING

This is a one day training to assist the Foster Parent Specialists to learn about the Casey Suite of Assessment tools including the Casey Foster Assessment Inventory and the Casey Home Assessment Protocol. These tools can help identify strengths of potential foster parents as well as provide information about additional supports foster parents may need to successfully manage children placed in their home.

Court Appointed Special Advocate/Guardian Ad Litem Training

DCS partnered with the state CASA/GAL programs and presented information at their annual conference on current DCS initiatives, policy and legislative changes as well as best practice in the area of child welfare.

TRAINING WITH INDIANA JUDICIAL CENTER

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

PERMANENCY PLANNING

This is a one day training designed to address permanency at each stage of a child welfare case. Permanency options are reviewed together with a review of permanency programs and transitional planning. Special emphasis is placed on judicial review of permanency options.

INTRODUCTION TO DEVELOPMENTAL DISABILITIES

This one day workshop provides an overview of developmental disabilities as they may affect parenting capacity; as well as an outline of how to complete a functional assessment related to child safety, well-being and permanency. Additional information is provided regarding services available to address identified needs.

ADOPTION SERVICES

This one and a half day workshop includes topics such as: Preparing children for adoption, a short overview of Reactive Attachment Disorder (RAD), AAP eligibility, and Post-adoption services available.

POSITIVE YOUTH DEVELOPMENT

This one day workshop reviews programs available for youth transitioning out of the child welfare system into independent living programs when Alternative Permanent Planned Living Arrangement (APPLA) is the permanency plan. It includes information on the Educational Training Voucher Program, the Chaffee Program and other resources available within the community.

LICENSING FOSTER PARENTS

This training covers all aspects of the licensing and re-licensing process for foster parents for regional foster care specialists (regionally based staff). It also includes the review of policy, procedure, completion of necessary forms and entry into the Indiana Child Welfares Information System.

THE ROLE OF FOSTER CARE SPECIALISTS

This two day training provides specific information to those FCMs who have been identified as Regional Foster Care Specialists. They learn the value of targeted foster parent recruitment, facilitating foster parent support groups, licensing regulations and expectations for documentation of an effective home study.

ENGAGING AND WORKING WITH CHALLENGING CLIENTS

This one day advanced course introduces theoretical frameworks and practice strategies for working with involuntary and mandated clients. This includes examination and analysis of power differentials between a client and Family Case Manager as well as the nature and dynamics of reactance. The training also provides participants the opportunity to develop knowledge and skills around self-presentation, role clarification, understanding the change process, and confronting involuntary populations in the context of Indiana's Practice Model.

ENGAGING PARENTS WITH MENTAL ILLNESSES

This one day advanced course shares techniques on how to use the DCS core conditions of professionalism, empathy, respect and genuineness as well as engagement skills when working with parents who have various mental illnesses.

ADVANCED DISABILITIES

This one day training is the follow-up course to the Introduction to Developmental Disabilities. Participants will learn about additional disabilities as well as methods to serve this population.

SERVICE STANDARDS – WHAT ARE THEY AND HOW TO I USE THEM?

This one day advanced course shares the specific techniques on how FCMs access family specific services based on identified needs from the CFTM. The FCMs will learn more about the service standards such as how they're developed, where they are located and how more can be developed once service gaps are identified.

DOMESTIC VIOLENCE: FACILITATING A CFTM WHEN DV IS PRESENT

Domestic Violence is a complex issue. In this 1-day training, participants will look at the dynamics of domestic violence and the impact it has on the Child and Family Team Meeting, and they will learn how to determine when to hold a CFTM with both the alleged DV offender and non-offending parent, how to effectively prepare all members of a CFT, facilitate a CFTM, and follow-up afterwards to ensure the safety of the children and DV survivor. Prerequisites: Recommended for trained facilitators of the Child and Family Team Meeting with a minimum of 3 months of facilitation experience.

TIME MANAGEMENT

A 1/2 day course designed to identify the participant's personal style for managing priorities as well as time management pitfalls and how to avoid them. Participants will learn the value of setting daily, weekly, and monthly goals, and they will develop time management skills that include effective decision making, planning, goal setting, and organization. Required Materials: Laptop

ADVANCED DOMESTIC VIOLENCE: CRITICAL DYNAMICS IN CHILD WELFARE

This one day advanced course is the follow-up course to the CFTM with DV is Identified in a Family. Participants will learn more about the Cycle of Violence and the Culture of Power.

WORKING WITH CLIENTS CHALLENGED WITH SUBSTANCE USE DISORDERS

This one day advanced course explains the variety of challenges FCMs might encounter with families who have substance abuse disorders. They will also learn of the most effective services to support these families are they continue to have a eye towards child safety, permanency and well-being.

HOMEBUILDERS: AN OVERVIEW FOR DCS STAFF

This session will introduce child welfare staff to the program philosophy, structure and treatment process for Intensive Family Preservation. It will include a history of the program, the program model, the service standards and the target population.

EFFECTIVE AND APPROPRIATE CUSTOMER SERVICE

This session will focus on providing practical information for all child welfare staff who interact with the public to include dealing with angry or upset individuals, maintaining self-care, and responding to difficult situations.

INTRODUCTION TO THE ATTACHMENT CONTINUUM

This course provides a one day overview of attachment theory and concepts in how to meet the challenge of caring for a child with attachment challenges. Participants will learn how the development of the brain may be affected by trauma, which disrupts the healthy attachment process. Participants will also learn that, by meeting the needs of the child, the brain and attachment process may be healed.

TEAMING IN THE FIRST 30 DAYS

This course provides a one day overview of teaming in the first 30 days of an assessment. Participants will discuss how teaming within the first 30 days is essential to a family-centered model of practice, and how introducing families to the teaming process early in their child welfare involvement, can positively impact the future of a case. In addition, participants will learn how to utilize these initial Child and Family Team Meetings (CFTMs) to critically analyze child safety, placement, and visitation. Furthermore, participants will learn how to prepare for and facilitate a CFTM at several critical junctures common to the first 30 days of an assessment.

ADVANCED CULTURAL COMPETENCE

Participants will examine what is meant by culture, cultural sensitivity, awareness, and competence. They will become aware of one's personal cultural lens and recognize its impact when working with diverse groups in child welfare. Participants will become familiar with practice recommendations to incorporate cultural understanding into child welfare work. Participants will explore concepts related to human diversity including bias, stereotyping, prejudice, and cycle of oppression.

ADVANCED WORKER SAFETY

Participants will recognize the potential dangerous situations workers may encounter in the field or at their local office. They will use preparation as a strategy for minimizing risk. Participants will recognize signs a client's behavior is escalating and use verbal de-escalation techniques to reduce tension, and they will recall the use of universal precautions to control the spread of infection.

PROTECTIVE FACTORS

Participants will learn how to identify a family's protective factors and consider the agency's goal of Safely Home Families First when working with families. Training for experienced FCMs when looking at the strengths a family has as it relates to their challenges. The course provides real life scenarios to encourage participants to "think outside the box" in ways to adhere to the agency directive - keeping children "Safely Home and Families First."

TRAUMA INFORMED CARE

Participants will learn to see families through a lens of trauma. This will inform the services and supports that are put in place to empower the family. Participants will learn how to reframe negative behavior with a view towards coping with trauma.

MaGIK POWER USER TRAINING
Selected DCS staff participate in intense two day training on the new case management system MaGIK in an interactive, hands-on training. Power Users will be the staff in the local offices to respond to questions once the system is active.

MaGIK TRAINING
All DCS field staff learn the fundamentals of the new case management system MaGIK in an interactive, hands-on training.

Resource Adoptive Parent Training (RAPT) Courses

RAPT I – INTRODUCTION TO DCS
This three hour course provides an introduction for resource parents to the child welfare system, permamency goals, the DCS mission, vision and values, and the steps of the licensing process.

RAPT II – EFFECTS OF ABUSE AND NEGLECT
This four hour course is the in-person alternative to the four hour online Foster Parent College course. Participants learn about normal child development as well as how abuse and neglect impact normal development.

RAPT III – OVERVIEW OF ATTACHMENT, DISCIPLINE AND EFFECTS OF CARE-GIVING ON THE FAMILY
This three hour course provides resource parents the guidelines/policies around discipline as it relates to the children in the child welfare system. It addresses the challenges of attachment as well as how resource families are often affected by bringing children into their home.

RAPT IV – ADOPTION
This six hour course is a requirement for families which to adopt children from the child welfare system. It explains the adoption triad, the common issues in adoption, the DCS policies surrounding an adoption case as well as the services available for both pre-adoption and post-adoption.

EDUCATIONAL ADVOCACY FOR RESOURCE PARENTS
This two hour course educates resource parents on the local resources, state and federal laws around the topic of educational advocacy. The target population is those resource parents who have school aged children, and there is also a component of the training that addressed preschool children.

UNDERSTANDING THE CFTM PROCESS
This four hour course explains the teaming process to resource parents, DCS policies as well as what role they play in the team meeting.

UNDERSTANDING SEXUAL ABUSE FOR RESOURCE PARENTS
This three hour course explains the statistics about the number of children in the child welfare system who are the victims or perpetrators of sexual abuse. It also provides information on local resources for resource parents who need to support the children in their home who have encountered sexual abuse in some manner.

UNDERSTANDING CHILDREN WHO HAVE ATTACHENT CHALLENGES

This four hour course explains the reasons children in the child welfare system develop attachment challenges, how those challenges are manifested in behaviors as well as how resource parents can support the children in the midst of these challenges.

THE NUTS AND BOLTS OF RESOURCE PARENTING

This two hour course educates resource parents on various practical information such as a short overview of the CANS assessment, car seat safety, where to locate policies, as well as how to find the appropriate staff in the child welfare system to meet their needs.

CULTURAL COMPETENCE

This is a multi-part course to address the variety of different cultures that resource parents will encounter: race/ethnicity, poverty, substance abuse and power. Resource parents will become educated on how to address the variety of different cultures children coming into their home might bring with them. They will learn about resources/services in their community to support their development and continued education.

FOSTERING OLDER YOUTH

This one day workshop reviews programs available for youth transitioning out of the child welfare system into independent living programs when Alternative Permanent Planned Living Arrangement (APPLA) is the permanency plan. It includes information for resource parents on the Educational Training Voucher Program, the Chaffee Program and other resources available within the community for youth ages 15-18.

TRAUMA-INFORMED CARE I, II, III

This three part series on Trauma Informed Care defines child trauma and describes how children may respond to traumatic events, how to promote resilience in children, how trauma can interfere with the children's development and functioning, and how trauma can affect children's view of themselves and their future. This training also gives recommendations on how Resource Parents can help children feel safe when talking about trauma.

MY FAMILY, YOUR FAMILY

This training will provide Resource Parent an understanding and look at how their cooperation with the biological family can help to make a difficult time better. Resource Parents assist in reunification but may face challenges when working with the parents or guardians of a child. This training looks at a biological parent through a trauma-informed lens and presents some tools and strategies for successfully engaging a child's parent or guardian.

Essential Learning course names and descriptions
* = new for period beginning July 1, 2012

- ***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, 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, 2012 and March 27, 2013 staff completed 765 classes with another 114 individuals in the process of completing classes and 78 more individuals enrolled who have not yet launched the course. Attendance at each training course continues to be reviewed so that courses not used frequently can be replaced with others from the Essential Learning catalog.

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.

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 am 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, and 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 was 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 was lower for FCMs trained after Practice Reform.
- Average total placements were lower for FCMs trained after Practice Reform.
- Average number of placements per child was lower for FCMs trained after Practice Reform.
- Average number of placements per case was 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.

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.

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.

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.

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. Scheduled to meet quarterly, this Board can provide valuable input and recommendations regarding the training needs of resource and adoptive parents
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.

A Computer Assisted Training (CAT) is in the development phase to incorporate needed changes due to the implementation of the MaGIK computer system.

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 DCS 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 200 DCS employees have begun their MSW studies and over 150 have graduated as of May 2013. 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. For example, six of the 18 (33%) of the Regional Managers and 20 out of the 92 (22%) of the Local Office Directors completed their degrees with IV-E support.

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 an FCM. Participants have a two-year work commitment with DCS 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. Twenty (20) students completed this program during the 2007-2008 academic year and began employment in DCS local offices during the summer of 2008. Additional students have participated in the program each year, and recently 35 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). This contract has also been extended another three years, through June of 2015.

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 Sate 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.

Children's Bureau Training and Technical Assistance Network

Staff Development continues to be actively involved with the National Resource Center for Organizational Improvement through its Peer to Peer Network. Indiana Staff Development has also worked closely with the National Child Welfare Workforce institute through its contractors The Midwest Implementation Center has been assisting all Region V and Region VII state training directors and support staff with coordination activities and networking opportunities although that support will end in the fall of 2013.

The DCS Division of Services and Outcomes recently requested technical assistance through JBS International regarding appropriate programming related to Domestic Violence as well as assistance in working with the Domestic Violence Community on collaborative efforts. The National Resource Center for Child Protective Services and the National Resource Center for Permanency and Family Connections have been identified as two possibilities to assist in this area and preliminary discussions have been held to develop a comprehensive plan based on approval from the Region V Office. No other requests are pending at this time.

B. TECHNICAL ASSISTANCE AND OTHER PROGRAM SUPPORT

In May 2009, DCS elected to redevelop the Indiana Child Welfare Information System (ICWIS) to a web-based architecture with an anticipated completion date of July 2012. ACF was notified on May 26, 2009 that Indiana was voluntarily withdrawing from SACWIS. MaGIK was implemented on July 5, 2012. A MaGIK Help Desk provides technical assistance to FCM's, supervisors, directors and support staff

throughout the State's counties and central office. MaGIK support staff includes senior management, child welfare business staff, technical staff, and extraneous support from the Indiana Office of Technology (IOT) for network connectivity and disaster recovery. The MaGIK technical staff is made up of individuals who have broad experience in the development of child welfare systems. DCS also contracts with individuals who provide SACWIS subject matter expertise from previous child welfare project engagements. Indiana will continue to seek individuals with experience in areas, such as finance, that will assist on an as needed basis.
DCS staff continue to attend ACF sponsored training in nationally and regionally held conferences, webinars, etc., and will seek technical assistance from ACF as needed.

Staff Development continues to be actively involved with the National Resource Center for Organizational Improvement through its Peer to Peer Network. Indiana Staff Development has also worked closely with the National Child Welfare Workforce Institute through its contractors The Midwest Implementation Center has been assisting all Region V and Region VII state training directors and support staff with coordination activities and networking opportunities and that will continue.
DCS Services and Outcomes used technical assistance from the National Resource Center for Youth Development (NRC) in completing a crosswalk between the Independent Living policies and best practice in this area. No additional technical assistance is anticipated at this time.

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), 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.

ATTACHMENT 4

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 Select
- Hoosier Healthwise
- M.E.D. Works
- Healthy Indiana Plan
- Waivers
- Medicaid Pharmacy Benefits
- Presumptive Eligibility
- Family Planning Eligibility Program[1]

All DCS foster children and youth were previously enrolled in Care Select. However, this was revised and DCS foster children and youth are now enrolled in Traditional Medicaid unless they have a qualifying medical condition. Those with qualifying medical conditions are enrolled in *Care Select*. Both Medicaid plans provide reminders and educational materials, as well as assistance with scheduling and transportation for EPSDT appointments.

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 Select:

Care Select is a health care program designed to serve Medicaid recipients with special health care needs and includes healthcare coordination.[2] In order to be eligible for *Care Select*, a DCS foster child or youth must have one of the following medical conditions:

- Asthma
- Diabetes
- Heart Failure
- Congestive Heart Failure
- Hypertensive Heart Disease
- Hypertensive Kidney Disease

[1] http://member.indianamedicaid.com/programs--benefits/medicaid-programs/care-select.aspx

- Rheumatic Heart Illness
- Severe Mental Illness
- Serious Emotional Disturbance (SED) for Wards and Fosters
- Depression

In *Care Select*, a primary doctor and a health plan is determined by choosing one of the Care Management Organizations (CMOs) contracted with the State to coordinate health care needs. The CMO assists in coordinating health care benefits and tailors them to the individual needs, circumstances, and preferences of the child or older youth.

Care Select services are managed or facilitated by two Care Management Organizations with whom FSSA has contracted. Advantage Health Solutions and MDwise, Inc. They manage the care of eligible members and ultimately improve the quality of care and health outcomes for members.

Advantage Health Solutions is a locally-owned provider-sponsored health plan that places an emphasis on Wellness and Care Coordination. Advantage Health Solutions subscribes to:

- A member-centered care management focus;
- Strong partnerships with community providers to coordinate behavioral, developmental and medical services;
- Utilizing assessments and risk stratification tools to determine needs at the member/provider level; and,
- Excelling in communication with members, their families and their caregivers.

MDwise, Inc. is a locally-owned health plan created in 1994. MDwise, Inc. is a Network model Health Maintenance Organization (HMO) that subscribes to:

- Member-focused promoting self-management and self-determination
- Personal, trusting relationship with member/caregiver
- Technology driven communication with providers, caregivers and members
- Goals aligned across team (medical, behavioral health, waiver and member/caregiver)
- Local partnerships with members, caregivers, advocates, and providers to provide relevant, effective care coordination

Care Select facilitates care coordination and continuity of health services through care coordinators. Care Coordinators are housed in the particular CMO working under *Care Select*. Care Coordinators facilitate individualized services and assist in gaining access to needed medical, social, educational, and other services. Care Coordinators assist members in arranging for initial and on-going key services. Examples include: (EPSDT); population-based disease management as well as targeting specific diseases; a Chronic Disease Management Program including diabetes, asthma, congestive heart failure, and hypertension; and utilization management allowing for the facilitation of appropriate use of facilities, services and pharmacy. Additionally, they may assist with arranging appointments, scheduling transportation, and assisting in educating members about managing their health conditions.

An integral part of the system of care for DCS children and youth enrolled in *Care Select* is the Primary Medical Provider (PMP). If members do not have a Primary Medical Provider and are enrolled in *Care Select*, DCS will receive a letter outlining the process for selecting a PMP and a CMO. If they do not select a PMP or CMO, one will be auto-assigned through *Care Select.*

The PMP becomes the member's "Medical Home" or the member's health care home base. In functioning as the Medical Home, the PMP functions as the point of entry to the health care system and serves as the member's main health care provider. A PMP can be either a primary care physician or a specialist, and can provide referrals to other specialist as the need warrants. The PMP works with the child, the child's custodial caregiver and the Care Manager (either MDwise, Inc. or Advantage Health Solutions) to improve the health of the child. DCS FCM's work with the PMP and/or the CMO to assist in the coordination of services for DCS foster children or youth.

Coordinated care for DCS foster children or youth in *Care Select* works though a Care Management Model. There are four steps to the Care Management Model beginning with a thorough assessment of the youths' needs, including input from numerous stakeholders. A care plan is designed for the youth based upon conclusions reached through the assessment. The Care Management Organization then coordinates care for the youth as outlined by the care plan. Finally, the results based on care plan for the youth are measured. The DCS ward or youth in foster care is then reassessed, and care plans are updated to reflect needed changes. The four-step Care Management Model includes:

1. Assess the needs of the youth
   - Identify high risk members through medical claims history/risk stratification
   - Identify and reach out to youth's family or Family Case Manager
   - Share existing assessments/care plans to avoid duplicative assessment questions or interventions
   - Conduct initial interview with youth or caregiver
     - Assign care management Level 1-4
     - Identify the need for more comprehensive medical, behavioral, psychosocial, and/or functional assessments
     - Identify immediate needs and implement immediate interventions if needed
2. Design a Care Plan
   - Involve member, caregivers and providers in developing the youth's Care Select Plan
     - Establishing care plan goals that are evidence-based and outcome-oriented
     - Taking responsibility for achieving care plan goals
   - Integrate goals/interventions across a member's other care plans
     - Primary Care
     - Family Teaming
     - Medicaid waiver program
     - Individualized Education Plan (IEP)
     - CMHC/behavioral health treatment plan
   - Prioritize goals/interventions recognizing the member's priorities
3. Coordination of Care
   - Share individualized care plan with youth and caregiver, the primary medical provider, waiver/CMHC case managers
   - Involve members, caregivers, Care Managers, Care Partners, Care Advocates, Family Case Managers, and providers in an active dialogue about barriers, goals, and progress through
     - Web-based care plans
     - Care conferences
     - Ongoing dialogue
   - Facilitate communication with health care providers (i.e. physicians, community organizations, waivers programs, school-based services, and DCS)
   - Connect member/caregiver with needed services
   - Advocate for member by removing barriers to care as well as providing education about conditions, access to care, and member rights and responsibilities
   - Facilitate member/caregiver independence through teaching and reinforcing self-management skills
   - Utilize the member's comprehensive assessment and care plan to provide contact and support for PA requests
4. Measure the Results
   - Member level outcomes

- Achievement of care plan goals
- Annual health needs assessment

- Program level outcomes
  - Member and provider satisfaction
  - Evidence-based practice
  - Improvement in quality of life metrics
  - Reduction in inpatient/ER admissions
  - Complaints, grievances/appeals

Enrollment of all eligible wards of DCS and youth in foster care in Medicaid provides the basis for this 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 further enhanced this base by creating 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 unit within DCS, the Medicaid Eligibility Unit (MEU), 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.

ADMINISTRATIVE FRAMEWORK:

DCS works collaboratively with Indiana FSSA, Department 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 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 health needs of wards of DCS and youth in foster care.

To support programs and services:

- DCS holds quarterly meetings with FSSA, OMPP, and DFR to develop service strategies, including encouraging providers of dental and mental health providers to accept Medicaid and develop both capacity and service availability geared toward prevention.
- DCS holds quarterly meetings with DFR and OMPP regarding the statewide implementation for the Medicaid Enrollment Unit.
- Effective 8-1-10, the MEU rollout was completed statewide and all DCS wards in out-of-home placement as well as adopted wards have their Medicaid enrollments, changes, and closures coordinated by the MEU.
- Additionally, DCS is participating on the Oral Health Task Force through the Indiana State Department of Health to assist in the implementation of Indiana's Strategic Oral Health Plan.

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).

DCS is working with the FSSA Office of Medicaid Policy and Planning (OMPP) to exchange vital medical information and facilitate enrollment of DCS wards and youth in foster care onto Medicaid

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 DCS foster children and youth, 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 partnered with the FSSA Division of Mental Health and Addictions to implement the CANS.

Statewide use of the Child and Adolescent Needs and Strengths (CANS) assessment tool was implemented statewide effective April 2010 in order 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.

DCS is 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 on-going 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 partnered to develop a technical framework that allows for the sharing of relevant medical data and other information related to health. The intent was 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. 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. It is expected to be fully implemented by December, 2013. The electronic sharing of medical information assists in ensuring that all wards of DCS and youth in foster care receive the most appropriate medical care possible.

1. 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 CANS:

To improve consistency and provide for better mental health outcomes for children and youth in the care of DCS, the agency has implemented statewide use of 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, and many 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.

The CANS assessment documents the intensity of behavioral health services needed by the child and family and will be the basis for planning individualized services for children. 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 trained and certified for its use.

Two versions of the CANS are used by DCS staff – the short CANS and the comprehensive CANS.

Short CANS

- Replaces the current Mental Health screen;
- Will be completed for every child under the supervision of DCS, regardless of age, within five (5) days of opening a case with the family for IAs or In-Home CHINS;
- Will be completed for every child under the supervision of DCS, regardless of age, who will be placed during the Assessment; the short CANS will be completed prior to placement if at all possible or within 5 days of removal or opening of a case if there was an "emergency" removal.

Comprehensive CANS

- Will be completed if the short CANS shows that there are mental health issues;
- Will be completed within thirty (30) days of the short CANS;
- 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.

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.

EPSDT: 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;
- 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;*

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 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.

To better serve youth and families with complex trauma histories, DCS has developed and implemented a Clinical Resource Team. This team consists of ten (10) 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.

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. Trauma Focused Cognitive Behavioral Therapy has been required as a core program component for all residential providers, since October 1, 12012. DCS plans to provide training for other contracted community based providers to increase their use of Evidence Based Practices including TF-CBT.

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 recently completed an MOU with the Indiana Office of Medicaid Planning and Policy (OMPP) which, when fully implemented, will allow for the electronic transfer of medical claim history from the Medicaid system to DCS' MaGIK system (see ATTACHMENT 4B). 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.

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 *Care Select.* CMO 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:

a. 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.

b. Psychotropic Medication Advisory Committee (PMAC)

The Indiana Psychotropic Medication Advisory Committee (PMAC) was initiated in January, 2013, 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, DMHA, pediatricians, social workers, psychologists, pharmacists, child advocates and other identified stakeholders (see ATTACHMENT 4A), for 2013 PMAC Members). 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.

In 2013, the PMAC will publish DCS Psychotropic Medication Protocols, with revisions made on a semi-annual basis. The guidelines will contain suggested baseline and follow up labs and other monitoring interventions that are based on the latest in evidence-based practice and research literature. Prescribing providers will be requested to utilize the guidelines and may be asked to provide clinical information and follow up based on this document.

The PMAC will also work with OMPP to publish the DCS Approved List of Medications that will contain a comprehensive listing of medications (generic and brand) approved for use with DCS children and adolescents. Requests for medications that are not listed on the formulary will require review and approval by the PMAC. Note: DCS will utilize the current OMPP formularies until such time as the PMAC can review and revise, as necessary.

c. 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 will be trained on these measures in 2013.

d. 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.

e. Psychotropic Medication Consultation

The IUSM Department of Psychiatry has agreed to serve as the consultation entity for DCS. The PMAC considered consultation models from several other states and determined that the model currently being used in Illinois would be the best fit for Indiana. In this model, the prescribing provider will complete a web-based consent and medical information form and forward to the IU Consultation Team – all Board Certified child and adolescent psychiatrists. Once a referral has been generated, the IU psychiatrist will review the information, and if necessary, will staff the case with the prescribing provider "physician to physician."
Once the IU Consultation Team has approved the request, the web-based form will be forwarded to DCS Central Office for final consent. Copies of the consent form will then be distributed to the family, DCS Family Case Manager and prescribing provider. The IU Consultation Team will also review any case that meets one or more of the "red flag" indicators listed in Table 1. Again, this consultation will take place "physician to physician" with the prescribing provider. The DCS Family Case Manager may be asked to provide background case information, including health records, treatment summaries, family histories, etc. In those instances where the IU Consultation Team member and the prescribing physician cannot agree on a course of treatment, the case may be referred to another provider, or the IU Consultation Team member may agree to staff the case on a monthly basis with the prescribing physician. It should be noted that IU is the sole training program for psychiatrists in the state of Indiana, and as such, the IUSM faculty have longstanding relationships with most psychiatrists and behavioral health programs in the state.

f. 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 from the Texas Psychotropic Medication Utilization Parameters for Youth in State Care and the AACAP Practice Parameters for Psychotropic Medication Use in Children and Adolescents:

- A DSM-IV-TR diagnosis should be made before the prescribing of psychotropic medications.
- 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).
- Except in the case of emergency, informed consent should be obtained from the appropriate party(s) prior to beginning psychotropic medication.
- 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.

- Appropriate monitoring of indices such as height, weight, blood pressure or other laboratory findings should be documented.
- Monotherapy regimens for a given disorder or target symptoms should be tried before polypharmacy.
- Doses should usually be started low and titrated carefully as needed.
- Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record.
- 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.
- In depressed children and adolescents, the potential for emergent suicidality should be carefully evaluated and monitored.
- 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.
- 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.
- 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.
- If a medication is being used in a child for a primary target symptom of aggression associated with a DSM-IV-TR nonpsychiatric 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.
- 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.

g. Data Management

DCS has completed an MOU with OMPP to share Medicaid claims data (see ATTACHMENT 4B - MOU Between FSSA and DCS EDS#MD29-3-06-13-LF-1181). As part of the MOU, OMPP will produce monthly utilization reports for DCS wards on psychotropic medication(s). The Medicaid claims data base captures psychotropic medication prescriptions on a "real time" basis, allowing for identification of cases that fall outside of best practice parameters. The OMPP reports will identify outliers (see Table 1 below), including prescribing physicians. In addition, the OMPP reports will include utilization statistics that can be used to benchmark against other states. Report formats will include the following:

1. Percentage of children prescribed psychotropic medication by age: 0-5 years old, 6-12 years old, 13-17 years old, 0-17 years old. DCS Wards vs. Non-DCS Medicaid Youth. (GAO). Within DCS Wards – In-home vs. out-of-home placements.

2. Children age 0-17 prescribed five or more psychotropic medications concomitantly. DCS Wards vs. Non-DCS Medicaid Youth. (GAO). Within DCS Wards – In-home vs. out-of-home placements.

3. Children 0-17 with a dosage exceeding maximum guidelines based on FDA-approved labels. DCS Wards vs. Non-DCS Medicaid Youth. (GAO). Within DCS Wards – In-home vs. out-of-home placements.

4. Children under age one year prescribed a psychotropic drug. DCS Wards vs. Non-DCS Medicaid Youth. (GAO). Within DCS Wards – In-home vs. out-of-home placements.

5. Children 0-17 with a dosage exceeding maximum standards published in the medical literature (i.e., medications for which there are no FDA-recommended dosages for the child's age – see Texas guidelines). DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

6. Children 0-17 prescribed a psychotropic medication without a DSM IV diagnosis. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

7. Children 0-17 prescribed a psychotropic medication that is not consistent with the listed DSM-IV diagnosis (e.g., Seroquel with ADHD). DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

8. Children age 0-17 prescribed two or more antidepressant medications concomitantly. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

9. Children age 0-17 prescribed three or more mood stabilizers concomitantly. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

10. Children age 0-17 prescribed two or more antipsychotic medications concomitantly. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

11. Children age 0-17 prescribed two or more stimulant medications concomitantly. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

12. Children age 0-3 prescribed an antidepressant medication. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

13. Children age 0-3 prescribed an antipsychotic medication. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

14. Children age 0-2 prescribed a stimulant medication. DCS Wards vs. Non-DCS Medicaid Youth. Within DCS Wards – In-home vs. out-of-home placements.

h. "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 will be automatically 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-IV diagnosis in the child's medical record
Prescription of psychotropic medication that is not consistent with the child's listed diagnosis
Prescription for five (5) or more psychotropic medications
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 stimulant medication to a child less than three (3) years old
Psychotropic polypharmacy for a given mental disorder is prescribed before utilizing psychotropic monotherapy.
Prescription of a psychotropic medication above the FDA or literature- based maximum dosage level

i. 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.

j. Education and Training

DCS will develop a training curriculum for DCS staff and for key stakeholder groups at the local and state level. Target audiences will include residential, foster care and community-based providers, as well as parents and child advocates (e.g., CASA, Guardian ad Litem). The training curriculum will include information about best practice guidelines, current psychotropic utilization trends and issues unique to you in the foster care system. DCS will establish mechanisms for sharing training with staff and other stakeholders, including computer-based, "train the trainer" and in-service formats.

k. Information Portal

DCS will develop a "psychotropic medication" information portal through the www.dcs.in.gov website. The information portal will include an overview of the DCS psychotropic medication initiative, contact information, summary performance data (e.g., quarterly utilization reports), and links to relevant research, resources and Federal legislation. The information portal will also include a list of answers to frequently asked questions for consumers.

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:

a. DCS is in the development stages of a Nursing Services Program. Some children who come into DCS' care have health concerns and may not have had appropriate or significant primary medical care, or may not have received adequate medical treatment or care during their lives. A large percent of the cases DCS oversees

involve neglect. This can result in chronic health problems, developmental delays, and can have psychological impacts on a child or youth.

To further strengthen efforts to ensure that all children receive the medical and dental care they need and deserve, the Nursing Services Manager (Director) along with a team of 14 nurses with pediatric nursing experience will be located throughout the regions statewide to assist and support family case managers. Typically, family case managers do not have formal medical training. Having nurses to assist with coordination of care for cases with complex / multiple medical needs; providing consultation, resources and education; performing medical record reviews and interpretation; collaborating with and being a liaison to service providers, resource families, and other DCS team members (including PEDS), is beneficial for all parties. Nurses will also be available to assist with the health / medical components of the CANS, facilitate the EPSDT process, and provide written documentation of recommendations.

b. 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.

c. DCS will continue to expand and update the Pediatric Evaluation and Diagnosis (PEDS) program contract. This 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 child abuse pediatricians who are able to provide 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.

d. A new component of the PEDS contract allows the 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

e. The PEDS program entails mandatory referrals of any allegation of a suspected injury to the head or neck of a child less than 10 years old; 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 all fractures and burns in these young children.

f. The PEDS program also handles Comprehensive Cases to include those that may be in need of a telephone review and consultation with a member of the team from the IU Child Protection Program. Family Case Managers, Supervisors, and the DCS Nurses can contact the Riley/IU Child Abuse Pediatricians to staff potential cases to determine the appropriateness of the referral.

g. The Pediatric Center of Hope is part of the IU Child Protection Program 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.

h. DCS Nurses receive consultation, education and training from the PEDS program. Weekly PEDS Meetings are held in which case reviews are staffed.

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 looses IV-E eligibility for any reason, 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. 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. 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, MEU explores all other categories of Medicaid coverage for potential Medicaid eligibility. 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 advised 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.

Proof of Compliance:

- DCS Administrative Letter regarding Care Select
- DCS Director's Note regarding EPSDT (September 6, 2011)
- DCS Policy 8.30 Psychotropic Medication
- Oral Health Task Force Committee Application

- FSSA Community Presentation Regarding Care Select
- CANS Policy
- MEU Implementation Protocol
- Indiana's Child and Family Services Plan for 2010-2014
- MOU - DSC and FSSA DMHA
- MOU – DCS and FSSA OMPP
- DCS Policy 11.6 Independent Living/Transitional Living
- Advanced Directives Video which can be found at http://www.in.gov/dcs/ChafeeIndependentLiving.htm
- PEDS Contract (See ATTACHMENT 4C - Director's Note)

MEMORANDUM OF UNDERSTANDING

BETWEEN

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

AND

THE INDIANA DEPARTMENT OF CHILD SERVICES (DCS)

EDS# MD29-3-06-13-LF-1181

The Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP) and the Indiana Department of Child Services (DCS) agree as follows:

I. AUTHORITY

1. This Memorandum of Understanding (MOU) is entered into between the above parties to facilitate compliance with the provisions of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351/H.R. 6893) ("Fostering Connections") that require the State's child welfare agency (DCS) and the agency responsible for administering the Medicaid State plan (OMPP) to implement a plan for ongoing oversight and coordination of health care services for children in foster care. (42 U.S.C. 622 (b) (15) (A))

2. DCS is authorized to disclose information to the Medicaid agency for purposes directly related to the administration of either agency's programs. (42 U.S.C § 671(a)(8)(A).)

3. OMPP is authorized to disclose information to DCS for purposes directly related to the administration of the Medicaid program. "Directly related" includes establishing eligibility, determining the amount of medical assistance and providing services for recipients. (42 U.S.C. § 1396 (a)(7); 42 C.F.R. §431.302.)

II. PURPOSE

The purposes of this MOU are to define the programmatic and administrative responsibilities of DCS and OMPP, who are separately and independently responsible for administering certain types of State aid to wards and foster children, and to work collaboratively in formulating DCS' State plan to ensure that the health needs of children in foster care are being adequately met. This collaboration will include the development of a technical framework for sharing relevant data and information related to health of children with the intent of improving health outcomes. The information exchange will serve the following specific purposes:

- OMPP will provide medical information about children under the care and supervision of DCS as in order for DCS to populate a Medical Passport and

ATTACHMENT 4A

DCS' electronic child welfare system so that this health information is available to family case managers, providers and foster parents to ensure that timely and appropriate health care is rendered to the child.

- OMPP will provide pharmacy claims data for children under the care and supervision of DCS in order for DCS to monitor the use of prescription medicines, particularly psychotropic medications. This will allow DCS to comply with Fostering Connections requirements and ensure children under the care and supervision of DCS are receiving appropriate medications.
- Enable DCS to provide enhanced case management to improve health outcomes for wards, foster and adoptive children.

III. AGENCY RESPONSIBILITIES

A. RESPONSIBILITIES OF DCS

1. DCS will use the data it obtains from OMPP to populate a Medical Passport (see DCS policy 8.27 Maintaining Health Records – Medical Passport) and its Indiana child welfare information system (currently MaGik) with health information about children under its care and supervision.

2. DCS will also use the claims data it obtains from OMPP to monitor and evaluate the use of drugs reimbursed by Medicaid and used by children under the care and supervision of DCS.

B. RESPONSIBILITIES OF OMPP

1. OMPP will provide DCS with claims data that contains the following information on current wards or foster children who are identified as wards: medical, dental, vision, pharmacy, mental health services information contained in claims or encounter data maintained by OMPP. The specific data elements, the format, the method and the interval at which the information will be provided shall be as mutually determined by the parties.

2. Upon request by DCS, OMPP will provide claims data from the past two years for children previously enrolled in Medicaid or CHIP who have subsequently become wards.

C. MUTUAL RESPONSIBILITIES

OMPP and DCS agree that:

1. Each of the parties hereto has carefully read and fully understands the terms, conditions, and effect of this agreement and is entering into this agreement freely and voluntarily.

2. Each of the parties will advise the other party of the names of individuals with the responsibility to fulfill the terms of the agreement. Notification of changes in those individuals will be made timely.

3. All the parties understand that OMPP's ability to provide claims data in a regular, systematic and reliable way depends on DCS' ability to timely and correctly identify wardship status and provide that information.

4. OMPP represents and DCS acknowledges that the data provided under this agreement obtained from Indiana*AIM* are primarily claims data related to the administration of the Medicaid and Children's Health Insurance programs. At any given time the information may be incomplete, inaccurate, or incorrect for various reasons including, but not limited to, errors made by providers in submission of claims for payment, the delay between the time treatment is provided and a claim is billed, data entry errors, and the failure of DCS to identify a child as a ward. DCS uses the data for the purposes set forth in this agreement at its own risk recognizing that the best and most reliable source of medical information about wards and foster children is more likely to be the provider of services or the foster parent/guardian of the child and not the data provided by OMPP.

5. Each of the parties will verify/synchronize information and/or data prior to the public release of any reports relating to mutually shared de-identified data.

6. Mutual exchange of data, depending on systems set up, will take place on a real time basis or at intervals determined by the parties and through the use of automated processes and system interfaces to the extent possible.

7. This agreement shall be binding upon the parties hereto and their successors in interest.

This agreement may be executed in counterparts, each of which shall constitute an original and all of which shall constitute one binding instrument once each party has signed one or more of the counterparts.

IV. COMMUNICATIONS

DCS and OMPP shall send appropriate staff representation to monthly DCS/OMPP meetings.

V. SECURITY AND PRIVACY OF HEALTH INFORMATION

Parties acknowledge their mutual goal of preserving the confidentiality of the information which is the subject of this MOU and that certain obligations arise under

laws and regulations of the Health Insurance Portability and Accountability Act of 1996 Privacy Regulations effective April 14, 2003, and Security Regulations effective on April 20, 2005. ("HIPAA.") While DCS is not a covered entity under HIPAA, the parties agree to comply with all applicable requirements of HIPAA in all activities related to the MOU. OMPP agrees to maintain HIPAA compliance throughout the life of the MOU and to operate any systems used to fulfill the requirements of this MOU in full compliance with HIPAA. DCS agrees to take no action to adversely affect the OMPP's HIPAA compliance.

Per the requirements under 45 CFR §164.502(b), parties agree to utilize the minimum necessary amount of Protected Health Information (PHI) to comply with the requirements of this MOU.

Parties further agree to abide by other applicable state and federal laws regarding disclosure and redisclosure of confidential information, including Indiana Code § 4-1-6-8.5 and 5-14-3-6.5.

VI. FUNDING

If the Director of the State Budget Agency makes a written determination that funds are not appropriated or otherwise available to support continuation of performance of this agreement, the agreement shall be canceled. A determination by the Budget Director that funds are not appropriated or otherwise available to support continuation of performance shall be final and conclusive.
There is no fiscal impact for either agency

VII. MODIFICATION and RENEWAL

A. This agreement may be amended by mutual consent. Any such amendment shall be by written agreement of the parties executed with the same formality as this original agreement.

B. This MOU may be renewed for two (2) year periods as agreed by the parties.

VII. TERMINATION

This MOU may be terminated by any party upon thirty days notice with respect to that party's participation in the partnership described herein. Terms of any separate agreements will not be affected by such termination.

IX. EFFECTIVE DATE

This Memorandum of Understanding is effective January 1, 2013, and shall terminate on June 30, 2015.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

EXECUTIVE DOCUMENT SUMMARY

State Form 41221 (R10/4-06).

Instructions for completing the EDS and the Contract process.

1. Please read the guidelines on the back of this form.
2. Please type all information.
3. Check all boxes that apply.
4. For amendments / renewals, attach original contract.
5. Attach additional pages if necessary.

1. EDS Number:	2. Date prepared:
MD29-3-08-13-LF-1181	1/10/2013

3. CONTRACTS & LEASES

- ___ Professional/Personal Services
- ___ Contract for procured Services
- ___ Grant
- ___ Maintenance
- ___ Lease
- ___ License Agreement
- ___ Attorney
- ___ Amendment# _____
- X MOU
- ___ Renewal # _____
- ___ QPA _____
- ___ Other _____

FISCAL INFORMATION

4. Account Number:	5. Account Name:
6. Total amount this action: $0.00	7. New contract total: 0.00
8. Revenue generated this action: $0.00	9. Revenue generated total contract: $0.00

10. New total amount for each fiscal year:

Year 2013	$0.00
Year 2014	$0.00
Year 2015	$0.00
Year _____	$ _____

TIME PERIOD COVERED IN THIS EDS

11. From (month, day, year):	12. To (month, day, year):
1/1/2013	6/30/2015

13. Method of source selection:

___ Bid/Quotation ___ Emergency ___ Negotiated ___ Special Procurement

___ RFP# _____ X Other *(specify)* MOU

AGENCY INFORMATION

14. Name of agency:	15. Requisition Number:
FSSA Medicaid	

16. Address: FSSA, Office of Medicaid
402 W WASHINGTON ST W374
INDIANAPOLIS, IN 46204

AGENCY CONTACT INFORMATION

17. Name:	18. Telephone #:
Stahley, Lisa K	317/234-4445

19. E-mail address: lisa.stahley@fssa.in.gov

COURIER INFORMATION

20. Name:	21. Telephone #:
FSSA / Contract Management	317/233-4703

22. E-mail address: contract.status@fssa.in.gov

VENDOR INFORMATION

23 Vendor ID # 0000022460

24. Name:	25. Telephone #:
STATE OF INDIANA	N/A

26. Address: 402 W WASHINGTON
INDIANAPOLIS, IN 46204

27. E-mail address: n/a

28. Is the vendor registered with the Secretary of State? (Out of State Corporations, must be registered) ___ Yes X No

29. Primary Vendor: M/WBE	30. If yes, list the %:
Minority: ___ Yes X No	Minority: _____ %
Women: ___ Yes X No	Women: _____ %
31 Sub Vendor:M/WBE	32. If yes, list the %:
Minority: ___ Yes X No	Minority: _____ %
Women: ___ Yes X No	Women: _____ %
33. Is there Renewal Language in the document? X Yes ___ No	34. Is there a "Termination for Convenience" clause in the document? X Yes ___ No

35. Will the attached document involve data processing or telecommunications systems(s)? ___ Yes: IOT or Delegate has signed off on contract

36. Statutory Authority *(Cite applicable Indiana or Federal Codes)*:
N/A

37. Description of work and justification for spending money. *(Please give a brief description of the scope of work included in this agreement.)*
This MOU is between the Indiana Office of Medicaid Policy and Planning (OMPP) and the Indiana Department of Child Services (DCS) to facilitate compliance with the Fostering Connections to Success and Increasing Adoptions Act of 2008.

38. Justification of vendor selection and determination of price reasonableness:
This is an MOU between state agencies.

39. If this contract is submitted late, please explain why: *(Required if more than 30 days late.)*

40. Agency fiscal officer or representative approval	41. Date Approved	42. Budget agency approval	43. Date Approved
Leslie Melton	2-4-13	Joseph M Hacker	2-4-2013
44. Attorney General's Office approval	45. Date Approved	46. Agency representative receiving from AG	47. Date Approved

JMH

69320-000

SIGNATURE PAGE

In Witness whereof, the Indiana Family and Social Services Administration, Office of Medicaid and Policy Planning, Division of Family Resources and the Indiana Department of Child Services, by their duly authorized representatives, enter into this Memorandum of Understanding (MOU). The parties, having read and understood the foregoing terms of this MOU, do by their respective signatures dated below hereby agree to the terms thereof.

Indiana Department of Child Services

John P. Ryan, Director

Date: 1/10/2013

Office of Medicaid Policy and Planning

Patricia Casanova, Director

Date: 1-18-13

State Budget Agency

Joseph M Hally FOR
Christopher D. Atkins, Director

Date: 2-4-2013

Indiana Psychotropic Medication Advisory Committee (IPMAC)
2013 Membership

Leslie A. Hulvershorn, M.D.
Deputy Medical Director
Indiana Division of Mental Health & Addiction
317-232-4714
leslie.hulvershorn@fssa.in.gov

Kelda Walsh, M.D.
President, ICCAP
Assistant Professor of Clinical Psychiatry
Riley Hospital for Children
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ATTACHMENT 4B

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317-234-5754
Jennifer.tackitt@dcs.in.gov

From: Ryan, John P (DCS)
To: #DCS (All Staff)
Subject: Director"s Note - PEDS
Date: Wednesday, January 09, 2013 3:51:52 PM
Attachments: PEDS Director"s Note 2013.docx

DIRECTOR'S NOTE

January 9, 2013

UPDATE: Pediatric Evaluation and Diagnostic Services (PEDS) Program

I am pleased to share with you that, because of the continued positive feedback from Family Case Managers and the IU Child Protection Program staff, the PEDS program is expanding. 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 child abuse pediatricians who are able to provide 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. Because of the increased volume of cases and overall success of the program, the contract has been renegotiated and extended through June 30, 2014. As part of the contract renegotiation, there have also been some significant additions and updates to the program. All additions and updates are effective January 1, 2013.

Additions, updates and reminders:

1. Any allegation of a suspected injury to the head or neck of a child less than 10 years old should be referred to the PEDS program. This is a change in practice, as previously the mandatory ages for referral were 0-18. PEDS referrals will still be accepted, and are encouraged, for children 10 and older if needed, but referrals for this age group are no longer mandatory. A PEDS referral should still be initiated by a phone call to the PEDS program, (317) 630-2617, for a determination of the type of review that may be needed. This review may consist only of a phone call consultation, but all calls should be followed up with an electronic referral form. Remember, a referral is still required for those children seen as a patient (either inpatient or outpatient) at Riley. If an emergent situation exists, please page the child abuse pediatrician on call at (317) 312-2911 and enter your complete phone number including area code followed by *extension, if needed (e.g. 317-123-4567*11111). Alternatively, you may call (317) 944-5000 and ask for the child abuse pediatrician on call. Do not ask for the PEDS doctor as most doctors at Riley are PEDS doctors = pediatricians. The electronic referral forms can be found and submitted via http://www.rileypeds.org/CP/Index.aspx. I recommend copying this link to your desktop or bookmarks so it is readily accessible. Please make sure to follow all directions on the link. (Please note attachments over 10 MB will require additional separate email submissions of the attachments.) A copy of the referral should arrive in your inbox after it is submitted electronically for record keeping purposes.

ATTACHMENT 4C

2. A new component to the PEDS contract is the addition of mandatory referrals for 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 all fractures and burns in these young children. The referral process is the same as detailed above for suspected head and/or neck injuries.

REMEMBER: The earlier in the case you call the IU Child Protection Program, the more likely they are to be able to help sort things out. You should call ASAP for all serious head trauma, serious burn and any fracture.

3. Other cases which include any other suspicious or questionable injury can still be reviewed and are included under this contract as "Comprehensive Cases":

a. Comprehensive Cases include those that may be in need of a telephone review and consultation with a member of the team from the IU Child Protection Program. Family Case Managers and Supervisors should not hesitate to contact the Riley/IU Child Abuse Pediatricians to staff potential cases to determine the appropriateness of the referral.

b. Formal case review of those cases that are considered Comprehensive Cases includes a comprehensive record review with a written report by a Riley/IU Child Abuse Pediatrician to determine the presence or absence of child abuse or neglect. The Riley/IU Child Abuse Pediatricians will be available and should be utilized to discuss the case with you to assist in determining if more formal record review and written consultation is indicated. If so, Riley will send confirmation of the recommendation for formal evaluation to the FCM, which can then be forwarded to the Regional Manager to assist with the approval process. Once deemed appropriate, referrals require the approval of the Regional Manager or their designee.

4. Another new component of the contract allows the 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.

5. Please note that, although both are programs of the IU Child Protection Program, a PEDS referral is not the same as a referral for a sexual abuse exam/consultation to the Pediatric Center of Hope. Many of you have plans in place with your local CACs for sexual abuse evaluations, but if you are in an area that utilizes the Pediatric Center of Hope for sex abuse exams/consultations, there is no change to the referral process. FCMs still need to contact the Pediatric Center of Hope to make a referral. For emergent response to a child sexual abuse concern, please call (317) 944-5000 and ask to speak to the Pediatric Center of Hope Nurse on call. The nurse can assist in determining the time and place for a medical examination depending upon the age of the child, type of contact and symptoms, and when the last incident took place. For non-emergent questions or appointments, call the Pediatric Center of Hope at (317) 692-2377. Referrals for non-emergency appointments may be faxed to 317-692-2376. Please use attached form (COH Referral) only for sex abuse referrals.

John Ryan

Director

Indiana Department of Child Services

302 W. Washington St., E306

Indianapolis, IN 46204

Office: (317)234-1391

Fax: (317)234-4497

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

LAKE COUNTY CITIZEN REVIEW PANEL

Annual Report 2012

ATTACHMENT 5

LAKE COUNTY CITIZEN REVIEW PANEL

ANNUAL REPORT

JUNE 2012

The Lake County Citizen Review Panel met bi-monthly from 12/1/12 through 6/21/12.

The team is comprised of the following members: Cynthia Cyprian, Clinical Director of The Villages; Jonelle Carns, Program Supervisor, Indiana MENTOR; Julie Villarreal, Program Manager, Indiana MENTOR; Penny Longoria, Case Manager, The Villages; Natalie Hanas, Foster Care Specialist, Department of Child Services (Lake County); Kristin Huseman; Foster Care Specialist, Department of Child Services (Lake County); Brenda Holmes, Foster Parent; Elaine Spicer, Therapist.

*Cynthia Cyprian and Penny Longoria served as co-chairs for the CRP meetings

Ann Arvidson, Foster Care Consultant for Department of Child Services, served as liaison to the Citizens Review Panel (CRP).

There appears to have been much discussion in the foster care arena regarding the use of the CANS in the leveling/rate setting process. It appears that the children in care have seen more disruptions/moves which the team feels could be associated with under-leveling of the CANS and level of care when a child is placed in a foster home setting. In turn, the team believes that the under-leveling and lack of services provided has lead to an increase in the number of placements a child will experience while in the child welfare system. In addition, because of the increased number of moves the child experiences a negative impact on their health and well-being, leading to an increase in Reactive Attachment Disorders, Anxiety, Depression, low self-esteem, poor performance and other issues of this nature.

Due to the nature of what is being reviewed, we felt that a brief description of the qualifications of each team member would be necessary. Cynthia Cyprian is a Licensed Clinical Social Worker (LCSW) and is trained in the use of the CANS. She manages a Licensed Child Placing Agency (LCPA) and has worked in the field using diagnostic tools for over 17 years. She is also a licensed foster parent. Julie Villarreal is also an LCSW and manages an LCPA. She is a CANS Super User and has been working with the CANS since its inception in Indiana. She was a participant on the team of people who worked to develop the tool. She has also worked in Child Welfare Services for over 16 years. Jonelle Carns is an LCSW, trained as a Super User for the CANS. She supervises TFC cases for the agency she represents and is very familiar with the inner-workings of the child welfare system. Penny Longoria is an LCPA case manager with many years of CANS experience. She is presently participating in the MSW program at IU.

Based on the information presented above, the team decided to focus on level of care and the impact on placement as the topic for review. The goal of the review was to determine if the children being under-leveled at placement lead to multiple moves, or if there little to no impact at all. We requested a random sample of participants from six randomly selected counties (Delaware, Lake, Owen, Posey, Pulaski, and Clark). The CRP chose specific demographics in which each Foster Care Supervisor from the six random counties was given the task of choosing one child from each age group with the ability to select a sibling group to be a sample of the review. The demographics included ages in the following

categories: 0-4 year olds, 5-13 year olds and 14 years old +. Each child selected was also required to have been in care for at least one year. Once the child was selected, the team requested a copy of the Case Plan along with the current CANS Assessment. The Foster Care Supervisor from each county chose the participants and provided the necessary information. Overall, there were 19 participants selected and reviewed. Initially, the team was going to look at Lake County specifically but felt that a larger, more diverse, sample would be more indicative of the overall possible impact across the state.

In order to accomplish this task, the team requested information about the level of care that the child was placed. We then reviewed the participant's Case Plan and the goals established. Based on the goals established, we reviewed the CANS Level. We compared to the number of disruptions/moves the child experienced while in care. The team then decided to review the case plan looking for information that aided in understanding the scoring of the CANS.

A survey has been developed and will be sent to each participant's foster parent in order to request additional information regarding their thoughts and feelings about the leveling process and the children placed in their home. The information will be used to make recommendations regarding the entire process of completing the CANS and determining an appropriate and democratic process for all involved. If a foster parent believes that the participant is inappropriately leveled, a professional team member will be contacting the foster parent and completing a CANS assessment to compare with the CANS score provided by the case worker. During the process, specific scoring information will be documented and shared with DCS as necessary.

The CRP will be continuing the project during the next fiscal year in order to continue to gather and develop our hypothesis and make prognostic and diagnostic recommendations toward practice and policy.

DRAFT

Citizens Review Panel

Annual Report

June 2012

Prepared by:

Marion County Child Fatality Review Team

Submitted to:

Indiana Department of Child Services

ATTACHMENT 6

DRAFT

Table of Contents

Introduction

Indiana Code (IC 31-25-2-20.4) provides for the establishment by the Department of Child Services (DCS) of at least three citizen review panels in accordance with the requirements of the federal Child Abuse Prevention and Treatment Act under 42 U.S.C. 5106a. Each citizen review panel (CRP) is appointed for a three year term. One of the CRPs must be either the statewide child fatality review committee or a local child fatality review team.

The purposes of CRPs are to evaluate how effectively a child welfare agency is discharging the agency's child protection responsibilities. This evaluation can be done by examining the agency's practices, policies and procedures; reviewing specific child protective services cases; and any other criteria the CRPs considers important to ensure the protection of children.

CRPs are to meet at least once every three months. They are also directed to prepare and submit an annual report describing a summary of its activities, conclusions and recommendations. In turn, the child welfare agency is to provide within six months a written response indicating whether and how it will incorporate the recommendations of the citizen review panel.

In early 2011 the chair of the Marion County Child Fatality Review Team (MCCFRT) was approached by representatives from the Indiana Department of Child Services about the possibility of that team serving as a CRP. At the team's March 2011 meeting, DCS representatives provided a presentation describing the CRP concept and purpose. At a subsequent meeting of the MCCFRT, the membership discussed the above request and agreed to serve as a CRP. Arrangements were then made for a presentation by National CRP Director Blake Jones, MSW, PhD at the team's September 2011 meeting. Dr. Jones provided an overview of the history of CRP, hints for making the CRP process effective, and ideas of areas to review.

For the sake of efficiency, the Marion County CRP decided to incorporate their meetings into the standing monthly meetings of the MCCFRT. At the October 2011 meeting the CRP reviewed potential topics and decided to evaluate the following two areas:

1. Assess what happens to surviving siblings of children in Marion County who have died, and

2. Review available data concerning child fatalities statewide which are reported to DCS.

Outcomes for Surviving Siblings of Children Who Died in Marion County

Methods

The MCCFRT is a multidisciplinary group of professionals which meets in a confidential forum each month. The following disciplines and agencies are represented: child protective services (Marion County DCS), law enforcement (Indianapolis Metropolitan Police Department), Marion County Coroner's Office, mental health (Midtown Mental Health Services), pediatrics (Riley Hospital for Children at IU Health, Peyton Manning Children's Hospital at St. Vincent, Wishard Health Services, IU School of Medicine), Indiana Perinatal Network, Marion County Department of Health, Marion County Prosecutor, and Marion County Child Advocacy Center.

Cases to be reviewed by the MCCFRT are selected after release of the death certificate. The team examines child deaths (age < 18 years) that occurred in Marion County. If the child resided in another county the death is examined but the available information is often limited. The team reviews every child death that meets one or more of the following criteria:

- Homicide,
- Suicide,
- Accident,
- Undetermined cause or manner,
- Possible SIDS (sudden infant death syndrome),
- Questions based on death certificate review, and
- DCS requests.

In addition to reviewing the information usually collected during its individual case fatality reviews, the Marion County CRP considered previously published empirical data. One such study (Damashek A and Bonner BL, Factors related to sibling removal after a child maltreatment fatality, Child Abuse & Neglect, volume 34, pages 563–569, 2010) examined social and ecological factors potentially related to the likelihood that siblings would be removed from their homes after a child maltreatment fatality. This study was a review of Oklahoma child death review and child welfare data for 250 families during the years 1993 to 2003. Damashek and Bonner found that younger sibling age, more previous family reports to child protective services, and type of maltreatment (abuse rather than neglect) predicted a greater likelihood of sibling removal from the home.

Based on the above review, the Marion County CRP decided to abstract the following data as it reviewed individual cases: whether any siblings or other children lived in the household where the child fatality occurred; ages of those children; whether and how risk to siblings was assessed; whether the surviving siblings were placed out of the home related to the risk assessment; whether mental health referrals were made for surviving siblings; whether the family had a previous history with child protective services and if so, the reason; relationship of the caregiver(s) to the surviving siblings/children; and whether any other services were offered for anyone else in the family and if so, were those services utilized.

Data collection for this project began at the November 2011 meeting of the MCCFRT and continued at each monthly meeting through May 2011.

Results

For the 7 month period, 51 child fatalities were reviewed. Table 1 below is a summary of the data collected about these cases with respect to surviving siblings.

Table 1. Surviving Siblings of Children Who Died in Marion County: All Cases Reviewed November 2011 – May 2012 (N=51)		
County of Family Residence	Total	Percent
Marion	34	66.7%
Other	17	33.3%
Surviving Siblings?	Total	Percent
Yes	27	52.9%
No	7	13.7%
Unknown	17	33.3%
	Median	Range
Number of Surviving Siblings	2	1-6
Age of Surviving Siblings (Yrs.)	3	0.4-12
Risk Assessed for Surviving Siblings	Total	Percent
Yes	16	31.4%
No Surviving Siblings	7	13.7%
Unknown*	28	54.9%
*Screened Out (12), No Report Made to DCS/No Info Available (16)		
Surviving Siblings Removed From Home	Total	Percent
No	25	49.0%
Yes	3	5.9%
No Surviving Siblings	7	13.7%
Unknown	16	31.4%
Mental Health Referral for Surviving Siblings	Total	Percent
Yes	13	25.5%
No Surviving Siblings	7	13.7%
Unknown	31	60.8%
Family With Prior CPS History	Total	Percent
Yes	13	25.5%
No	9	17.6%
Unknown	29	56.9%
Services Offered to Family	Total	Percent
Yes	14	27.5%
Unknown	37	72.5%

As noted in Table 1, of the 34 cases about which information was known, 27 (79%) had at least one surviving sibling. The surviving siblings were generally young, with a median age of 3 years.

The Indiana DCS policy addressing child fatality and near fatality assessments (http://www.in.gov/dcs/files/4.31_Fatality_and_Near_Fatality_Assessments_(Investigations)3.pdf) directs the responding DCS case manager to place any surviving siblings in a safe environment if all legal caregivers have been arrested, and to assess risk to any surviving siblings and document same in the Assessment of Alleged Child Abuse or Neglect Report narrative. For the 51 cases reviewed, in only 23 (45%) was there was information available as to whether risk was assessed for surviving siblings. Of the 16 cases with surviving siblings, all had a risk assessment for the siblings documented.

For the 28 cases with surviving siblings and for whom information was available, nearly 90% (25 of 28) were not removed from the home. In all 13 cases known to have surviving siblings and where information about mental health referrals was available a referral was documented; however, in 31 cases no information was known. Of 22 cases with information available, a majority (59%) had prior involvement with child protective services. In 14 cases (28%) services were known to have been offered to the family of the deceased child; services varied from informational brochures (e.g., regarding grief and counseling services) to actual referrals.

Unfortunately, whether there was a surviving sibling was unknown in one-third of cases. Furthermore, information was not known regarding the surviving siblings in a substantial proportion of cases (31% to 72%, depending on the item). Because one-third of the child fatalities which were reviewed involved families that resided in other Indiana counties, the Marion County team usually had no information except what was on the death certificate. Therefore, cases outside Marion County were excluded in order to have a better idea of the proportion of surviving siblings and family members that did receive services. Table 2 below summarizes this data.

Table 2. Surviving Siblings of Children Who Died in Marion County and Who Resided in Marion County: Cases Reviewed November 2011 – May 2012 (N=34)

County of Family Residence	Total	
Marion	34	
Surviving Siblings?	Total	Percent
Yes	18	52.9%
No	6	17.6%
Unknown	10	29.4%
	Median	Range
Number of Surviving Siblings	2	1-6
Age of Surviving Siblings (Yrs.)	3	0.4-12

Risk Assessed for Surviving Siblings	Total	Percent
Yes	15	44.1%
No Surviving Siblings	6	17.6%
Unknown*	13	38.2%
*Screened Out (9), No Report Made to DCS (4)		
Surviving Sibling Removed From Home	Total	Percent
No	26	76.5%
Yes	2	5.9%
No Surviving Siblings	6	17.6%
Mental Health Referral for Surviving Siblings	Total	Percent
Yes	13	38.2%
No Surviving Siblings	6	17.6%
Unknown*	15	44.1%
*Screened Out (9), No Report Made to DCS (4), Caseworker Not Present at Review (2)		
Family With Prior CPS History	Total	Percent
Yes	12	35.3%
No	7	20.6%
Unknown*	15	44.1%
*Screened Out (9), No Report Made to DCS (4), Caseworker Not Present at Review (2)		
Services Offered to Family	Total	Percent
Yes	14	41.2%
Unknown*	20	58.8%
*Screened Out (9), No Report Made to DCS (4), No Info (7)		

Of the 12 Marion County cases involving families with prior DCS history, the manners of death as listed on the death certificate were as follows: Natural - 5, Accidental - 5, Homicide - 1, and Suicide - 1.

While excluding non-Marion County cases helped to eliminate some of the "unknowns", there are still significant proportions of cases for which the CRP had no information beyond that on the death certificate (29% to 59%, depending on the item). The reasons which could be identified included that a case was screened out by the DCS Hotline and therefore not assigned for investigation, a report was not made to DCS, and the DCS case manager not present or their information not available to the DCS representatives present at the review.

Conclusions

Where information is available it appears that for child fatalities in which DCS is involved and in which there are surviving siblings, case managers generally are assessing risk to those siblings and providing information, services and referrals for affected families. However, conclusions from the data available are obviously limited due to the significant percentage of data items being unknown. Why the data items are unknown may provide helpful information and therefore suggest potential recommendations for professionals responding to child fatalities. As noted above, information was not available from DCS for cases which were screened out by the Hotline or were never reported to DCS. Other possible reasons for a high number of unknowns include:

- Sibling data is not collected,
- Sibling data is not documented,
- Child fatality review team does not have access to the data,
- DCS data management system may not include data set questions regarding siblings,
- Information is not consistently collected throughout the state,
- Lack of a written policy for surviving sibling interventions, and/or
- For cases in which DCS is not involved, responding agencies and professionals should have policies in place and training for their responders to address the needs of surviving siblings.

Recommendations

Improved data collection on the following items is recommended:

- The number of surviving siblings,
- The risk assessment done on surviving siblings
- The number of siblings removed from the home,
- The mental health referrals done and the kind of referral provided,
- Previous history of CPS involvement of the family
- The type and number of family services offered

If the issue is an access issue for the CFR, then providing access to the surviving sibling information.

Review of the DCS data management system and the existing surviving sibling data collection items.

The development of a more detailed written DCS policy regarding surviving siblings of child fatalities may be helpful in assuring consistency throughout the state. In addition, staff education about expectations in assessments and services for surviving siblings should be helpful.

Careful assessment of the siblings of child fatalities is likely a strategic way to prevent future child abuse in high-risk families.

A significant proportion of families – and about whom information was available – had a history of prior involvement with child protective services. This has been documented in prior research. Though the reasons for previous CPS involvement in our cases were not always known, it indicates concerns about child safety in the family previous to the child fatality. Having the manner of death added to the data collection could be of assistance in determining future risks to siblings.

Child Fatalities in Indiana Reported to the Department of Child Services (FY 2009)

Methods

At the time the Marion County CRP decided to review statewide child fatalities, the most recently published DCS report was for FY 2009. It is entitled "Child Abuse and Neglect Annual Report of Child Fatalities 2009" and available at http://www.in.gov/dcs/files/ChildFatalityReportSFY2009.pdf. It is a review of child fatalities which were investigated by DCS and substantiated as due to abuse/neglect. However, this report does not provide data regarding the actual number of reports to DCS involving fatalities, how many were investigated, the causes and manners of death, and outcomes. This information, though, may be important in comparing cases (screened out vs. unsubstantiated vs. substantiated), assessing opportunities for prevention, and demonstrating the actual resources utilized by DCS in responding to child fatalities.

In order to assess the above items, the Marion County CRP therefore requested from DCS the following data for the year covered in the above noted report (FY 2009):

- Total number of DCS reports concerning a child fatality,
- The number of reports which were screened out and therefore not investigated,
- The number of reports actually investigated,
- The number of reports unsubstantiated,
- The number of reports substantiated,
- Demographic and household data,
- Any aggregate data regarding the causes of death,
- Any aggregate data regarding the manners of death, and
- Any aggregate data regarding outcomes.

With respect to outcomes, the CRP was primarily interested in the following data in order to compare between substantiated and unsubstantiated cases:

- Proportion of cases in which there was found to be impairment of the parent, guardian, or custodian at the time of a child's death;
- Proportion of cases in which services were recommended, offered or court-ordered as a result of DCS involvement;
- What types of services were recommended, offered or court-ordered for the family as a result of DCS involvement; and
- Proportion of cases in which the family actually utilized any services which were recommended/offered or court-ordered?

As DCS did not have aggregate data readily available for unsubstantiated cases, the agency instead provided the final report (Form CW 311, Assessment of Alleged Abuse or Neglect Report) for each of the cases. This report was expected to contain most if not all of the demographic information requested by the CRP in order to allow for comparisons between the unsubstantiated and substantiated cases.

Results

For FY 2009 (July 1, 2008 to June 30, 2009), DCS received 306 reports concerning a child fatality. Of those, 32 were screened out at the time the report was made and therefore not investigated. Of the 274 remaining cases which were investigated and assessed, 236 were determined to be unsubstantiated with respect to abuse/neglect. Thus 38 cases were substantiated as being due to abuse/neglect; these were the focus of the previously cited DCS annual fatality report.

Of the 274 cases which DCS investigated, the final 311 reports were available and reviewed in 231 cases. Therefore in 43 cases the final 311 report was not available for review (22 in the unsubstantiated group, 21 in the substantiated group). Table 3 below summarizes the data abstracted about these cases. Because data for over half (21 of 38) of the substantiated cases were not available, statistical comparisons between groups were not performed.

Table 3. Statewide Child Fatalities Reported to Indiana Department of Child Services, July 2008 – June 2009 (Total Reports: 231,Unsubstantiated: 214, Substantiated: 17)

	Total (%)	Unsubstantiated (%)	Substantiated (%)
County of Incident			
Marion	48 (20.8)	45 (21.0)	3 (17.6)
Other	183 (79.2)	169 (79.0)	14 (82.4)
Child Gender			
Female	102 (44.2)	97 (45.3)	5 (29.4)
Male	129 (55.8)	117 (54.7)	12 (70.6)
Child Ethnicity			
Caucasian	158 (68.4)	146 (68.2)	12 (70.6)
African American	54 (23.4)	50 (23.4)	4 (23.5)
Other	16 (6.9)	15 (7.0)	1 (5.9)
Unknown	3 (1.3)	3 (1.4)	0
Child Age			
0 - 5 months	100 (43.3)	91 (42.5)	9 (52.9)
6 - 12 months	31 (13.4)	29 (13.6)	2 (11.8)
1 - 5 years	47 (20.3)	42 (19.6)	5 (29.4)
6 - 12 years	22 (9.5)	21 (9.8)	1 (5.9)
13 - 18 years	28 (12.1)	28 (13.1)	0
Unknown	3 (1.3)	3 (1.4)	0
Death Certificate Cause Of Death			
SIDS / SUID*	56 (24.2)	53 (24.8)	3 (17.6)
Asphyxia**	72 (31.2)	64 (29.9)	8 (47.1)
Natural	53 (22.9)	48 (22.4)	5 (29.4)
Drowning	14 (6.1)	13 (6.1)	1 (5.9)
Gunshot Wound	9 (3.9)	9 (4.2)	0
Blunt Force Trauma	10 (4.3)	10 (4.7)	0
Drug Overdose	3 (1.3)	3 (1.4)	0
Fire (Burn)	3 (1.3)	3 (1.4)	0

No Information	3 (1.3)	3 (1.4)	0
Electrocution	1 (0.4)	1 (0.5)	0
Undetermined	7 (3.0)	7 (3.3)	0
*SIDS, sudden infant death syndrome; SUID, sudden unexplained infant death			
**Includes: Mechanical/Positional, Strangulation/Smoke, and Choking			
Death Certificate Manner of Death	**Total (%)**	**Unsubstantiated (%)**	**Substantiated (%)**
Accidental	91 (39.4)	83 (38.8)	8 (47.1)
Natural	78 (33.8)	71 (33.2)	7 (41.2)
Undetermined	45 (19.5)	43 (20.1)	2 (11.8)
Suicide	12 (5.2)	12 (5.6)	0
No Information	3 (1.3)	3 (1.4)	0
Homicide	2 (0.9)	2 (0.9)	0
Prior CPS History			
Yes	62 (26.8)	53 (24.8)	9 (52.9)
No	116 (50.2)	111 (51.9)	5 (29.4)
Unknown	53 (22.9)	50 (23.4)	3 (17.6)
Attributed to Unsafe Sleep			
No	87 (37.7)	85 (39.7)	2 (11.8)
Yes	65 (28.1)	58 (27.1)	7 (41.2)
Unknown	47 (20.3)	41 (19.2)	6 (35.3)
Identified as Risk Factor (Associated)	32 (13.9)	30 (14.0)	2 (11.8)
Sleeping Location For Unsafe Sleeping Deaths			
With Adult	53 (54.6)	47 (53.4)	6 (66.7)
Crib	11 (11.3)	10 (11.4)	1 (11.1)
Alone on Adult Bed or Furniture	17 (17.5)	15 (17.0)	2 (22.2)
Bassinet	6 (6.2)	6 (6.8)	0
Pack-n-Play	6 (6.2)	6 (6.8)	0
Other	4 (4.1)	4 (4.5)	0
Surviving Siblings			
Yes	166 (71.9)	153 (71.5)	13 (76.5)
No	65 (28.1)	61 (28.5)	4 (23.5)
Risk Assessed for Surviving Siblings			
Yes	150 (90.4)	138 (90.2)	12 (92.3)
No	5 (3.0)	5 (3.3)	0
Unknown	11 (6.6)	10 (6.5)	1 (7.7)

Sibling Removed			
No	151 (91.6)	147 (96.1)	4 (30.8)
Yes	14 (8.4)	6 (3.9)	8 (61.5)
Unknown	1 (0.6)	0	1 (7.7)
Services Offered to Surviving Siblings	**Total (%)**	**Unsubstantiated (%)**	**Substantiated (%)**
Yes	46 (27.7)	43 (28.1)	3 (23.1)
No	7 (4.2)	6 (3.9)	1 (7.7)
Already in Counseling	10 (6.0)	10 (6.5)	0
Unknown	103 (62.0)	94 (61.4)	9 (69.2)
Services Offered to Family			
Yes	108 (46.8)	103 (48.1)	5 (29.4)
Already In Counseling	24 (10.4)	21 (9.8)	3 (17.6)
No	1 (0.4)	1 (0.5)	0
Unknown	98 (42.4)	89 (41.6)	9 (52.9)
Result of Caregiver Drug/Alcohol Test			
Concern For Drug/Alcohol Use (Not Tested)*	23 (10.0)	19 (8.9)	4 (23.5)
Positive	17 (7.4)	12 (5.6)	5 (29.4)
Negative	20 (8.7)	20 (9.3)	0
Unknown (Testing Not Indicated in Report)	171 (74.0)	163 (76.2)	8 (47.1)
*Includes: History of Drug Use, Evidence of Drug Use, Admission of Drug/Alcohol Use			
Time Elapsed From Death To DCS Notification			
Within 24 hrs.	171 (74.0)	156 (72.9)	15 (88.2)
More than 24 hrs.	51 (22.1)	49 (22.9)	2 (11.8)
Unknown	9 (3.9)	9 (4.2)	0
Case Manager First Contact With Family			
Within 3 Hours of Fatality	33 (14.3)	32 (15.0)	1 (5.9)
More Than 3 Hours	129 (55.8)	119 (55.6)	10 (58.8)
Unknown*	64 (27.7)	58 (27.1)	6 (35.3)
No Info	5 (2.2)	5 (2.3)	0
*Within first 24 hours but exact time not provided in report			

HouseHold Type			
Single Parent	99 (42.9)	86 (40.2)	13 (76.5)
Two Parent	110 (47.6)	107 (50.0)	3 (17.6)
Extended Family	13 (5.6)	12 (5.6)	1 (5.9)
Foster Parents	5 (2.2)	5 (2.3)	0
Unknown	4 (1.7)	4 (1.9)	0

As expected, the largest numbers of reported child fatalities were generally from the most heavily populated counties (Marion – 48, Lake – 24, Allen – 19, Elkhart – 7, Porter – 7, Vanderburgh – 7, Hendricks – 6, Delaware – 5, Hamilton – 5, LaPorte – 5, Madison – 5, Wayne – 5).

As has been noted in others' reports, males seemed overrepresented among the substantiated cases, accounting for 70%.

Ninety percent of SIDS deaths nationally occur in infants 0-5 months of age, which is the reason for the age breakdown in Table 3. Of the 56 SIDS/SUID deaths, 43 (77%) occurred in infants 5 months-old or younger. Nine were 6-12 months of age, 3 were 1-5 years of age, and the remaining case had no birth date or age listed. Of those cases over 12 months of age,1 was 13 months-old and 2 were 17 months-old.

With respect to the manners of death as listed on the death certificates, the two unsubstantiated cases ruled as homicides were both gunshot wounds. One was a 17 year-old male who was shot while playing with a shotgun with several of his friends. The other was a 14 year-old female who was shot by her brother while in an argument.

In approximately one quarter of cases overall the family had had prior involvement with child protective services. However, just over half of the substantiated cases had a prior history with child protective services.

One of the most significant contributions of the child fatality review team process in this country has been the recognition of the role that unsafe sleep environments play in sudden unexpected infant deaths. A significant proportion (28%) of all child deaths reported to DCS was attributed to unsafe sleep conditions, with another 14% in which unsafe sleep conditions were identified as a risk factor. The proportion of deaths substantiated as abuse/neglect which was attributed to unsafe sleep was even higher (41%). The most common sleeping location for unsafe sleep associated deaths was with an adult in a little over half of cases.

More than two-thirds of children who died and about whom a report was made to DCS had a surviving sibling. Case managers are clearly paying attention to the surviving siblings, as manifested by the data indicating that in 90% of cases their risk was assessed. Only 8% of all surviving siblings were removed from their home relating to the death of the index sibling, though not unexpectantly among substantiated cases over half of surviving siblings were removed. Unfortunately, whether services were offered to surviving siblings or to the family was unknown in 62% and 42%, respectively.

Drug/alcohol abuse by caregivers is a recognized risk factor for child maltreatment. In only about a quarter of all cases was information available as to whether there was concern for drug/alcohol abuse or testing requested or done. Of note and concern, though, is that for all child deaths investigated by DCS , 17 of 37 (46%) were positive. While the numbers are small, among the substantiated cases, all 5

caregivers tested were positive. Of additional concern is there were 10 cases in which the report indicated concern for drug/alcohol use by the caregiver, but that individual was not tested.

In 74% of cases DCS was notified within 24 hours of the child's death. While the median time from death to DCS notification was 1 day, the range extended to as many as 200 days. The median time from a child's death until a DCS case manager's first contact with the family was 2 days (range 4-360 days).

Of the 17 substantiated cases with information available for review, 16 involved neglect of some type. The remaining case was substantiated as due to abuse. This case involved a 15 month-old with subdural hematoma and fractures (ribs, foot). The unrelated caregiver gave a statement to law enforcement in which he admitted to shaking the child. According to the autopsy report, the cause and manner of death were listed as undetermined. However, the death certificate listed the cause of death as asphyxiation and manner of death as undetermined. This case highlights an item of interest in the data provided by DCS; namely that with individual cases both "Autopsy Cause / Autopsy Manner" and "Death Certificate Cause / Death Certificate Manner" was listed. One would assume that both the cause and manner from the autopsy and death certificate would be the same; however, that is not always the case in the reports obtained by DCS. For that reason DCS now tracks both cause and manner on both documents to be sure all possible data is captured.

Conclusions

How many more cases reported investigated and unsubstantiated vs. substantiated? This gives an idea about DCS resources actually devoted to investigating child deaths in Indiana…

Were we able to answer all the questions we asked?

Cause and manner of death from post-mortem examination and recorded on the death certificate not always consistent? Why? What to do?

DCS policy concerning notification about child deaths reads as follows: "The Coroner shall immediately notify DCS by using the statewide hotline and either the local child fatality review team or if the county does not have a local child fatality team, the statewide child fatality review committee of each death of a person who is less than 18 years of age, or appears to be less than 18 years of age and who has died of an apparently suspicious, unexpected, or unexplained manner."
(http://www.in.gov/dcs/files/4.31_Fatality_and_Near_Fatality_Assessments_(Investigations).pdf). This policy is based on the statute IC 36-2-14-6.3
(http://www.in.gov/legislative/ic/code/title36/ar2/ch14.html#IC36-2-14-6.3). This statute is clearly not being followed, given that in over 20% of child fatalities reported to DCS, more than 24 ours elapsed between the death and DCS being notified.

Another DCS policy concerning the potential for caregiver drug use contributing to a child's death reads as follows: "In the event of a child fatality, if DCS has reason to believe a parent, guardian, or custodian was impaired, intoxicated, or under the influence of drugs or alcohol immediately before or at the time of death, DCS or LEA can request that the parent, guardian, or custodian submit to an alcohol/drug screen. DCS or LEA must make the request within three (3) hours of the death of the child."
(http://www.in.gov/dcs/files/4.31_Fatality_and_Near_Fatality_Assessments_(Investigations).pdf) This policy is also based on state law (IC 31-34-12-7,
http://www.in.gov/legislative/ic/code/title31/ar34/ch12.html#IC31-34-12-7). The rationale for a 3 hour

time window is not clearly explained in the law or policy but likely related to the importance of a timely collection of a specimen for a drug screen. However, it is clearly not realistic given that in over 50% of cases the case manager's first contact with the family was more than 3 hours after the child's death.

Acknowledgements

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Thanks to Andrew Campbell for reviewing the reports, abstracting and entering the data from them, and organizing the data for the report.

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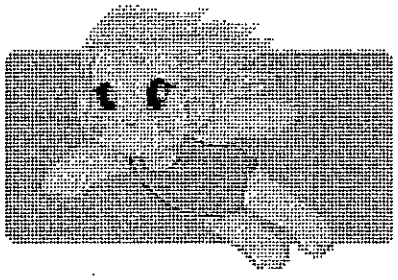
Wayne County Citizens Review Panel

Annual Report 2012



ATTACHMENT 7

Wayne County Citizen Review Panel

Annual Report

June 2012

The Wayne County Citizen Review Panel (CRP) met monthly from January 2012 through May 2012 beginning on the first Thursday of each month.

The team is comprised of Child Protection Team members, Todd Barker- WCSD-Detective, Tom Legear- RPD-Detective , Karen Bowen- GAL/CASA , Paul Rider, MD-Reid HS , Angi Raver, Deputy Prosecutor , Josie Seybold- Direcctor of Community Corrections , Kim Flanigan Health Dept.-DON , Barb Mayle- GAL-Civil courts , Phil Stevenson- Superintendent Centerville Schools, John Engle-Principal Western Wayne Schools, Heather Handley, Kathy Pribble-Principal NES, Sgt. Jon Bales-Detective DivisionRPD, DeAdra Baldwin-Juvenile Probation OfficerWC Probation, Michael E, Moore-School Psycologist Centerville School, John B. Baren-Clinical Director-Wernle , Meagan Terlep of Child & Family Services-Centerstone, Deceil Moore-Mgr. of Developmental Disabilities Program-Meridian, Sgt. Randy Wright-Wayne County Sheriff's Dept., Kevin Strahan-Meridian, Emily Williamson-Meridian and Department of Child Services, Wayne County staff including local office Director, Kelly Broyles and Carol Stough, clerical assistant.

Pam Hillagoss served as CRP Chairman and Norm Smith served as co-chairperson for the CRP meetings.

Central Office Consultant Ann Arvidson provided statistics and guidance to the panel throughout the year.

The Citizen Review Panel determined the focus of the 2012 project should be on child water safety. The first Thursday in January 2012 the Wayne County CRP discussed and began planning the specifics for a child water safety program with the goal to offer free swimming lessons to children who are involved with DCS and either reside in foster care/relative care or in their own homes. Our decision to focus on water safety was due to the increase in child fatalities in 2011 due to drowning. Department of Child Services, Region 12, had at least 3 deaths due to accidental drowning over the summer months of 2011.

The program chosen was the Starfish Aquatics Water Safety program. Some of the factors that made this program appealing for the CRP were the fact Starfish is a nationally accredited program designed to offer swimming instruction suitable for all ages and abilities, including students with special needs. The program focuses on developing core competencies that are vital in ensuring water safety. The Wayne County CRP felt it important to our mission to ensure that children are safe at all times, including during the summer months when drowning occur. One goal is to teach children the importance of asking an adult for permission prior to playing in or near

water. With proper supervision, swimming and playing in water can be a family fun time but more importantly it can be a safe time for our youth. The ultimate goal is to avoid accidental drowning. The Wayne County CRP, along with the Department of Child Services encourages caregivers to be pro-active regarding the children in their care and this water safety program is designed to give caregivers and their youth a general understanding of water safety.

This program was facilitated locally at Family Fitness Works. Lessons were offered free of charge to youth and funded by the Wayne County Prosecutor's office.

The initial class consisted of a total of 14 youth that were divided into two groups based upon their skill level. The classes took place on Saturdays and total instruction lasted one month. It was reported to the CRP all students progressed.

The Wayne County CRP is currently in the process of recruiting for a second class which is to start in Fall 2012. Wayne County Prosecutor Mike Shipman has indicated his office will continue to fund this program. A minimum of 10 students are required to facilitate a class.

The Indiana Department of Child Services strives to keep children safe and is continuing to raise awareness across the State regarding this issue. A news release regarding water safety was just issued on June 15, 2012 and is, in part, as follows:

DCS and DNR Issue Alert to Parents about Water Safety for Children

INDIANAPOLIS (June 14, 2012) – Recent drownings have prompted the Indiana Department of Child Services and the Department of Natural Resources to remind parents and guardians to make sure to keep a close eye on children playing in or near water. The reminder comes just days after two Indiana children died due to accidental drowning.

When done with proper supervision in the proper places, swimming can be the safe, healthy recreational activity that has helped kids stay cool during hot summer days for centuries. But DCS Director James Payne says even one child's death due to accidental drowning is too many.

"Accidental drowning is something that's highly avoidable with proper supervision and vigilance," Payne said.

While millions of children and adults swim safely without incident, the U.S. Centers for Disease Control and Prevention report that accidental drowning is the second largest cause of death among children ages 14 and younger.

DNR reports that both last year and the year before, eight Indiana children younger than 17 drowned. So far this year, three from that age group have drowned in Indiana.

It's important for parents and guardians to watch what their children are doing in and around the

Mitchell E. Daniels, Jr., Governor
John P. Ryan, Director

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

317-234-KIDS
FAX: 317-232-4497

www.in.gov/dcs

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

December 2012

The Lake County Foster Care Citizen Review Panel (CRP) Annual Report 2012 was received in June. It was reviewed by the Department of Child Services and this response has been developed.

The CRP report recommended that the Indiana Department of Child Services continue to look at foster care placements using the child's CANS score in determining the level of care and services chosen for them. Based on the information presented, the team decided to focus on level of care and the impact on placement as the topic for review. The goal of the review was to determine if the children being under-leveled at placement lead to multiple moves, or if there little to no impact at all. There was a random sample of cases from across the State with parameters established by the CRP.

In December 2012, the Lake County CRP began to look at the second CANS score for each child and again the placements and moves or disruptions. Additionally, there is a plan to factor in whether the Foster Parent asked for a review of the child's level because of what they were seeing in the home. Or, if a critical case juncture had occurred that lead to another CANS assessment given. A foster parent survey has also been developed and will be implemented in the coming year asking for input on how this process is working for the resource families.

The findings may be useful in helping the DCS make informed decisions finding the best placement options and in our overall best practice. We welcome the identification of trends identified which would enable us to utilize your findings when considering level of care and overall policy decisions. We are continually seeking the views of other partners as we work towards providing the right placement for each child. The result is limiting moves which often means another layer of trauma for the child. We are hoping that the CRP's work will show us both the challenges and the strengths in our methods. The findings will indicate whether using the CANS as a tool will help us limit disruptions and moves. These events can impact the both child and the foster parents negatively in many ways and it will be helpful to see our progress. Looking at the services and behavioral health plans would also help us in our holistic approach. We look forward to viewing the finished product which will in turn help us guide our future decision making as it impacts the children in our care.

We appreciate the opportunity to respond to the CRP Annual Report and, we will make ourselves available to speak to the issues in the response or to respond to any questions or comments.

Sincerely,

Ann Arvidson
Foster Care Consultant

ATTACHMENT 8

Mitchell E. Daniels, Jr., Governor
John P. Ryan, Director

Indiana Department of Child Services
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Child Abuse and Neglect Hotline: 800-800-5556

DCS Response to the Marion County Child Fatality Review Team Citizen Review Panel June 2012 Report Recommendations

DCS was pleased to review the thorough recommendations provided by the Marion County Child Fatality Review Team/Citizen Review Panel. The feedback of this esteemed team will no doubt provide ongoing opportunities for DCS to enhance its services and impact on prevention in the area of child fatalities and near fatalities. With regard to the recommendations provided in the 2012 report, there are 3 major initiatives that DCS believes will provide an impact or initial/partial impact on most of the areas of concern expressed by the CRP. The initiatives are as follows:

1. In approximately July of 2011, DCS began the use of an improved data collection tool called the National Center for the Review and Prevention of Child Death (NCRPCD) Case Report Form. This tool is more comprehensive and provides the opportunity for enhanced information gathering around surviving siblings of child fatality or near fatality victims, as well as what services were offered to the family, when those services were offered, and whether a family accepts or declines service referral information. It is the hope of DCS that the impact of this tool on data reporting for child fatalities/near fatalities may begin to be seen in the SFY 2012 child fatality cases. While the intent of DCS is to continue to gather as much data as possible to inform prevention efforts, consultation with Terry Covington, Director of the aforementioned NCRPCD, has suggested that data collection and the ability to provide meaningful follow-up regarding surviving siblings continues to be a challenge in most jurisdictions. DCS is also limited in its ability to glean information about how surviving siblings and families cope when the circumstances don't warrant continued formal involvement through some type of case. Despite these barriers, DCS is looking forward to seeing what improvements may be observed as assessments utilizing this new Case Report Form come under review.

2. From 2011- 2012, DCS placed much effort into research and collaboration to develop a model for Regional Fatality Review Teams, and DCS Regional Management staff is currently working to engage various multi-disciplinary community members to participate in these teams. With an emphasis on facilitating multi-disciplinary collaboration, these teams are

intended to provide an opportunity for comprehensive review of child fatalities and near fatalities with a goal of shared learning and responsibility for improvement. Lessons learned or gaps identified can be addressed more easily when representatives of all relevant professional groups are at the table together to evaluate situations from multiple perspectives. Another goal of the teams is to take those lessons learned and provide prevention education within their communities. These teams also provide a forum for the development of expertise through targeted continuing education opportunities that may be recommended for members. While the statewide rollout of these teams is in its beginning stages, DCS is enthusiastic to see these Regional Fatality Teams have a positive impact on community education and prevention.

3. Finally, DCS has previously identified and specially trained Regional Fatality Specialists who have developed expertise in the areas of child fatality/near fatality scene investigations. This year there has been a renewed commitment to the development of ongoing training and clear procedures/expectations for DCS staff related to these assessments. Currently, there is a pilot project within DCS Region 7 to develop and implement a targeted training to all assessment staff within that region on best practices, protocols, and expectations in child fatality/near fatality assessments. Additional to this training is the development of a comprehensive guidance and procedural manual that will act as an ongoing resource to staff. Upon successful implementation in Region 7, the goal is to develop a plan for implementation in all DCS regions. More details will be available as this project progresses.

Each of these initiatives poses significant opportunities to enhance DCS practice and inform prevention efforts across the state. More information regarding these initiatives can be made available upon request.

In closing, DCS wishes to express gratitude for the time, wisdom, and recommendations put forth by the Marion County Child Fatality Review Team/Citizen Review Panel. The objective lens provided through these reviews is invaluable to continued efforts to grow and strengthen child safety and prevention efforts, and DCS looks forward to continued collaboration with the team toward that end.

Respectfully submitted,

Ann Arvidson
Citizen Review Panel Liaison
Department of Child Services

Regina Ashley
Deputy Director
Department of Child Services

Mitchell E. Daniels, Jr., Governor
John P. Ryan, Director

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December 2012

The Wayne County Child Protection Citizen Review Panel (CRP) Annual Report 2012 was received in June. It was reviewed by the Department of Child Services and this response has been developed.

The CRP report recommended that the Indiana Department of Child Services encourage parents to be pro-active and involved in keeping their children safe around water. The team offered water safety and swimming instruction through the Starfish Aquatics Water Safety Program to families involved with the DCS. This program had minimal fiscal impact on the DCS as, the CRP joined forces with the County Prosecutors Office who funded the project. With the many drownings across our state, along with those in Wayne County, they felt this program empowered parents to take steps to ensure the safety of their children. The class gave the families knowledge rules that pertain water safety and water experiences to aid in the prevention of such a tragedy.

The DCS will be able to address similar ideas and programs, such as these identified by the Citizens Review Panel, through our Communications Department. We can publicize the available resources on DCS Websites that are accessible to the public - including the DCS Foster Parent Website. The Starfish Aquatics Water Safety Program was very successful in Wayne County and we hope that the Department can continue to address this issue, by encouraging programs such as the one that you implemented, throughout Indiana. Additionally, it will be suggested that the DCS publish the schedule of local Red Cross, YMCA, and Parks and Recreation learn to swim programs that are available to citizens and their children in DCS regional newlsetters.

On June 14, 2012 the DCS and DNR participated in a joint press conference discussing water safety and the role all adults can play in preventing drownings in our State. We hope

through programs such as the one established by the Wayne County CRP will lead to continued water safety awareness and a reduction in drownings in Indiana.

We appreciate the opportunity to respond to the CRP Annual Report and, we will make ourselves available to speak to the issues in the response or to respond to any questions or comments.

Sincerely,

Ann Arvidson
Foster Care Consultant
Indiana Department of Child Services

LAKE COUNTY CITIZEN REVIEW PANEL

ANNUAL REPORT

JUNE 2013

The Citizens Review Panel in Region 1 is comprised of the following members: Cynthia Cyprian, Clinical Director of The Villages; Jonelle Carns, Independent Contractor (foster /adoptive parent); Julie Villarreal, Program Director, Indiana MENTOR; *Cynthia Cyprian and Julie Villarreal served as co-chairs for the CRP meetings. Ann Arvidson, Foster Care Consultant for Department of Child Services and Kimberly Miller, Attorney/Federal Compliance Manager, served as liaison to the Citizens Review Panel (CRP). The Lake County Citizen Review Panel met bi-monthly from 7/1/12 through 6/30/13.

The team followed up on last year's agenda and report which looked at the role of the Child and Adolescent Needs and Strengths Assessment (CANS) in determining the level of care for children in placement. It was hypothesized that children who were under-rated by the CANS were at risk of disruption in their foster home due to a lack of supportive services. CANS levels are directly linked to the amount of supervision needed by the assigned agency, and the intensity and frequency of needs that are provided to the foster family and the identified child. For example, a level 1 child will be seen in the foster home one time per month. A level 2 child is seen twice per month. A level 3 child is seen I time per week. However, a level 4 child is seen twice per week.

This year, the members of the panel were all experienced management for Licensed Child Placing Agency's (LCPA). As a team, there was awareness that the children who were coming into therapeutic care were in need of much greater services than were required in the past. This is assumed to be due in part to the decision by the DCS to systematically reduce the number of children in residential treatment in an effort to control costs and allow children to remain in a least restrictive environment. The children who are no longer placed in residential facilities are now being placed in therapeutic foster homes.

It is believed that these high-acuity children, coupled with a miscalculated needs assessment, resulted in multiple disruptions for the child. In addition, because of the increased number of moves, the child experiences a negative impact on their emotional health and well-being, leading to an increase in runaways, reactive attachment disorders, anxiety, depression, low self-esteem, poor school performance and other issues of this nature.

In order to explore the notion that multiple disruptions were a result of a lack of supportive services for the child, we took a random sample of 19 children from random counties across the state. The sample was pulled from six randomly selected counties (Delaware, Lake, Owen, Posey, Pulaski, and Clark). The CRP chose specific demographics in which each Foster Care Supervisor from the six random counties was given the task of choosing one child from each age group with the ability to select a sibling group to be a sample for the review. The demographics included ages in the following categories: 0-4 years of age, 5-13 years of age and 14+ years of age. Each child selected was also required to have been in care for at least one year. Once the child was selected, the CRP requested a copy of the Case Plan along with

the current CANS Assessment(s). The Foster Care Supervisor from each county chose the participants and provided the necessary information. Overall, there were 19 participants selected and reviewed.

Initially, the team was going to look at Lake County specifically but felt that a larger, more diverse, sample would be more indicative of the overall possible impact across the state. Once we received the data, members compared the CANS data with the Case Plan. We were looking for consistency between the two tools which were used to provide the level of treatment services to the child. The team made the following discoveries:

- 14 out of 19 CANS improperly scored the foster family instead of the biological family. The only time that a foster family should be rated as the identified caregiver is when the permanency plan includes Adoption by that foster family.

- 10 out of 19 improperly used the short form CANS instead of the Comprehensive CANS. (Per *DCS Policy Chapter 4, Section 32: Assessment* – it states that the Short Form will be used for "each child in the home when abuse and/or neglect have been substantiated or for each child placed out-of-home during the abuse and neglect assessment"). The policy also indicates that if any item is rated a 2 or 3 on the Short Form then a Comprehensive should be completed within 30 days. This was also not consistently completed as stated in the policy.

- 10 out of 19 did not indicate a child was removed and therefore did not properly calculate the level.

- The average number of moves in the sample was 4 moves per child. The child with the most moves was 16 moves (This child was also rated on the CANS a Level 1 with no services identified).The child with the least amount of moves was 2 moves.

- 15 out of 19 indicated a "0" on the cans when the Case Plan indicated otherwise. Meaning, an item was rated a "0" on the CANS, but clearly identified as a need on the Case Plan.

For example;

- 0-Child is performing well in school, yet the child has an IEP.

- 0- Child is doing well in relationships with family members, yet the child was removed due to physical abuse.

In an effort to encourage more objectivity the CRP decided to gather information on the "experience" of the child placed in care. As a result, a survey was conducted and sent to all foster parents identified in the random sample. A series of questions regarding the foster parents experience with DCS and the CANS were developed. The surveys were mailed to each of the foster parents. Interestingly, there were no responses to our survey. The CRP then contacted the state consultant for permission to call the foster parents directly. We were given the phone numbers and attempted to make contact with all identified foster parents. We were only able to obtain responses from about 50% of our sample.

Incorrect telephone numbers and no response from left message were reasons that 100% were not included. Members contacted the identified foster parents and compiled the results to the following questions:

1) They believed that their child was properly leveled

   Yes: 30% NO: 70%

2) If they knew about the appeal process

   YES: 50% NO: 50%

3) Had they asked for an appeal?

   YES: 0 NO: 100%

4) Did they feel that the child received the support that they needed?

   YES: 0 NO: 100%

5) Were they informed of the child's known behaviors prior to placement?

   YES: 10% NO: 90%

6) Did they ask for the child's removal?

   YES: 0 NO: 100%

   *Some clients remain in the current placement, others were reunified.

As a result of the information gathered, the CRP would like to make the following recommendations to help improve the use and objectivity of the CANS tool:

- The CANS should be completed in collaboration with the foster parent, therapist and licensing agency (if applicable). The best setting for this would be a Child and Family Team Meeting (CFTM). The CFTM should be a means to gather all updated information on the child in order to score with an accurate picture of the client's current level of functioning and supportive service needs.
- Based on the improper use of the Short CANS and the lack of consistency with regards to the CANS and the Case Plan, DCS staff would benefit from additional training regarding the scoring and implementation of the CANS tool and the policies put in place.
- An additional identified issue and concern would be the rating of medically fragile children using the CANS. This tool does not allow for proper rating in the needs of these types of children. The CANS is developed and geared toward behavioral challenges, not medical needs. Yet, they both

require supervision and intervention. The team would like for the Department to consider exploring other tools that have been shown to be successful in rating the needs of medically fragile children.

Citizens Review Panel

Annual Report

Prepared by:

Marion County Child Fatality Review Team

Submitted to:

Indiana Department of Child Services

June 28, 2013

Table of Contents

Introduction

Indiana Code (IC 31-25-2-20.4) provides for the establishment by the Department of Child Services (DCS) of at least three citizen review panels in accordance with the requirements of the federal Child Abuse Prevention and Treatment Act under 42 U.S.C. 5106a. Each citizen review panel (CRP) is appointed for a three year term. One of the CRPs must be either the statewide child fatality review committee or a local child fatality review team.

The main purpose of CRPs is to evaluate how effectively a child welfare agency is discharging the agency's child protection responsibilities. This evaluation can be done by examining the agency's practices, policies and procedures; reviewing specific child protective services cases; and any other criteria the CRPs consider important to ensure the protection of children.

CRPs are to meet at least once every three months. They are also directed to prepare and submit an annual report describing a summary of its activities, conclusions and recommendations. In turn, the child welfare agency is to provide within six months a written response indicating whether and how it will incorporate the recommendations of the citizen review panel.

This is the second year the Marion County Child Fatality Review Team (MCCFRT) has served as a CRP. The 2012 Marion County CRP report documents the Panel's evaluation of two specific areas: (a) assessing outcomes for surviving siblings of children who died in Marion County, and (b) review of available data concerning child fatalities statewide which had been reported to DCS. The results and recommendations are detailed in the CRP report dated June 2012.

This report describes the work, results and conclusions of the Marion County CRP during FY 2012-2013, as well as our plans for our third year.

2012-2013 Marion County Citizens Review Panel Activity

As noted in the 2012 report, the CRP planned to continue to study statewide child fatalities this year and next, in order to track deaths due to sudden infant death syndrome (SIDS) and determine whether they are actually decreasing over time. Data for the 2012 report was acquired from a review of DCS final reports (Form CW 311, Assessment of Alleged Abuse or Neglect Report) for each case from the most recent year available, which was FY 2009. Therefore the CRP requested the CW 311 forms from the subsequent FY (2010) for all cases reported to DCS statewide involving a fatality. Only 59 of those reports were received. This compares to 306 total reports received the previous year; of those, there were 231 cases which were not screened out and had adequate information to review. The 59 reports received represented only 26% of the total reports reviewed for the prior year. Upon inquiring about the significantly lower number of CW 311 reports made available, the CRP was told this was because records for unsubstantiated cases had been purged and that this would also be the case in future years. Because such an incomplete sample would likely be biased and invalid, the CRP decided that further review of this topic would not be a worthwhile exercise.

Another area the Marion County CRP explored was the possibility of assessing outcomes for newborns found to be drug-exposed (positive for illicit drugs at birth), and whether this may be a risk factor for infant/child death. There is a sense among some team members that drug-exposed newborns are at risk but there also seems to be little data available about them. Trying to track cases, e.g. between our county review and statewide CW 311 forms, was considered but not felt to be very feasible as it would likely necessitate institutional review board approval. The CRP then considered attempting to track this data prospectively as the MCCFRT reviews cases. We have not been successful, though, in collecting adequate data as the information is not routinely available from individual case reviews.

Some of the most interesting data reviewed by the Marion County CRP relates to the work of the MCCFRT and has prompted a change in our process for selecting which child deaths to review in detail. Traditionally the MCCFRT has selected for detailed review child deaths which were (1) coroner cases, (2) known to have had DCS involvement, and/or (3) team members knew of concerns relating to the child's death. What was brought to the team's attention this year is that there are higher numbers of child deaths in certain zip codes of residence in Marion County (Figure 1).

What we also came to realize is that the largest numbers of child deaths occurred in zip codes that, perhaps not coincidentally, have the highest:

- Numbers of registered convicted violent offenders and sexual offenders (according to publically accessible data),
- Numbers of infants and children referred for sexual assault examinations;
- Numbers of infants and children hospitalized and diagnosed with definite or likely physical abuse;
- Percentages of Medicaid births (Medicaid being acknowledged as a proxy for poverty); and
- Infant mortality rates.

Five zip codes in Marion County appeared particularly concerning with respect to the number of child fatalities as well as the other factors noted above: 46201, 46218, 46222, 46226, and 46227. Of particular concern is that for cases reviewed by the MCCFRT during meetings between August 2011 and July 2012, 39 child deaths were identified in these five zip codes. Based on the team's review criteria described above, only 14 (36%) of those 39 deaths were reviewed by the team (Figure 2).

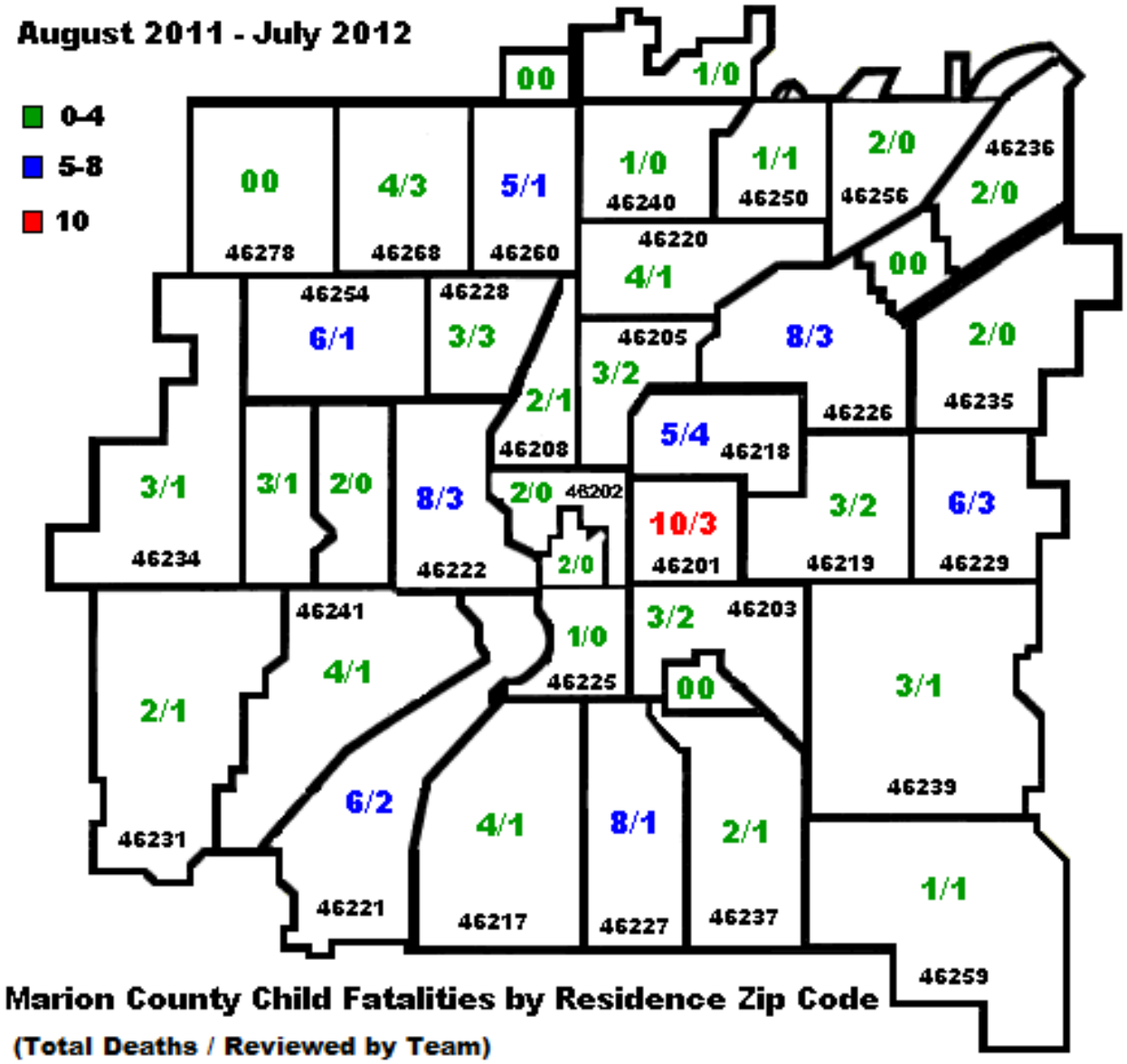
This compelling data clearly suggests many psychosocial difficulties faced by the families living in the identified areas. It also raised the following questions for the Marion County CRP:

1. Might there be opportunities for prevention of child deaths among cases not reviewed especially considering their locations? (For example, extreme prematurity listed as the cause of death on the death certificate, and detailed review by MCCFRT might identify factors such as domestic violence, fetal drug exposure or other health risks related to the premature labor and infant death.)
2. Is our process for selecting deaths to review allowing us to truly identify cases with DCS involvement and cases with opportunities for prevention?

Therefore, at the June 2013 CRP meeting it was proposed that the MCCFRT review all cases from these 5 zip codes on a trial basis for the next 12 months. Review of all cases in these specific zip codes would be done regardless of whether a coroner's case or whether there had been DCS involvement. If after one year the team identifies no additional useful information with prevention implications, the team has the option to return to their previous method of selecting cases for review. On the other hand, if additional useful information with implications for prevention of child fatalities is identified, then the team should consider continuing or even expanding the child death reviews to additional zip codes with higher numbers of deaths. We anticipate that our findings during the upcoming year may have implications for other child death review teams around the state.

In summary, the Marion County CRP was unable to continue a follow-up study of child fatalities statewide due to lack of access to data which had been available for the previous year. This is unfortunate because this statewide data could have allowed us to confirm anecdotal information suggesting that SIDS deaths were decreasing. Consideration should be given to de-identifying case data so that it could be available in a general format for reviews by Federal or state mandated bodies such as Citizens Review Panels. Finally, based on our observation that there are higher numbers of child deaths in certain zip codes of residence in Marion County, which also have higher numbers of other psychosocial problems, the MCCRFT has changed its process for reviewing child deaths on a trial basis for the upcoming year. This may help identify additional opportunities for prevention of child deaths, and have implications for child death review statewide.

Figure 1


August 2011 - July 2012
0-4
5-8
10
00
1/0
00
46278
4/3
46268
5/1
46260
1/0
46240
1/1
46250
2/0
46256
46236
2/0
46220
4/1
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46254
6/1
46228
3/3
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46208
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6/3
46229
46241
4/1
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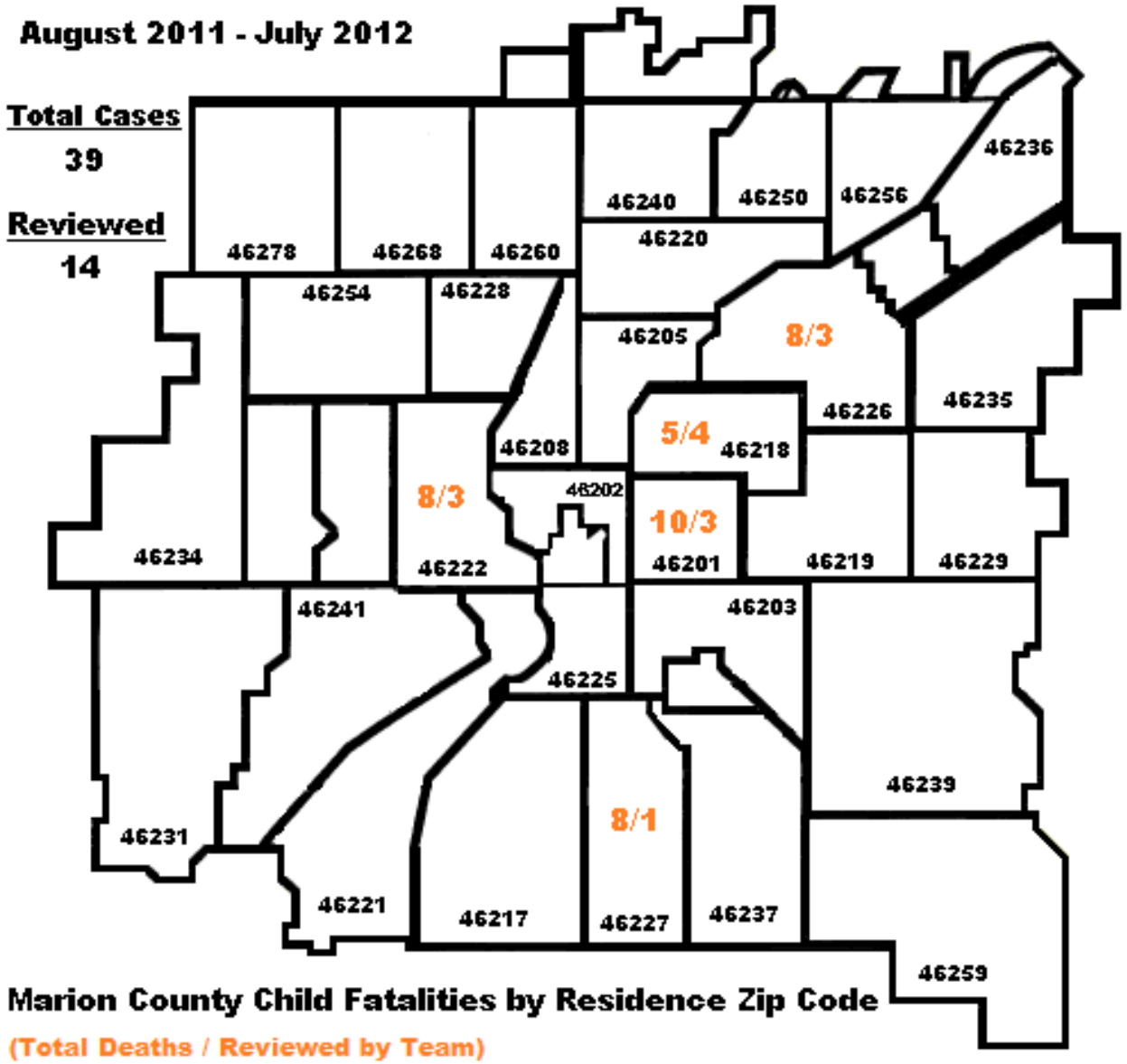
46231
1/0
46225
3/2
46203
00
3/1
46239
6/2
46221
4/1
46217
8/1
46227
2/1
46237
1/1
46259
Marion County Child Fatalities by Residence Zip Code
(Total Deaths / Reviewed by Team)

Figure 2


August 2011 - July 2012
Total Cases
39
Reviewed
14
46278
46268
46260
46240
46250
46256
46236
46254
46228
46220
46205
8/3
46226
46235
46208
5/4
46218
8/3
46202
10/3
46234
46222
46201
46219
46229
46241
46203
46225
46239
8/1
46231
46221
46217
46227
46237
46259
Marion County Child Fatalities by Residence Zip Code
(Total Deaths / Reviewed by Team)

Acknowledgements

The Marion County Citizens Review Panel thanks Andrew Campbell for bringing to the CRP's attention his review of infant/child deaths and other data by zip code, and in preparing the Figures.

Members of the Marion County Citizens Review Panel and Child Fatality Review Team

Melissa Anderson-Traylor, Fatality Specialist, Marion County Department of Child Services
Tom Arkins, Chief of IT and Informatics, Indianapolis Emergency Medical Services
Alfarena Ballew, Marion County Coroner's Office
Milon Berry, CQI Officer, Indianapolis Emergency Medical Services
Marly Bradley, MD, Wishard Urgent Visit Center
Amanda Brewer, MD, Forensic Fellow, Marion County Coroner's Office
Andrew Campbell, Research Specialist, IU Child Protection Program
Joye Carter, MD, Marion County Coroner's Office
John E. Cavanaugh, MD, Marion County Coroner's Office
Robert Collins, MD, Riley Hospital for Children Emergency Department
Teri Conard, RN, Fetal Infant Mortality Review Coordinator, Marion County Public Health Department
Erin Connelly, MD, IU Child Protection Program
Captain Craig Converse, Indianapolis Metropolitan Police Department
Sheila Day, Social Worker, Peyton Manning Children's Hospital at St. Vincent / Child Protection Team
Cortney Demetris, MD, Peyton Manning Children's Hospital at St. Vincent / Child Protection Team
Lisa Emberton, Social Worker, IU Child Protection Program
Stephanie Fahner, Nurse Program Manager, Indiana Emergency Medical Services for Children
Cara Fast, Coordinator, Community Education & Child Advocacy, Riley Hospital for Children
Kevin Gill, Marion County Coroner's Office
Kama Grund, Fatality Specialist, Marion County Department of Child Services
Tara Harris, MD, IU Child Protection Program
Sergeant Doug Heustis, Indianapolis Metropolitan Police Department
Roberta Hibbard, MD, Director, IU Child Protection Program
Ralph Hicks, MD, IU Child Protection Program (*Coordinator, Citizens Review Panel and primary author*)
Barb Himes, State SIDS Coordinator / Safe Sleep Educator, Indiana Perinatal Network, IU Child Protection Program
Lynette Hiser, Safe Sleep Educator, IU Child Protection Program
Linda Hogan, Indianapolis Public Schools
Debra Johnson, Nosologist, Marion County Public Health Department
Kellie Kilrain, RN, CPNP, IU Child Protection Program
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Kristina Korobov, Marion County Prosecutor's Office
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Frank Lloyd, MD, Marion County Coroner
Lieutenant Jim Madison, Indianapolis Metropolitan Police Department
Gretchen Martin, Indiana Department of Child Services
Corey Miller, Division Manager, Marion County Department of Child Services
Jessica Miller, Deputy Coroner, Marion County Coroner's Office
Monique Miller, Supervisor, Marion County Department of Child Services

Lieutenant Michael Perkins, Indianapolis Metropolitan Police Department
Kim Rasheed, Executive Director, Marion County Child Advocacy Center
Melinda Schwer, Chief Legal Counsel, Marion County Department of Child Services
Dae Smiley, Fatality Specialist, Marion County Department of Child Services
Chanin Smith, Social Worker, IU Child Protection Program
Jamie Smith, Safe Kids Indiana
Lloyd Sprowl, II, Marion County Coroner's Office
Thomas J. Sozio, DO, Marion County Coroner's Office
Peggy Surbey, Director, Marion County Department of Child Services
Shannon Thompson, MD, Peyton Manning Children's Hospital at St. Vincent / Child Protection Team
Michelle Willis, Marion County Coroner's Office

Wayne County Citizens Review Panel

Annual Report 2013

ATTACHMENT 13

Wayne County Citizen Review Panel

Annual Report

June 2013

The Wayne County Citizen Review Panel met quarterly from August 2012 to May 2013.

The team is comprised of the following members: Pam Hilligoss, Assistant Director of Special Education, Richmond Community Schools, Dr. Paul Ryder, Pediatrician, Mike Moore, School Psychologist Centerville School District, Norm Smith, Wernle Children's Home, De Adrdra Baldwin Wayne County Probation Department, Kelly Broyles Local Department of Children's Services.

Ann Arvidson, Foster Care Consultant for Department of Child Services, served as liaison to the Citizens Review Panel.

Discussions and concerns at our first meeting involved the concern from members of the panel as well as concerns from members of the local Child Protection Committee about the large number of suspected abuse and/or neglect calls to the state level that were being screened out. The local and surrounding school districts as well as members on the panel and information from Child Protection team members gathered specific instances of reports that were screened as well as the number of total reports that were being screened out. This information was given to our local Department of Children's Services director to be shared at the state level.

As a panel we also wanted to continue with the water safety program that we implemented last year for those children who were in Department of Children Foster care placement in Wayne County. We were not able to secure a funding source.

Other topics shared and discussed at our meetings included the growing number of babies born in our local hospital, Reid Hospital that were drug addicted to maintenance drugs or illegal drugs during 2011-12. There were a total of 39 babies born during 2011-12 who were addicted. The health effects early in life as well as the on-going risk factors as these children enter school were also discussed. This discussion lead to discussions about the number of persons lodged in our local jail for drug offenses. There was also a discussion about several deaths related to heroin.

In May the Citizens Review Panel agreed to not continue as a voluntary site for a team. There was consensus from the team that the Wayne County Child Protection Team was a very active

team and that they pursued issues of concern at those meetings as well. Everyone agreed that they were a problem solving team that often worked outside of its' typical boundaries due to the vast makeup of the team.

WHY IAITMH ENDORSEMENT?

Serious shortages in mental health workforce capacity affect all agencies, programs and settings where young children are served in Indiana. The Indiana Association for Infant and Toddler Mental Health (IAITMH) is addressing this need by providing a competency-based endorsement process for all providers involved with the care and support of infants and young children and their families. This endorsement will enhance professional credibility and provide Indiana families greater access to well-trained providers closer to home.

Individuals who earn the endorsement say it has enhanced their professional development. Families benefit from greater access to well-trained providers of child care, family support and mental health services. Agencies find the endorsement helpful in structuring training and ensuring a well-prepared early care and intervention workforce.

Indiana's Endorsement is made possible by support from these partners:

Indiana Head Start Collaboration

Department of Child Services

Division of Mental Health and Addiction

Indiana Department of Health's Sunny Start Project

Indiana Association for Infant and Toddler Mental Health (IAITMH)

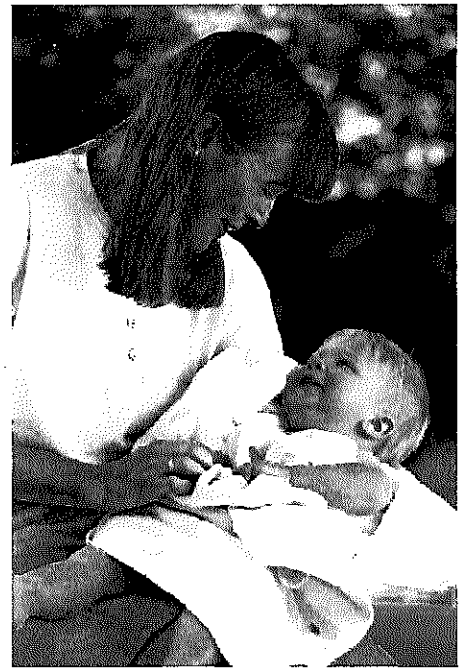
1431 N. Delaware Street
Indianapolis, IN 46202

317-638-3501, ext. 228
Email tpeek@mhai.net
www.iaitmh.org

Indiana Association for Infant and Toddler Mental Health

Endorsement

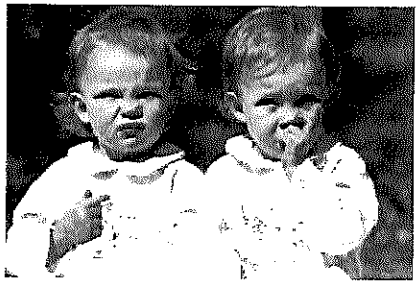
for culturally sensitive, relationship-focused practice promoting infant mental health



www.iaitmh.org

ATTACHMENT 14

IAITMH: A Path to Professional Endorsement



What is endorsement?

Endorsement supports and recognizes the development of professionals who work with or on behalf of infants, toddlers and their families. This process uses a nationally recognized set of competencies that defines best practice and guides professional growth.

The four levels of endorsement correspond to education, skills and experience:

- Infant Family Associate: Level 1
- Infant & Family Specialist: Level 2
- Infant Mental Health Specialist: Level 3
- Infant Mental Health Mentor: Level 4

Endorsement establishes a set of professional competencies, assures that professionals provide culturally sensitive, relationship-based services that promote infant and toddler mental health, and recognizes the importance of continuing education and training.

Who can apply?

All professionals who have experience working with or on behalf of infants, toddlers, parents and/or other caregivers and who meet the educational, work, training and reflective supervision/consultation requirements of any endorsement level may apply.

Why should I apply?

- Endorsement helps you grow and develop as a professional in the rapidly expanding infant and family service field.
- Endorsement ensures you'll be recognized by employers and peers for having attained a level of competency in culturally sensitive, relationship-focused practice that promotes mental health.

FOR MORE INFORMATION ABOUT IAITHM ENDORSEMENT, VISIT WWW.IAITMH.ORG OR CALL 317-638-3501 EXT. 228

- Endorsement helps you better support infants, toddlers, families, students, agencies and institutions in the promotion of infant and toddler mental health.

How do I apply?

1. Contact the IAITMH endorsement coordinator Tiffany Peek at 317-638-3501, ext. 228, or at tpeek@mhai.org. Or simply download a preliminary application at www.iaitmh.org.
2. Complete and submit the preliminary application, including the application fee and the IAITMH membership fee.
3. Prepare and submit a completed professional portfolio* along with the endorsement processing fee.
4. IAITMH will document your competencies, which includes a two-level portfolio review and (for levels 3 and 4 only) successful completion of a written exam

*The professional portfolio includes the completion of an e-form listing your training and experiences; sealed official transcripts from every college/university attended; three sealed reference rating forms; a signed code of ethics; a signed endorsement agreement; and an endorsement processing fee for the level at which the applicant is applying.

For a list of competencies needed for each of the four levels of endorsement, please see the document, "IAITMH Endorsement Levels of Competency."

Information on Child Protective Service Workforce:

Information on the education, qualifications and training requirements established by the State for child protective service professionals, including requirements for entry and advancement in the profession, including advancement to supervisory positions

FCM Minimum Qualifications:

- Bachelor's degree from an accredited college/university is required with 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.

FCM Supervisor Qualifications:

- 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.

- Plus 2 years full-time professional experience in the provision of education or social services to children and/or families. At least 1 year of the required experience must be in an administrative, managerial, or supervisory capacity.

- Or Master's degree in Social Work from an accredited university/college. Substitution: Accredited graduate training in any one of the following areas may substitute for the required experience on a year for year basis: Child Development, Criminology, Criminal Justice, Education, Healthcare, Home Economics, Psychology, Guidance and Counseling, Social Work, or Sociology.

Local Office Director Qualifications:

- 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.

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. Since 2006, 168 individuals have received IV-E supported BSW degrees with another 36 scheduled to begin their Senior Year August of 2012. Since 2001, 218 DCS staff have obtained a Title IV-E supported MSW degree.

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.

The Institute for newly hired Family Case Managers is 12 weeks in length including 29 classroom days, 21 transfer of learning days and 10 on the job reinforcement days. Curriculum is based on established child welfare competencies. Please see the Updates to the Training Plan section for additional detail related to new worker training.

Demographic Information of Current Staff and Recent Hires

Please see Attachment 17 for information about the age, gender, race/ethnicity by position type for DCS workers.

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 will continue to work with national leaders and organizations as these discussions bring more mathematical certainty to those designations.

In 2009, Regional Managers began utilizing a software tool to monitor FCM caseloads when assigning assessments and ongoing cases. 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 Teams to review and provide recommendations to local offices for those cases where traditional measures have failed to achieve permanency.

In addition, Regional Managers also monitor the number of overdue assessments or assessments that are not completed within the required thirty day timeframe. It is important to note that in June 2008 the required timeframe for completing CPS investigations was reduced from 60 days to 30 days, thus ensuring that abused and neglected children are receiving agency intervention and services as quickly as possible.

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.

Child Protective Services Demographics - Age

Family Case Managers and Family Case Manager Trainees

22-25	26-30	31-40	41-50	51+	Total
186	474	540	253	197	1650
11%	29%	33%	15%	12%	100%

FCM Supervisors

25-30	31-40	41-50	51+	Total
50	86	92	64	292
17%	29%	32%	22%	100%

County Welfare Directors

28-30	31-40	41-50	51+	Total
2	23	21	43	89
2%	26%	24%	48%	100%

Executives

28-40	41-50	51+	Total
7	15	29	51
14%	29%	57%	100%

ATTACHMENT 16

JOB GROUP ANALYSIS

Job Group #1:
Executives

Agency/BU: Dept. of Child Services (BU 00502)

Job Title	Department	Job Codes	Total Employees	Total Minorities	FEMALE							MALE						
							Non-Hispanic or Latino							Non-Hispanic or Latino				
					Total	H/L	W	B/AA	AI/AN	A	NHOPI	Total	H/L	W	B/AA	AI/AN	A	NHOPI
*Agency Head		00EXAH	1*		1*		1*											
Attorney E6		00EOA6	13	2	8	1	7					5	1	4				
Attorney E7		00EOA7	107	12	70	1	62	5		2		37	4	33				
Broad Band Executive		00EXBB	51	3	31		29	2				20		19	1			
Controller E7		00ERB7	1									1		1				
County Welfare Director E4		00EIA4	2		2		2											
County Welfare Director E5		00EIA5	20		16		16					4		4				
County Welfare Director E6		00EIA6	23	3	17	1	16					6	1	4	1			
County Welfare Director E7		00EIA7	44	1	34		34					10		9	1			
Deputy/Asst IT Director		00EAJ5	1		1		1											
Program Director E7		00EUE7	8	1	8		7			1								
State Program Director E5		00EUE5	3		3		3											
State Program Director E6		00EUE6	30	9	23	1	14	8				7		7				
*Appointed outside of the agency/facility		TOTAL	303	31	213	4	191	15	0	3	0	90	6	81	3	0	0	0
		%TOTAL	100%	10.23%	70.30%	1.32%	63.04%	4.95%	0.00%	0.99%	0.00%	29.70%	1.98%	26.73%	0.99%	0.00%	0.00%	0.00%

ATTACHMENT 17

JOB GROUP ANALYSIS

Job Group #2:
Consultants & Analysts

Dept. of Child Services (BU 00502)

Job Title	Department	Job Codes	Total Employees	Total Minorities	FEMALE							MALE						
							Non-Hispanic or Latino							Non-Hispanic or Latino				
					Total	H/L	W	B/AA	AI/AN	A	NHOPI	Total	H/L	W	B/AA	AI/AN	A	NHOPI
Budget Analyst E7		00ERI7	4		4		4											
Business Systems Cnsit Mgr		00EAL6	2		1		1					1		1				
IT Project Manager Int		00EAU7	4	1	3		2	1				1		1				
IT Project Manager Senior		00EAU6	4		1		1					3		3				
		TOTAL	14	1	9	0	8	1	0	0	0	5	0	5	0	0	0	0
		%TOTAL	100%	7.14%	64.29%	0.00%	57.14%	7.14%	0.00%	0.00%	0.00%	35.71%	0.00%	35.71%	0.00%	0.00%	0.00%	0.00%

JOB GROUP ANALYSIS

Job Group #3:
Social Service Professionals

Dept. of Child Services (BU 00502)

Job Title	Department	Job Codes	Total Employees	Total Minorities	FEMALE							MALE						
							Non-Hispanic or Latino							Non-Hispanic or Latino				
					Total	H/L	W	B/AA	AI/AN	A	NHOPI	Total	H/L	W	B/AA	AI/AN	A	NHOPI
Family Case Manager 2		002AP2	1448	363	1222	45	911	257	2	7		226	10	174	41		1	
Family Case Manager Sup 3		007AP3	15	5	11		8	3				4		2	2			
Family Case Manager Sup 4		007AP4	277	63	230	3	176	48	2	1		47		38	8		1	
Family Case Manager Trainee		002AP3	177	57	147	4	100	41		2		30	2	20	7		1	
		TOTAL	1917	488	1610	52	1195	349	4	10	0	307	12	234	58	0	3	0
		%TOTAL	100%	25.46%	83.99%	2.71%	62.34%	18.21%	0.21%	0.52%	0.00%	16.01%	0.63%	12.21%	3.03%	0.00%	0.16%	0.00%

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

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

1. State or Indian Tribal Organization (ITO):	**2. EIN:**
3. Address:	**4. Submission:** [x] New [ ] Revision
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds	6,744,110
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	674,411
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.	6,366,734
a) Total Family Preservation Services	2,096,989
b) Total Family Support Services	1,273,353
c) Total Time-Limited Family Reunification Services	449,687
d) Total Adoption Promotion and Support Services	1,273,353
e) Total for Other Service Related Activities (e.g. planning)	636,676
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)	636,676
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)	402,205
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	40,220
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____, PSSF $__0____, and/or MCV(States only)$____0____.	
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS $_0____, PSSF $_____0_____, and/or MCV(States only)$_____.	
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)	554,666
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds	3,588,775
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)	1,076,633
11. Estimated Education and Training Voucher (ETV) funds	1,203,781
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	-
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program	-
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program	-
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	-

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	

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

State or Indian Tribal Organization (ITO)_____ For FFY OCTOBER 1 ,2013 TO SEPTEMBER 30, 2014

SERVICES/ACTIVITIES	TITLE IV-B			(d) CAPTA*	(e) CFCIP	(f) ETV	(g) TITLE IV-E	(h) STATE, LOCAL, & DONATED FUNDS	(i) NUMBER TO BE SERVED		(j) POPULATION TO BE SERVED	(k) GEOG. AREA TO BE SERVED
	(a) Subpart I-CWS	(b) Subpart II-PSSF	(c) Subpart II-MCV *						Individuals	Families		
1.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)		1,273,353						26,214,063	41,502	13,800	At Risk AB/NE	Statewide
2.) PROTECTIVE SERVICES	2,815,765			554,666				102,478,005	183,438		Reports of AB/NE	Statewide
3.) CRISIS INTERVENTION (FAMILY PRESERVATION)		2,096,989						23,501,121		5,961	AB/NE	Statewide
4.)TIME-LIMITED FAMILY REUNIFICATION SERVICES		449,687						49,403,129	9,649		Children in Foster Care & their Families	Statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES		1,273,353						2,045,651	-	300	Adoptive Families	Statewide
6.) FOR OTHER SERVICE RELATED ACTIVITIES (e.g. planning)		636,676						418,702	-			Statewide
7.) FOSTER CARE MAINTENANCE: (a) FOSTER FAMILY & RELATIVE FOSTER CARE							18,464,778	83,999,306	8,719		Children in Foster Care	Statewide
(b) GROUP/INST CARE							16,214,608	136,422,338	715		Children in Foster Care	Statewide
8.) ADOPTION SUBSIDY PMTS.							51,340,249	43,259,157	8,592		Adoptive Children	Statewide
9.) GUARDIANSHIP ASSIST. PMTS.								1,800,000	-	53		Statewide
10.) INDEPENDENT LIVING SERVICES					3,588,775		302,220	1,126,574	1,794		All Eligible Children	Statewide
11.) EDUCATION AND TRAINING VOUCHERS						1,076,633		269,158	440		Children Ages 18-20	Statewide
12.) ADMINISTRATIVE COSTS	674,411	636,676						59,645,653				
13.) STAFF & EXTERNAL PARTNERS TRAINING	1,107,133						510,593	1,084,645				
14.) FOSTER PARENT RECRUITMENT & TRAINING	1,193,680						550,507	879,928				
15.) ADOPTIVE PARENT RECRUITMENT & TRAINING	953,121						439,565	620,736				
16.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING												
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING			402,205					40,220				
18.) TOTAL	6,744,110	6,366,734	402,205	554,666	3,588,775		87,822,520	533,208,386				

*** States Only, Indian Tribes are not required to include information on these programs**

ATTACHMENT 19

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 2011: October 1, 2010 through September 30, 2011

1. State or Indian Tribal Organization (ITO): INDIANA	2. EIN: 36-6000158-J7	3. Address: Department of Child Services, 402 W. Washington Street, W306 MS 08, Indianapolis, IN 46204-2739				
4. Submission: [X] New [ ] Revision						
Description of Funds	***Estimated Expenditures***	***Actual Expenditures***	***Number served***		***Population served***	***Geographic area served***
			Individuals	*Families*		
5. Total title IV-B, subpart 1 funds	$ 6,253,205.00	$ 6,253,205.00	-	-	AB/NE	Statewide, 92 Counties
a) Total Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	$ 625,320.05	$ 625,320.50				
6. Total title IV-B, subpart 2 funds (This amount should equal the sum of lines a - f.)	$ 7,150,742.00	$ 6,453,035.45	7,274	5,920	AB/NE Foster Children	Statewide, 92 Counties
a) Family Preservation Services	$ 2,502,760.00	1,275,817.91				
b) Family Support Services	$ 1,430,148.00	$ 1,427,115.00				
c) Time-Limited Family Reunification Services	$ 357,537.00	1,427,114.80				
d) Adoption Promotion and Support Services	$ 1,430,148.00	895,872.95				
e) Other Service Related Activities (e.g. planning)	$ 715,074.00	713,557.40				
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment after October 1, 2007)	$ 715,074.00	713,557.40				
7. Total Monthly Caseworker Visit Funds (STATE ONLY)	$ 428,370.00	$ 424,621.00				
a) Administrative Costs (not to exceed 10% of MCV allotment)	$ 42,837.00	$ 42,461.00				
8. Total Chafee Foster Care Independence Program (CFCIP) funds	$ 3,559,387.00	$ 3,923,550.00				
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	$ 1,067,816.00	$ 1,177,065.00	186	-	Children ages 18-21	Statewide, 92 Counties
9. Total Education and Training Voucher (ETV) funds	$ 1,193,290.00	$ 1,137,105.95	305	-	Children ages 18-23	Statewide, 92 Counties
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	***Date***	***Signature and Title of Central Office Official***				***Date***
Mary Beth Bonaventura	6/28/13					

ATTACHMENT 20

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

Fiscal Year 2013, October 1, 2012 through September 30, 2013

1. State or Indian Tribal Organization (ITO): INDIANA	**2. EIN:** 36-60000158-J7	
3. Address: Department of Child Services, 402 W. Washington Street, W306 MS 08, Indianapolis, IN 46204-2739	**4. Submission:** [ ] New [X] Revision	
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds	$	6,744,110.00
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	$	674,411.00
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.	$	6,366,734.00
a) Total Family Preservation Services	$	2,096,989.00
b) Total Family Support Services	$	1,273,353.00
c) Total Time-Limited Family Reunification Services	$	449,687.00
d) Total Adoption Promotion and Support Services	$	1,273,353.00
e) Total for Other Service Related Activities (e.g. planning)	$	696,676.00
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)	$	636,676.00
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)	$	402,205.00
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	$	40,220.00
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 $0.00, and/or MCV(States only)$0.00.		
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)	$	554,666.00
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds	$	3,588,775.00
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)	$	1,076,633.00
11. Estimated Education and Training Voucher (ETV) funds	$	1,203,781.00
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	$	-
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program	$	-
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for 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	6/28/13

Attachment B
OMB Approval #0980-0047
Approved through October 31, 2014

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

Fiscal Year 2012, October 1, 2011 through September 30, 2012

1. State or Indian Tribal Organization (ITO): INDIANA	**2. EIN:** 36-60000158-J7	
3. Address: Department of Child Services, 402 W. Washington Street, W306 MS 08, Indianapolis, IN 46204-2739	**4. Submission:** [ ] New [x] Revision	
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds	$	6,265,770
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	$	626,577
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.	$	6,552,150
a) Total Family Preservation Services	$	2,293,253
b) Total Family Support Services	$	1,310,430
c) Total Time-Limited Family Reunification Services	$	327,607.50
d) Total Adoption Promotion and Support Services	$	1,310,430
e) Total for Other Service Related Activities (e.g. planning)	$	655,215
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)	$	655,215
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)	$	428,370
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	$	42,837
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 $0.00, and/or MCV(States only)$0.00.		
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)	$	548,735
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds	$	3,923,550
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)	$	1,177,065.00
11. Estimated Education and Training Voucher (ETV) funds	$	1,310,990
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	$	-
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program	$	-
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for 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	

Section G: Financial Information

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 2011 expenditures for these purposes may not exceed FY 2005 amounts.

	FY 2005	*FY 2011*
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	$4,133,459.51
Child Welfare Training	$ 1,137,534.26	$1,501,388.37
Administration	$ 667,539.40	$634,066.91
TOTAL FEDERAL (75%)	$ 6,675,394.00	$6,268,914.68
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	$1,377,819.80
Child Welfare Training	$ 445,026.27	$500,462.79
Administration	$ 222,513.13	$211,355.64
TOTAL STATE MATCH (25%)	$ 2,225,131.33	$2,089,638.23

ATTACHMENT 23

Section G: Financial Information

Payment Limitations – Title IV-B, Subpart 2

In order to meet the non-supplantation requirements in section 432(a)(7)(A) of the Act, the Indiana Department of Child Services provides the following illustration of FY 2011 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 2011*
Federal Share	$0.00	$ 10,296,553.64
State Share	$ 3,246,083.00	$ 3,432,184.55
Total Expenditures	$ 3,246,083.00	$13,728,738.19

ATTACHMENT 23

Training Finanacial Report with ER Added Allocation and Costs

Course Code	Course Title	Module	Course Description	Level/ Category (IV-E Adm Function Served)	Base FFP Rate	Cr. Hrs	Venue	Duration	Target Audience	Allocation Methodology	Courses Per Yr	Cost per Course	Estimated Total Cost
DCS01001	Local Office Directors Workshop	N/A	Workshop will cover several topics identified by a committee of Local Office Directors. Topics include Domestic Violence, Developmental Disabilities, Finance, Human Resources, Data Review and Understanding and the Statewide Abuse and Neglect Hotline. This workshop will assist Local Office Directors with helpful information and provide an opportunity for networking.	Managers and Directors	50%	12	Classroom	12	Managers and Directors	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	1	$0.00	$0.00
DCS01007	Leadership from Within for New Directors and Managers	N/A	This 4-day series affords New Local Office Directors the opportunity to plan and develop their leadership legacy while working independently and as a group. Throughout this training, each Director will utilize a combination of coursework, group work and individual life work that will introduce theories, assessments, tools and practices to support his/her leadership legacy. Participants will use the â€œDISCâ€ behavioral assessment tool to analyze their own approach to leadership development and to enhance communication skills with their local office team. Having established an understanding of the DISC behavioral language, participants will explore work place challenges and opportunities by covering the following topics: time management, developing tone, group problem solving, managing up, change management, TQM principles, managing a team. Participants should leave this series ready to begin the implementation of their own unique leadership legacy.	Managers and Directors	N/A	24	Classroom	24	Managers and Directors	Curriculum still being developed-no methodology determined	1	$0.00	$0.00
DCS03001	Orientation	Supervisor CORE	Introduction to Supervisors Training Modules.	Family Case Supervisors - New	50%	12	Classroom	12	Family Case Supervisors-New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	5	$0.00	$0.00

DCS03002	Administrative Supervision	Supervisor CORE	New supervisors will explore ways to maximize management effectiveness, use data in decision making, ensure accountability to stakeholders, build relationships with staff and effectively advocate for clients and staff.	Family Case Supervisors - New	50%	18	Classroom	18	Family Case Supervisors - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	5	$0.00	$0.00
DCS03003	Educational Supervision	Supervisor CORE	Participants will review learning styles, new worker training, different supervision styles, TOL, mentoring process, policies and rules of agency, coaching techniques, use of constructive feed-back, empowerment of workers and structured supervision.	Family Case Supervisors - New	50%	18	Classroom	18	Family Case Supervisors - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	5	$0.00	$0.00
DCS03004	HR and MaGIK	Supervisor CORE	HR:Participant receive practical information including information on documentation and performance appraisals. MaGIK: Participants practice use of the automated tracking system in their required daily activities.	Family Case Supervisors - New	50%	18	Classroom	18	Family Case Supervisors - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	5	$0.00	$0.00
DCS03005	Supportive Supervision	Supervisor CORE	Participants review motivation of staff, dealing with secondary trauma in self and others, burnout, assessment of team functioning, successful resolution of conflict, increasing job satisfaction of workers.	Family Case Supervisors - New	50%	18	Classroom	18	Family Case Supervisors - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	5	$0.00	$0.00
DCS03008	DCS Annual All-State Supervisor Workshop	N/A	Workshop will cover several topics identified by a committee of Field Supervisors. Topics include Domestic Violence, Developmental Disabilities, Finance, Human Resources, Data Review and Understanding and the Statewide Abuse and Neglect Hotline. This workshop will assist Field Supervisors with helpful information and provide an opportunity for networking.	Family Case Supervisors - Experienced	50%	12	Classroom	12	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	1	$5,320.02	$5,320.02

DCS03009	Workshop 1: The Role of Leaders in Staff Retention	DCS IN Supervisor Series	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.	Family Case Supervisors - Experienced	50%	6	Classroom	6	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	1	$194,865.22	$194,865.22
DCS03010	Workshop 2: The Practice of Retention-Focused Supervision	DCS IN Supervisor Series	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.	Family Case Supervisors - Experienced	50%	6	Classroom	6	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	1	$194,865.22	$194,865.22
DCS03011	Workshop 3: Working with Differences	DCS IN Supervisor Series	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.	Family Case Supervisors - Experienced	50%	6	Classroom	6	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	0	$0.00	$0.00
DCS03012	Workshop 4: Communication s Skills	DCS IN Supervisor Series	Provides specific information, tools and activities to model effective communication skills within the supervisory relationship.	Family Case Supervisors - Experienced	50%	6	Classroom	6	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	0	$0.00	$0.00
DCS03013	Workshop 5: The First Six Months	DCS IN Supervisor Series	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 stress of the job, as well as the growing workload.	Family Case Supervisors - Experienced	50%	6	Classroom	6	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	0	$0.00	$0.00

DCS03014	Workshop 6: Recruiting and Selecting the Right Staff	DCS IN Supervisor Series	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.	Family Case Supervisors - Experienced	50%	6	Classroom	6	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	0	$0.00	$0.00
DCS03026	Coaching for Successful Practice	N/A	A 1-day training that builds on the coaching/mentoring skills learned in Supervisor CORE. Participants will use a real case study example from their own practice to identify challenges family case managers face with Practice Model skills and apply coaching/mentoring/modeling skills to move the practice forward.	Family Case Supervisors - Experienced	50%	6	Classroom	6	Family Case Supervisors - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	5	$0.00	$0.00
DCS04001	Orientation in Central Office	Module 1: Orientation and Introduction to Child Welfare	Welcome to New Family Case Managers at the Indiana Government Center and official swearing in as a State Employee. During this 1-day training, workers are provided employment information by a Human Resources specialist (ethics, insurance, deductions, etc.), fingerprinted, photographed for their ID and sworn in by the director. The pre-test is administered to new workers at the end of the day.	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04002	Getting to Know the Department of Child Services	Module 1: Orientation and Introduction to Child Welfare	During this 2-day training, participants will learn the history and guiding principles of the Indiana Department of Child Services including the Mission, Vision and Values, Strengths Based Perspective, and Practice Model. This course includes an overview of the roles and responsibilities of a Family Case Manager. Participants will learn practical information related to payroll, travel and the training schedule. This introduction to the big picture of the Agency gives each participant what they need to be a successful member of the State Team.	Family Case Managers - New	75%	12	Classroom	12	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04003	Laptop Distribution and MaGIK Overview	Module 1: Orientation and Introduction to Child Welfare	During this 1-day training participants will receive their laptops which will be used throughout training and in the field. Participants will learn how to effectively use the functions of their laptop and docking station, along with state policy regarding use of state equipment. The DCS Policy Manual will be accessed and navigated online. An overview of the MaGIK application including how to locate MaGIK Help and Tutorials will be presented; participants will learn how to login to the MaGIK application. Additionally, participants will be given helpful tips about how to organize information within the State network using Outlook functions and the H Drive for storing DCS documents.	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04004	Orientation in County Office of Hire	Module 1: Orientation and Introduction to Child Welfare	Introductions to unit, staff, county. Participants may shadow experienced workers, observe case conferences, familiarize self with agency locations, court, community resources, etc. The Supervisor will discuss expectations of worker regarding training. The Supervisor will familiarize new worker with evaluation procedures and timeframes. Trainees would familiarize themselves with the physical layout of the office and location of parking, court facilities, prosecutor's office, probation office, space they will occupy on TOL days, etc. The Trainee may have discussions with payroll clerk or other personnel to obtain more specific information about selection of benefits, direct deposit for payroll/travel, etc. Trainees could obtain pertinent phone, email, and fax information which they will need to maintain communications such as in the event of an absence. On-call sign up could be completed, but only scheduled following the trainee's anticipated graduation date. Trainees may wish to speak to Supervisor who will be handling the trainee's A-4 (following initial A-4), about the process. Participants may listen in on screening calls. Sometime during the day, the trainee should be afforded the opportunity to have exposure to some aspect of the job.	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04005	Engagement	Module 2: Assessing for Safety	Provides an overview of engagement as an essential and continuous step in a strength-based and family-centered model of practice. Introduces participants to the skills necessary to create and maintain trust-based relationships with children, families, and team members. Participants will explore concepts and strategies that promote respect, genuineness, empathy, and professionalism in their interactions with families.	Family Case Managers - New	75%	12	Classroom	12	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04008	Worker Safety	Module 2: Assessing for Safety	This 2-day training covers a variety of issues as they relate to the safety of the worker. Issues include escalation of anger and de-escalation techniques, mental illness, substance abuse, domestic violence and dangers associated with dogs. Class includes 3-hour presentation by the State Police Methamphetamine Suppression Unit regarding recognition and understanding of danger associated with "meth labs." Content is important for new workers to insure that they will be able to take steps to reasonably ensure their own safety. Increased understanding of the above topics as well as methods to deal with these issues will increase the likelihood that they will be able to protect themselves by avoiding dangerous situations if possible and making appropriate decisions when confronted with a dangerous situation.	Family Case Managers - New	75%	12	Classroom	12	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04012	Culture and Diversity	Module 1: Orientation and Introduction to Child Welfare	Families and children will interact with workers who are culturally competent. Workers will apply values that underlie a family-centered approach to child welfare, including keeping families together, building on family and individual strengths, promoting growth and change, and respecting each family's uniqueness and individuality. Training is intended for new and experienced FCMs. FCMs will gain an appreciation of how their values and beliefs may be different from those of families and children that they work with. FCMs will recognize ways in which an ethnocentric perspective can interfere with one's ability to serve families and children from different cultural groups. Training defines and identifies stages of cultural competence and recognition of one's own level competence. Definitions and concepts related to culture are utilized throughout training. FCMs are encouraged to seek out and use culturally relevant information that is factually derived (books, statistics, articles, etc.). Also includes explanation of components of the Cycle of Oppression: ethnocentrism, stereotypes, bias, discrimination, ""isms,"" oppression, and how they link to one another. Examples are given of how cultural values, norms, and behaviors, traditions, child-rearing practices, etc., may vary within and between cultural groups serviced by DCS.	Family Case Managers - New	75%	12	Classroom	12	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04015	Field Mentoring & Job Skill Building in County	Module 5: Transfer of Learning	Skill Reinforcement Activities provide choices for how the tasks are completed and performance criteria. Timing of tasks depends upon events occurring in the office, with families, and in the community. All objectives and activities are to be overseen by Supervisor and written documentation of completion dates and assessments to be filed. The four learning Modules with Transfer of Learning (TOL) and three-week on-the-job Skill Reinforcement (OTHJSR) Module intend to develop/build particular skills and Practice standards. TOL and OTHJSR Activities represent choices the Supervisor and Worker can make to optimize the individual worker's capacity to perform the job. Some activities require completion. Others are available for enriching and enhancing competence, or may be opportunities that cannot be predicted to occur (if they occur, take advantage of them!). The Supervisor and Worker can choose HOW these activities get completed in best meeting the individual worker's needs.	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04018	Legal Roles and Responsibilities	Module 3: Planning for Stability and Permanency	A 2-day class that explores in-depth the legal roles and responsibilities of a Family Case Manager. Course provides comprehensive information on CHINS Statutes, case timelines, practical experience writing and filing reports, and mock court testimony. Participants walk through a case and apply their knowledge of the court system. 1 of 2 days is taught by a DCS attorney and provides opportunities for pertinent legal questions.	Family Case Managers - New	75%	12	Classroom	12	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04019	Teaming	Module 2: Assessing for Safety	Provides an overview of the teaming process as an essential and continuous step in a strength-based and family-centered model of practice. This course introduces participants to the principles of the child and family team process, steps of a Child Family Team Meeting (CFTM), how to prepare team members for a CFTM, and the roles of a CFTM facilitator. At your local office, participants will work with Peer Coaches to become certified facilitators. Participants will identify formal and informal supports for a fictionally family team and walk through the steps of the teaming process. Participants will practice preparation interviews and participate in fictional family's team meeting. Trainees will identify the meeting goal, family functional strengths, and develop a plan of action for goal achievement.	Family Case Managers - New	75%	12	Classroom	12	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04022	On the Job Skill Reinforcement, post-training	Module 5: Transfer of Learning	The Field Mentor Program has been developed to help reinforce learning with practice in real life situations. After trainees complete their initial nine week training program and subsequent three week on the job training can work alongside a designated mentor. This mentor will help prepare the individual trainee to accept a caseload upon graduation. As part of the Field Mentor Program, the field mentor will complete six skill assessments as he or she works with the trainee completing training. Prior to working with a trainee, the field mentor and supervisor will receive training on how to complete these rating sheets. The skill assessments require the field mentor to rate the trainee's progress in numerous areas; the trainee will be evaluated on some skill daily, while other skills are applicable to only certain situations or as the training program develops. If the new employee does not rate "average" consistently in specified areas, a remedial program will be developed by the trainee's supervisor in consultation with the training staff to meeting the specific needs of that employee. Throughout the training process, the field mentor will work one-on-one with the trainee to ensure that effective staff development occurs. The field mentor will work with the trainee throughout the 12 weeks of	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04023	Summation and Graduation	Module 4: Tracking and Monitoring Well-Being	An opportunity for workers to review their pre-service learning experience, project how they will utilize what they have learned and to thoroughly examine how to care for themselves when under stress. Time is set aside to recognize their peers and to celebrate their accomplishments.	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04026	The Effects of Abuse, Neglect, and Separation on Child Development	Module 4: Tracking and Monitoring Well-Being	Focuses on the effects that child abuse, neglect, and family separation have on child development. The Family Case Manager will learn about the stages of normal physical, cognitive, social, and emotional development of children from birth through adolescence as well as behaviors that are commonly observed with children that have been abused, neglected, and / or separated from their families.	Family Case Managers - New	75%	18	Classroom	18	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04027	Permanency Outcomes for Children & Families	Module 4: Tracking and Monitoring Well-Being	Emphasizes the importance of permanency planning for children and families who are involved with the Department of Child Services. Participants will review available permanency options and programs, how to develop effective permanency and transition plans, how the effective use of concurrent case planning can increase the likelihood of permanency, and how to assess these plans to ensure permanency is achieved along a case continuum.	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04028	Time Management	Module 4: Tracking and Monitoring Well-Being	Focuses on the importance of time management, planning, prioritizing, and maintaining a positive work/life balance. The Family Case Manager will self-assess his/her time management skills, will learn new planning and prioritization techniques, and will understand how effective time management can lead to a positive work/life balance.	Family Case Managers - New	75%	6	Classroom	6	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04029	Case Planning and Intervening	Module 3: Planning for Stability and Permanency	In this 5-day course participants will learn to engage and involve families in the service planning and delivery process through best practice in ongoing case management. Included is training on family issues related to mental health, substance abuse, domestic violence, and childhood trauma and the impact intervening may have, positive or negative, with families that present with these issues. Participants will learn how to complete a family's case plan, including developing appropriate goals, objectives, and activities, and how to enter case information into MaGIK throughout the ongoing case management process.	Family Case Managers - New	75%	24	Classroom	24	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40
DCS04030	Assessing Child Maltreatment	Module 2: Assessing for Safety	This 5-day training highlights the importance of conducting a holistic assessment to ensure the safety, stability, well-being, and permanency of Indianaâ€™s children and families. In this training, participants will learn how to gather information in a culturally competent manner to draw conclusions and make decisions about the best interests of a child. To do so, participants will learn the physical and behavioral indicators of abuse and neglect, practice using assessment models and tools to identify safety factors, risks, strengths, and needs, and review the assessment process and relevant policies of DCS. In addition, this training offers practical strategies for interviewing parties to a case and how to document these contacts and findings in the ICWIS system.	Family Case Managers - New	75%	30	Classroom	30	Family Case Managers - New	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$575.32	$13,232.40

DCS04104	Forensic Interviewing	N/A	Interviewing a child for the courts requires specific tactics and knowledge. Over 3 days, participants will be introduced to a semi-structured model for conducting interviews with children in a strength-based, family centered practice. Prominent research findings will be reviewed, and participants will learn common language, interviewer characteristics and kinds of questions associated with forensic interviewing along with how child memory and suggestibility influence case outcomes. Participants will also learn how to document a forensic interview, how to ensure cultural competency during an interview, and how to practice and explore strategies that promote best practice in the legal field as it pertains to forensic interviewing.	Family Case Managers - Experienced	50%	18	Classroom	18	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	10	$916.86	$9,168.56
DCS04107	Making Visits Matter	N/A	In this 2-day course, participants will be able to best utilize Indianaâ€™s Practice Model in order to promote the four major outcomes in a childâ€™s welfare â€“ safety, stability, well-being, and permanency for both children and family. Participants will also learn new skills for interviewing, observing, individualizing, tracking, and adjusting in order to ensure that visitations are successful.	Family Case Managers - Experienced	75%	12	Classroom	12	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	12	$1,064.69	$12,776.26
DCS04108	Field Mentor	N/A	Designed to increase leadership and mentoring skills. Participants will cover effective communication, providing feedback, learning styles, and time management. Field Mentors will also learn how to use the Transfer of Learning curriculum to help their mentee complete required Transfer of Learning activities prior to graduation.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	8	$117.23	$937.86
DCS04110	Licensing Foster Parents	N/A	Covers all aspects of the licensing and re-licensing process for foster parents. Includes a review of policy, procedure and necessary forms and processes and information about MaGIK entry.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	1	$0.00	$0.00

DCS04118	Engaging Fathers in Child Welfare	N/A	Fathers are incredibly important to the family unit and when missing, can cause the unit to become unstable. In this 1-day training, participants will examine the role fathers play in the care of children, and participants will be provided the tools and resources to engage and involve nonresident fathers in an effort to strengthen and preserve families by restoring fathers to family life.	Family Case Managers - Experienced	50%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	4	$625.25	$2,500.98
DCS04119	Court Testimony	N/A	A 1/2-day training focusing on the role a Family Case Managerâ€™s testimony plays in the hearing of a CHINS/Termination of Parental Rights Case. Participants will learn how to prepare for court, give direct testimony, respond to cross examination questions, and communicate with their families regarding court proceedings. Prerequisites: Recommended for experienced case managers a minimum of six months post-graduation.	Family Case Managers - Experienced	75%	3	Classroom	3	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	4	$0.00	$0.00
DCS04120	Casey Foster Family Assessment Tools	N/A	Foster family assessment is an important aspect of selecting foster families for children. At the end of this 1-day course, participants will understand the CFFA approach to foster family assessment, the assessment process, and the advantages of this process for all involved. Participants will be able to identify and locate the CFFA tools, describe the subscales of the CFAI, locate help topics on the website, describe the CHAP measures, and access the website to complete an assessment. Participants will know how to fill out the Instructions for Foster Parents Applicants form, and access and explain the contents of the Comparison Report and Summary Report. And finally, they will be able to discuss the CFFA results with caregivers and use CFFA results to evaluate caregivers training needs. Required Materials: Laptop	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	1	$12,504.88	$12,504.88
DCS04122	An Overview to Concurrent Planning	N/A	This 1/2-day course is an overview of the concurrent planning policy. Participants will learn the purpose and basic roles of concurrent planning, review indicators and timelines for developing a concurrent plan, discuss full disclosure, and review documentation requirements for a concurrent plan.	Family Case Managers - Experienced	75%	3	Classroom	3	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	0	$0.00	$0.00

DCS04123	Domestic Violence: Holding a CFTM When DV is identified in the Family	N/A	Domestic Violence is a complex issue. In this 1-day training, participants will look at the dynamics of domestic violence and the impact it has on the Child and Family Team Meeting, and they will learn how to determine when to hold a CFTM with both the alleged DV offender and non-offending parent, how to effectively prepare all members of a CFT, facilitate a CFTM, and follow-up afterwards to ensure the safety of the children and DV survivor. Prerequisites: Recommended for trained facilitators of the Child and Family Team Meeting with a minimum of 3 months of facilitation experience.	Family Case Managers - Experienced	N/A	6	Classroom	6	Family Case Managers - Experienced	Curriculum still being developed- no methodology determined	4	$0.00	$0.00
DCS04124	Introduction to Developmental Disabilities	N/A	Provides a 1-day overview of individuals with developmental disabilities. Participants will learn definitions of developmental disabilities and dual diagnosis, discuss characteristics of specific disability groupings, and learn how disabilities can impact an individual across their lifespan. Participants will also learn to incorporate practice model skills into their work with individuals who have a disability.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	4	$8,117.88	$32,471.52
DCS04125	Adoption	N/A	In this 1.5-day training, participants will learn about one of the key elements of child welfare â€“ adoption. They will be prepared on how to engage, team, assess, plan, and intervene in adoption cases. They will also learn about the Adoption Triad, core issues of adoption, how to best prepare Child and Family Team Members for the adoption process, how to identify service providers, what pre- and post- adoptive tools and services are available, and what are the recent changes and trends in the field of adoption. Required Materials: Laptop	Family Case Managers - Experienced	75%	9	Classroom	9	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	4	$0.00	$0.00

DCS04126	Positive Youth Development	N/A	1-day course focused on the role of a Family Case Manager in youth engagement and facilitation of a Child and Family Team Meeting for a youth aging out of the system. Key issues include developing relationships, communication and effective listening, application of knowledge of cultural and developmental needs, and working with groups including youth with mental health issues and gay/lesbian/bisexual/transgender-questioning youth.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	2	$0.00	$0.00
DCS04127	Engaging Challenging Clients	N/A	Working with clients can be challenging, especially when they begin to disengage. After completing this training, participants will be able to better recognize and repair the relationship through self-presentation, role clarification, an understanding of the change process and how to confront and reengage involuntary clients through the context of Indianaâ€™s Practice Model.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	2	$0.00	$0.00
DCS04131	Caregiver Mental Illness	N/A	1-day training looking at the dynamics of caregiver mental illness and it's impact on the safety and well-being of children. Participants learn about common mental health diagnoses in adults and common treatments, side effects, and possible impact of the illness on children. It explores the DCS service array for mental health services and discusses safety planning, and as a part of this training, participants learn common terminology used in mental health evaluation reports and how to interpret service provider reports for service planning for the best possible outcomes for families and children. Required Materials: Laptop	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	4	$0.00	$0.00

DCS04132	Teaming in the First 30 Days	N/A	Participants will review the benefits of teaming within the first 30 days to develop a family-centered practice model in this 1/2 day training. They will also analyze how teaming early in the child welfare process can positively impact a familyâ€™s case. Participants will use initial Child and Family Team Meetings to critically analyze child safety, placement, and visitation, as well as prepare and facilitate a CFTM at several critical junctures common to the first 30 days.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	4	$547.09	$2,188.36
DCS04135	Introduction to DCS Service Standards	N/A	Service Standards are an important aspect of Child Services. In this 1-day training, participants will explore the variety of community-based services in the DCS service array, and identify the information contained in a service standard and how it defines the expectations of the service provider. Additionally, participants will learn the role of the Regional Service Coordinators and how to follow up when a service is needed or a service provider is not meeting the expectations of the service standard. Information will be presented on how MRO fits into the DCS service array, and participants will apply their new knowledge of service standards to their current cases. Required Materials: Laptop	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	8	$0.00	$0.00
DCS04136	Basic Presentation Skills Training	N/A	During this 3-day training, participants will learn presentation and platform skills, ways to engage adult learners, and how to deliver information participants with confidence. This course is intended for trainers, foster care specialists who train, local office directors or anyone who makes community presentations. Required Materials: Presentation materials used in the context of the participantâ€™s job.	Family Case Managers - Experienced	50%	18	Classroom	18	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	1	$0.00	$0.00

DCS04138	Introduction to the Attachment Continuum	N/A	In this 1-day overview, participants will learn about the attachment continuum and concepts in how to meet the challenge of caring for a child with attachment challenges. They will also learn how the development of the brain may be affected by trauma, disrupting the healthy attachment process. Participants will find that by meeting the needs of the child, the brain and attachment process may be healed.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	6	$208.41	$1,250.48
DCS04139	Domestic Violence: Critical Dynamics in Child Welfare	N/A	In this 1-day training, participants will look at the dynamics of domestic violence, the impact it has on children, and the role of protective factors, resiliencies, and safety planning. Participants will use critical thinking skills to make decisions about whether to substantiate or unsubstantiated child abuse or neglect around the issue of domestic violence. Appropriate services for a family to address domestic violence from the DCS service array will also be explored.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	12	$61,350.80	$736,209.64
DCS04140	Customer Service Management	N/A	A 1/2-day course that intends to enhance customer service management skills. Participants will discuss the interconnectedness between customer service management and the core conditions of the Indiana department of Child Services. In addition, participants will review techniques for providing excellent customer service in person, over the phone, and via email. Finally, participants will evaluate steps for engaging challenging customers and managing challenging workplace situations.	Family Case Managers - Experienced	50%	3	Classroom	3	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	6	$207.52	$1,245.12

DCS04141	Overview of Substance Abuse	N/A	A 1-day training that provides an overview of substance abuse as it applies to child welfare work. Participants will begin to understand the addiction process and the latest substance abuse research. Participants will also examine the effects of substance abuse on individuals and family. This course provides information regarding individual with a dual diagnosis of substance abuse and other mental health disorders. Finally, participants will receive information relating to substance abuse topics such as current drug trends, treatment planning, case management and working with service providers.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	16	$260.52	$4,168.30
DCS04142	Advanced Developmental Disabilities	N/A	In this 1-day course, participants review the definition of developmental disabilities and the characteristics of common developmental disabilities that were learned in the previous training, Introduction to Developmental Disabilities (DCS04124). Participants will learn to distinguish between normal safety efforts and child abuse/neglect in the context of a childâ€™s developmental disability. They will also learn about the array of evaluations, waivers, and services to persons with developmental disabilities and how to access them. Participants will also learn about the IEP process and key issues during various transitional points. Required Materials: Laptop Prerequisites: Participants should have previously attended the Introduction to Developmental Disabilities (DCS04124) or have previous education and experience working with individuals with developmental disabilities.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	12	$49,103.91	$589,246.88

DCS04145	Practice Model Training for the Greater DCS Child and Family Team Part 2 Webinar	N/A	This webinar is designed to be attended after the Practice Model for Non-Field Staff Computer Aided Training CAT. During this webinar, participants will recall and discuss how the core conditions can be used in their office environment. Participants will connect the value of the core conditions in fulfilling the mission, vision, and values of DCS. Prerequisites: Practice Model for Non-Field Staff Computer Assisted Training (DCS09022)	Family Case Managers - Experienced	N/A	1	Webinar	1	Family Case Managers - Experienced	Curriculum still being developed- no methodology determined	38	$0.00	$0.00
DCS04146	Understanding Culture & Embracing Diversity	N/A	A 1-day training that reviews the knowledge, awareness, and skills needed to work in todayâ€™s diverse society. Participants will reflect on how oneâ€™s personal cultural lens impacts child welfare outcomes, and they will identify best practice guidelines for culturally-responsive communication skills and interactions in child welfare. Required Materials: Laptop	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	16	$91.97	$1,471.50
DCS04147	Worker Safety Refresher	N/A	A 1/2-day training that provides experienced Family Case Managers a refresher on risk management and safety awareness. This course reminds workers to recognize unsafe situations and develop practical and useful methods for safety intervention, including verbal de-escalation. Participants will also recall universal precautions to be used in the field.	Family Case Managers - Experienced	50%	3	Classroom	3	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	4	$0.00	$0.00
DCS04149	Secondary Trauma	N/A	Secondary Trauma is a one day training that addresses the effects of secondary trauma on job related stress. Participants will learn to recognize risk factors for child welfare workers in experiencing secondary trauma, and develop strategies to build resilience. Participants will develop a plan for building balance between personal and professional demands into the work week.	Family Case Managers - Experienced	50%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	9	$806.12	$7,255.04

DCS04150	Time Management	N/A	A 1/2 day course designed to identify the participantâ€™s personal style for managing priorities as well as time management pitfalls and how to avoid them. Participants will learn the value of setting daily, weekly, and monthly goals, and they will develop time management skills that include effective decision making, planning, goal setting, and organization. Required Materials: Laptop	Family Case Managers - Experienced	50%	3	Classroom	3	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 50% FFP	4	$1,094.18	$4,376.70
DCS04152	Trauma Informed Care	N/A	A 1-day course that looks at the dynamics of trauma and the impact it has on the safety and well-being of children. Participants will learn about categories of trauma and the effect trauma may have on child and youth development. They will also review data from the ACES study, exploring the consequences of early or frequent trauma. This training will also present an array of evidence-based treatment options and information about using service provider reports to plan the best possible outcomes for families and children. As a part of this training, participants will have an opportunity to improve personal practice skills critical to understanding the potential impact of traumatic stress on children served by the child welfare system.	Family Case Managers - Experienced	75%	6	Classroom	6	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	14	$1,565.68	$21,919.56
DCS04153	Protective Factors	N/A	Protective Factors is a ½ day of training that examines the characteristics of parent and child protective factors and how these characteristics relate to the prevention of child abuse and neglect. Participants will need their DCS issued cell phone. Participants will learn how to evaluate a family's protective factors, help families identify and build their protective factors, and use protective factors as a common framework for collaboration with service providers. Additionally, participants will focus on the importance of incorporating protective factors into case work documents	Family Case Managers - Experienced	75%	3	Classroom	3	Family Case Managers - Experienced	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	4	$0.00	$0.00

DCS09001	Americans with Disabilities Act (ADA)	N/A	Training on the Americans with Disabilities Act (ADA).	Other	0%	0.35	Web-based	0.35	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09002	Domestic Violence for Child Welfare Workers	N/A	Training on Domestic Violence for Child Welfare Workers.	Other	0%	0.2	Web-based	0.2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09004	GenoPro Training	N/A	Training on the use of the GenoPro application as it is used in the development of Family Network Diagrams and Ecomaps.	Other	0%	0.5	Web-based	0.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09005	Quest Electronic Form Submission	N/A	Training on the Quest Electronic Form Submission System.	Other	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09006	Medicaid Enrollment Unit (MEU)	N/A	Training covering the DCS Medicaid Enrollment Unit (MEU).	Other	0%	0.2	Web-based	0.2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09009	Field Mentor Transfer of Learning (TOL)	N/A	Training covering the Field Mentor Transfer of Learning Curriculum.	Other	0%	0.15	Web-based	0.15	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09010	Indiana Adoption Program - 2010	N/A	Training on the 2010 Indiana Adoption Program. Covers rules and requirements of AAP/SAS Eligibility and administration updated for 2010.	Other	0%	0.24	Web-based	0.24	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09011	Foster Care Title IV-E and Title IV-A Emergency Assistance Eligibility	N/A	Training Covering Foster Care Title IV-E and Title IV-A Emergency Assistance (EA) Eligibility Requirements.	Other	0%	0.28	Web-based	0.28	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09012	DCS Code of Conduct	N/A	Training on the DCS Code of Conduct.	Other	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09013	Safe Sleep Practices and Reducing the Risk of SIDS	N/A	Training on Safe Sleep Practices and Reducing the Risk of SIDS.	Other	0%	0.5	Web-based	0.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09014	DCS Disaster Plan	N/A	Training on the DCS Disaster Plan.	Other	0%	0.5	Web-based	0.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09015	Pediatric Evaluation and Diagnostic Services Module 1	N/A	Training on the IU Pediatric Evaluation and Diagnostic Services (PEDS) Program. Part 1 of 3.	Other	0%	1	Web-based	1	Family Case Managers - Experienced	IV-B Child Welfare Services	open & available 24/7/365	$0.00	$0.00
DCS09016	Pediatric Evaluation and Diagnostic Services Module 2	N/A	Training on the IU Pediatric Evaluation and Diagnostic Services (PEDS) Program. Part 2 of 3.	Other	0%	1	Web-based	1	Family Case Managers - Experienced	IV-B Child Welfare Services	open & available 24/7/365	$0.00	$0.00
DCS09017	Pediatric Evaluation and Diagnostic Services Module 3	N/A	Training on the IU Pediatric Evaluation and Diagnostic Services (PEDS) Program. Part 3 of 3.	Other	0%	1	Web-based	1	Family Case Managers - Experienced	IV-B Child Welfare Services	open & available 24/7/365	$0.00	$0.00

DCS09018	QAR Report Instructional Guide	N/A	Training on how to access/view QAR Reports.	Other	0%	0	Web-based		Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09020	Educational Advocacy for FCMs Module 1 - General Education	N/A	Training on Educational Advocacy for FCMs - General Education. Module 1 of 2.	Other	0%	0.4	Web-based	0.4	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09021	Educational Advocacy for FCMs Module 2 - Special Education	N/A	Training on Educational Advocacy for FCMs - Special Education. Module 2 of 2.	Other	0%	0.6	Web-based	0.6	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09022	Practice Model Training for the Greater DCS Child and Family Team Part 1	N/A	Training on the DCS Practice Model for the Greater Child and Family Team.	Other	0%	0	Web-based		Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09023	Field Operations MyShare Reports	N/A	Training on the Field Operations MyShare Reports SharePoint site.	Other	0%	0.5	Web-based	0.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09024	DCS Rate Changes Information and Procedures	N/A	Training on rate changes and procedures that taking effect on 01/01/2012.	Other	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09025	DCS Guidelines for using Psychological Testing	N/A	Training on DCS Guidelines for using Psychological Testing.	Other	0%	0.5	Web-based	0.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09026	Supervisor Mentor for New Supervisors Manual	N/A	Training on the DCS Supervisor Mentor for New Supervisors Manual.	Other	0%	0.1	Web-based	0.1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09027	Indiana Child Abuse and Neglect Hotline	N/A	Training on the Indiana Child Abuse and Neglect Hotline.	Other	0%	0.5	Web-based	0.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09100	Chapter 2 - Child Welfare Administration Policy	N/A	Training on Chapter 2 - Child Welfare Administration Policy.	Policy	0%	0.11	Web-based	0.11	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09101	Chapter 2 - CAPTA Policy	N/A	Training on DCS Chapter 2 - Child Abuse Prevention Treatment Act (CAPTA) Policy.	Policy	0%	0.11	Web-based	0.11	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09102	Chapter 4 - Assessment (Investigation) Policy	N/A	Training on DCS Chapter 4 - Assessment (Investigation) policy.	Policy	0%	0.3	Web-based	0.3	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09103	Chapter 5 - General Case Management Policy	N/A	Training on DCS Chapter 5 - General Case Management Policy.	Policy	0%	0.15	Web-based	0.15	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09104	Chapter 6 - Court Involvement Policy	N/A	Training on DCS Chapter 6 - Court Involvement Policy.	Policy	0%	0.15	Web-based	0.15	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09105	Chapter 7 - In-Home Services Policy	N/A	Training on DCS Chapter 7 - In-Home Services Policy.	Policy	0%	0.2	Web-based	0.2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09106	Chapter 8, Part 1 - Out-of-Home Services Policy	N/A	Training on DCS Chapter 8 - Out-of-Home Services Policy. Part 1 of 2.	Policy	0%	0.13	Web-based	0.13	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09107	Chapter 8, Part 2 - Out-of-Home Services Policy	N/A	Training on DCS Chapter 8 - Out-of-Home Services Policy. Part 2 of 2.	Policy	0%	0.2	Web-based	0.2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09108	Chapter 9 - Interstate Compact (ICPC) Policy	N/A	Training on DCS Chapter 9 - Interstate Compact (ICPC) Policy.	Policy	0%	0.12	Web-based	0.12	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09109	Chapter 10 - Adoption and Permanency Policy	N/A	Training on DCS Chapter 10 - Adoption and Permanency Policy.	Policy	0%	0.11	Web-based	0.11	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09111	Domestic Violence Policy (Updated 4/2010)	N/A	Training on Domestic Violence Policy and Response Protocol.	Policy	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09112	Safety, Risk, Reunification, and Strengths and Needs Assessments	N/A	Training on the new Safety, Risk, Reunification, and Strengths and Needs Assessments policy and tools.	Policy	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00

DCS09201	Alcohol and the Family	N/A	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.	Essential Learning	0%	2.5	Web-based	2.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09202	Adolescent Suicide	N/A	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.	Essential Learning	0%	2.5	Web-based	2.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09203	Bipolar Disorder in Children and Adolescents	N/A	This course discusses the signs and symptoms of Bipolar Disorder in children and adolescents, reviews the latest pharmacological and psychotherapeutic treatment for this population.	Essential Learning	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00

DCS09204	Child and Adolescent Psychopharmacology	N/A	This course intended for non-MD mental health professionals, including marriage-family therapists and licensed clinical social workers â€“ 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.	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09205	Dual Diagnosis Treatment	N/A	Computer Assisted Training covering Dual Diagnosis Treatment for co-occuring disorders provided for employees of the Indiana Department of Child Services.	Essential Learning	0%	3	Web-based	3	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09206	Domestic Intimate Partner Violence	N/A	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.	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09210	Fundamentals of Fetal Alcohol Spectrum Disorders	N/A	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 â€“ 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.	Essential Learning	0%	1.5	Web-based	1.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09211	Post Traumatic Stress Disorder	N/A	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.	Essential Learning	0%	3	Web-based	3	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09212	Substance Abuse and Violence Against Women	N/A	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.	Essential Learning	0%	3.5	Web-based	3.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09213	Safety Crisis Planning for at Risk Adolescents and Their Families	N/A	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.	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09215	Trauma Informed Treatment for Children with Challenging Behaviors	N/A	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.	Essential Learning	0%	3	Web-based	3	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09219	ADHD: Diagnosis and Treatment	N/A	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.	Essential Learning	0%	4	Web-based	4	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09220	Stress Management for Mental Health Professionals	N/A	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, 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	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09221	Attitudes at Work	N/A	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.	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09222	Time Management	N/A	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.	Essential Learning	0%	2.5	Web-based	2.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09223	A Culture-Centered Approach to Recovery	N/A	Culture is central, not peripheral, to the journey of recovery. This course includes a review of the many dimensions of culture, the impact of worldview on psychosocial rehabilitation (PSR) practice, 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.	Essential Learning	0%	3	Web-based	3	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09225	Communication Skills and Conflict Management for Children's Services Paraprofessional s	N/A	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.	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09226	Identifying and Preventing Child Abuse and Neglect	N/A	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 â€“ 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.	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09227	Motivational Interviewing	N/A	This course helps you understand what Motivational Interviewing is and become familiar with strategies to help you with your client counseling.	Essential Learning	0%	4	Web-based	4	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09229	Overview of Serious Mental Illness for Paraprofessionals	N/A	This course provides an overview of serious mental illness including schizophrenia, bipolar disorder, and children and adolescents mental disorders.	Essential Learning	0%	3	Web-based	3	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09230	Overview of Suicide Prevention	N/A	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).	Essential Learning	0%	3.5	Web-based	3.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09231	Overview of Psychopharmacology	N/A	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.	Essential Learning	0%	4	Web-based	4	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00

DCS09233	Valuing Diversity in the Workplace	N/A	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.	Essential Learning	0%	2.5	Web-based	2.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09234	The ABC's of Bullying	N/A	School bullying is no longer regarded as just something that happens during playground routinesâ€" it is seen as a serious problem that can lead to more severe long-term problems for individuals and communities. This course examines the causes and effects of bullying, prevention techniques, and programs and treatment options for bullying. By applying the knowledge you gain in this course, you will be well on your way to recognizing and preventing bullying.	Essential Learning	0%	3.75	Web-based	3.75	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09235	Barriers to Recovery	N/A	This course reviews the various factors that can become barriers to a person's recovery. It addresses the impact of stigma (including professional stigma and internalized stigma) and discrimination. It examines the problems experienced by individuals and families in accessing services. It identifies ways in which medical insurance, both private and public, can impede the recovery journey. Suggestions for ways in which the learner can become involved in combating these barriers are included. **Audio/Video Required	Essential Learning	0%	1.75	Web-based	1.75	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00

DCS09236	Cultural Diversity	N/A	Human services organizations and their staff provide services for a wide variety of individuals from highly diverse backgrounds. This course gives you a clear overview of the various components of cultural competence along with concrete examples of how they apply to providing mental health and other human services. By taking this training, you will be better prepared to work effectively with the culturally diverse individuals that your organization serves. ** Flash Required	Essential Learning	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09237	Coaching and Mentoring in the Workplace	N/A	Welcome to Coaching and Mentoring in the Workplace! This course is designed to review a process that anyone responsible for coaching can use to improve the coachee's performance.	Essential Learning	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00
DCS09238	Customer Relations	N/A	Did you know that using best practices in customer relations is everybodyâ€™s responsibility? Many health and human services providers lack the top ten most valued skills needed to achieve successful customer service. By offering concrete information about service techniques, including ways to manage dissatisfied customers and illustrate the importance of verbal and non-verbal communication, this course teaches you the brass tacks of quality customer service. Blending interactive exercises and practical scenarios will further guide you to the true meaning of customer relations and how to implement these techniques with your own internal and external customers. Drawing upon material from the Academy for Educational Development, the information in this training is designed for any customer service provider who would like to learn more about how to enhance customer relations. So even if you are already familiar with how to provide good customer service, this course will deepen your knowledge of how to use your existing service skills in order to meetâ€"and exceedâ€" performance expectations.	Essential Learning	0%	1.5	Web-based	1.5	Family Case Managers - Experienced	No ongoing cost-not allocated	open & availabl e 24/7/36 5	$0.00	$0.00

DCS09239	Eating Disorders: Diagnosis and Treatment	N/A	This course is about eating disorders. This course has 1 credit and will take you approximately 1 hour to complete including pass the final exam and taking the course survey	Essential Learning	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09240	Effective Teams	N/A	Being a member of an effective team enhances your experience on the job as well as the care you provide to consumers. This course begins by explaining the definition of a team and the different types of teams that you find in a health care setting. You will also learn about the different roles and responsibilities effective team members can have. Finally, you will learn about the challenges and benefits to building effective teams. This training contains a variety of interactive exercises and reviews that will enable you to use the information you learn in your own work. By taking this training, you will have a clear understanding of how to work with others in order to successfully contribute.	Essential Learning	0%	2	Web-based	2	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09241	Drugs in the Workplace	N/A	Drug and alcohol abuse by professionals in the behavioral health care environment can be harmful to everyone. This course tells you what substance abuse is, what signs to look for, and how substance abuse affects people in the workplace as well as consumers. It also covers steps to take to ensure a drug free workplace. Interactive exercises and vignettes will help you to understand this information so that you will be ready to assist co-workers who may have alcohol or other drug problems.	Essential Learning	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00
DCS09242	Person-Centered Planning	N/A	This course is about how teamwork and getting to know the people we deal with enhances how we treat and react to people that affect our lives. It discusses how to work as a team member in a person-centered planning process and how to assess the quality of services offered to individuals you support.	Essential Learning	0%	1	Web-based	1	Family Case Managers - Experienced	No ongoing cost-not allocated	open & available 24/7/365	$0.00	$0.00

DCS09243	Workplace Violence	N/A	In most occupations, people can go to work without much concern of being physically harmed by others. While workplace violence may be more common in some professions than in others, it can happen in any job, and many people are ill-equipped to deal with such circumstances. If you do find yourself face to face with a potentially violent co-worker or consumer, being properly prepared to handle the situation could be the difference between life and death, or avoiding serious injury. This course teaches you how to identify and prevent violence from happening while you are at work. You will learn about the prevalence of violence in various professions, as well as how to recognize potential violent conditions and properly respond, whether it involves a consumer/patient or a coworker. Additionally, you will learn important safety and administrative practices. To help facilitate your learning, you will encounter a series of interactive exercises and review questions throughout the course. This course is appropriate for anyone who comes into contact with other people at work.	Essential Learning	0%	1.5	Web-based	1.5	Family Case Managers - Experienced	No ongoing cost- not allocated	open & available 24/7/365	$0.00	$0.00
DCS09244	Working with Difficult People	N/A	This course shows you how to identify and to manage a common issue at work- difficult people. You will learn about the people, situations, and interactions that can result in having a difficult time at work. The information presented in this course covers new ways to think about how to deal more effectively with difficult people and situations at work- by changing your thinking and trying some new approaches.	Essential Learning	0%	2.5	Web-based	2.5	Family Case Managers - Experienced	No ongoing cost- not allocated	open & available 24/7/365	$0.00	$0.00
DCSR0001	RAPT 1 Introduction to DCS	N/A	Introduction to the mission, vision, and values of the Indiana Department of Child Services.	Resource Adoptive Parent Training	75%	3	Classroom	3	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	102	$149.28	$15,226.36

DCSR0002	RAPT 2 Child Abuse and Neglect	N/A	Learn the definitions of abuse, neglect, and sexual abuse. Learn the characteristics of maltreating families and recognize predisposing attitudes and behavior in a maltreating family.	Resource Adoptive Parent Training	75%	4	Classroom	4	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	open & available 24/7/365		$515.16
DCSR0003	RAPT 3 Attachment, Discipline and Effects of Care-giving on the Family Overview	N/A	Know how a child's developmental level affects his/her understanding and reactions to out-of-home placement.	Resource Adoptive Parent Training	75%	3	Classroom	3	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	225	$156.26	$35,158.30
DCSR0004	RAPT 4 Adoption	N/A	Recognize common adoption issues for children, parents, and families. Be aware of resources in the community.	Resource Adoptive Parent Training	75%	6	Classroom	6	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	81	$281.99	$22,841.04
DCSR0005	Attachment	N/A	This training provides an overview of attachment theory and how to meet the challenge of caring for a child with attachment challenges.	Resource Adoptive Parent Training	75%	4	Classroom	4	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	53	$150.76	$7,990.46
DCSR0006	Child and Family Team Meeting	N/A	Participants will understand the purpose of a Child and Family Team Meeting as it fits into the Indiana Practice Model, and understand the important role of the resource parent as a part of the team and in the Child and Family Team Meeting.	Resource Adoptive Parent Training	75%	4	Classroom	4	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	29	$90.30	$2,618.78

DCSR0007	Cultural Competence Series Part 1: A look at the topics of Poverty and Race/Ethnicity	N/A	Participants will become aware of their own values in relation to what is considered necessary to care for a child.	Resource Adoptive Parent Training	75%	6	Classroom	6	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	34	$427.02	$14,518.80
DCSR0008	Cultural Competence Series Part 2: Language of Power	N/A	Participants will understand exclusive and inclusive power and how that can affect a child and family. Participants will also be aware of the power of language, including laws that create power within society.	Resource Adoptive Parent Training	75%	3	Classroom	3	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	34	$494.14	$16,800.60
DCSR0009	Cultural Competence Series Part 3: Substance Use Disorders	N/A	Participants will learn how substance use disorders affects families involved in child welfare.	Resource Adoptive Parent Training	75%	3	Classroom	3	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	37	$42.10	$1,557.70
DCSR0010	Cultural Competence Series Part 4: Supporting Lesbian, Gay, Bisexual, Transgender and Questioning Youth	N/A	Participants will learn ways to create a safe and affirming atmosphere for all youth in care. Current research on youth in LGBTQ community will be covered.	Resource Adoptive Parent Training	N/A	3	Classroom	3	Resource and Adoptive Parents	Curriculum still being developed- no methodology determined	16	$0.00	$0.00
DCSR0011	Educational Advocacy	N/A	Participant will understand what is required to be an effective educational advocate; be aware of federal laws and state statues that apply to student care; understand the process in identifying and assisting children with a disability that adversely affects learning.	Resource Adoptive Parent Training	75%	2	Classroom	2	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	23	$50.40	$1,159.14

DCSR0012	Nuts and Bolts	N/A	This training takes a look at some of the immediate practical issues that every resource parent needs to know.	Resource Adoptive Parent Training	75%	3	Classroom	3	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	43	$199.81	$8,592.02
DCSR0013	Sexual Abuse	N/A	Participants will understand natural and healthy sexual behaviors for children at different ages. This training assists participants in being aware of behavior signs, including problematic sexual behaviors, which might indicate a child has been sexually abused.	Resource Adoptive Parent Training	75%	3	Classroom	3	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	30	$41.50	$1,245.00
DCSR0014	Fostering Older Youth	N/A	Participants will review the federal and state legislation, policies, and programs that assist in improving the outcomes of youth aging out of care.	Resource Adoptive Parent Training	75%	6	Classroom	6	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	22	$33.20	$730.36
DCSR0015	My Family, Your Family	N/A	For children in care, cooperation between the resource family and the biological family can help to make a difficult time much better.	Resource Adoptive Parent Training	75%	4	Classroom	4	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	25	$972.13	$24,303.22
DCSR0016	Resource Family Self-Care	N/A	Resource Parents provide care for traumatized children and through that care-giving are, themselves, subject to compassion, fatigue and secondary trauma. Resource Parents will become aware of the importance of practicing self-care and maintaining well-being through a review of the topics of compassion fatigue, secondary traumatic stress, grief and self-awareness.	Resource Adoptive Parent Training	N/A	6	Classroom	6	Resource and Adoptive Parents	Curriculum still being developed-no methodology determined	15	$0.00	$0.00

DCSR0017	Trauma-Informed Care I, II, III	N/A	In this 3-part series on Trauma Informed Care, we will define child trauma and describe how children may respond to traumatic events, how to promote resilience, in children, how trauma can interfere with the children's development and functioning, and how trauma can affect children's view of themselves and their future.	Resource Adoptive Parent Training	75%	4	Classroom	4	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	6	$0.00	$0.00
DCSR0018	Adoption Legal Overview	N/A	This unique class is taught by a DCS staff attorney and participants will gain knowledge about the Adoption Assistance Program.	Resource Adoptive Parent Training	75%	2	Classroom	2	Resource and Adoptive Parents	Combined Eligibility Ratio benefiting IV-E Foster Care, IV-E Adoption, and IV-B Child Welfare at 75% FFP	25	$0.00	$0.00

Annual Reporting of State Education and Training Vouchers Awarded

Name of State: Indiana

	Total ETVs Awarded	Number of New ETVs
Final Number: **2011-2012 School Year** (July 1, 2011 to June 30, 2012)	421 students for a total of $797,761.58	27 New ETV's
2012-2013 School Year* (July 1, 2012 to June 30, 2013)	416 students 22 pending summer applications. 438 students for 2012-2013 $ 892,106.90	143 New ETV's

Comments: Dollar amount will increase once all documents are received for the 22 pending applications.

2011-2012 ETV had 368 1st year applicants, but only 27 were funded. 2011-2012 ETV had online application and paper applications.

ATTACHMENT 25

Forecast for APSR Services Under 5

7 months of data plotted, beginning with Oct 2012. Prior to Oct 2012, there we some large fluctuations in the data.

Excel was used to generate a linear trendline based on the 7 months of data.

The linear model assumes a constant growth.

The slope of the trendline was 32.857, so about 32 new cases per month.

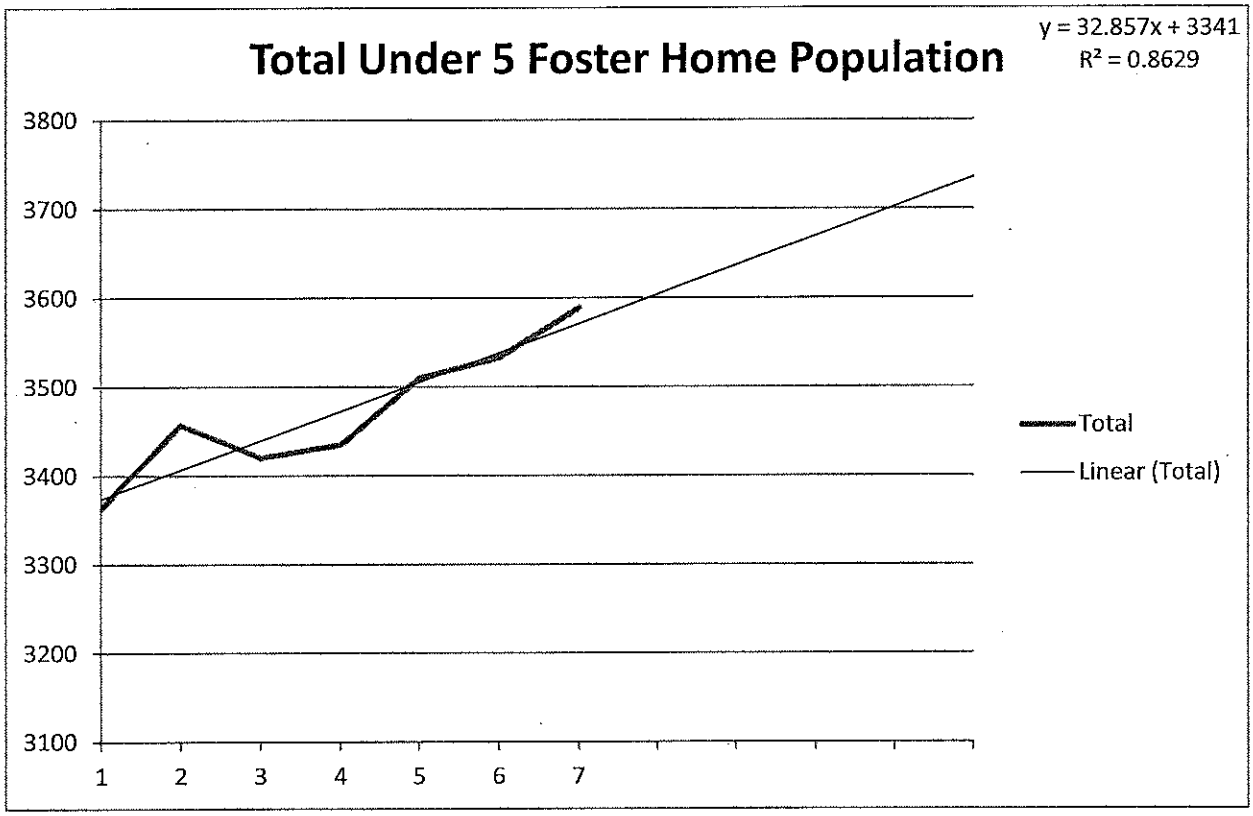
The R square value for the curve was 0.8629.

R square values run from 0 (a bad fit) to 1 (a perfect fit).

The resulting trend line gives the following estimates for the number of children in foster care:

Historical Data						
ReportDate	CHINS_Under5	Relative_Home	Foster_Home	Residential	Other	Total
October 1, 2012	4720	1559	1768	7	29	3363
November 1, 2012	4830	1635	1777	18	27	3457
December 1, 2012	4842	1647	1743	12	18	3420
January 1, 2013	4827	1669	1738	11	17	3435
February 1, 2013	4921	1703	1778	12	17	3510
March 1, 2013	4948	1711	1792	11	19	3533
April 1, 2013	5012	1730	1818	14	27	3589

Projection						
ReportDate	CHINS_Under5	Relative_Home	Foster_Home	Residential	Other	Total
May 1, 2013	5042	1768	1804	13	19	3604
June 1, 2013	5084	1794	1812	13	18	3637
July 1, 2013	5127	1819	1819	14	17	3670
August 1, 2013	5169	1845	1827	14	16	3702
September 1, 2013	5212	1871	1835	14	15	3735
October 1, 2013	5254	1897	1843	14	15	3768
November 1, 2013	5297	1922	1850	15	14	3801
December 1, 2013	5339	1948	1858	15	13	3834
January 1, 2014	5382	1974	1866	15	12	3867
February 1, 2014	5424	2000	1873	15	11	3900
March 1, 2014	5467	2025	1881	16	11	3932
April 1, 2014	5509	2051	1889	16	10	3965
May 1, 2014	5552	2077	1896	16	9	3998
June 1, 2014	5595	2103	1904	16	8	4031
July 1, 2014	5637	2128	1912	17	7	4064
August 1, 2014	5680	2154	1919	17	6	4097
September 1, 2014	5722	2180	1927	17	6	4130


Total Under 5 Foster Home Population
y = 32.857x + 3341
R² = 0.8629
3800
3700
3600
3500
3400
3300
3200
3100
1
2
3
4
5
6
7
Total
Linear (Total)