Safely Home, Families First

Indiana Department of Child Services

Title IV-E Prevention Plan

Implementation Date
September 29, 2021

Contents

Executive Summary

The Family First Prevention Services Act (FFPSA) was adopted in February 2018 as part of the Bipartisan Budget Act (HR. 1892). FFPSA makes federal resources available through reimbursement for prevention services related to mental health services, substance abuse treatment and improved parenting skills for children who are at imminent risk of entering foster care or who are a candidate for foster care. FFPSA is designed to help the public child welfare system focus on improving family stability, scaling up prevention services, decreasing foster care entry and decreasing congregate care to only when clinically necessary. The Indiana Department of Child Services (DCS) has committed to use the tools in FFPSA to support the DCS vision. DCS is focusing on preserving Hoosier families in their home of origin when it is safe to do so, improving outcomes across the child welfare system, ensuring appropriate residential treatment use only when children demonstrate the clinical need for such care, and thriving financially in a post-Title IV-E Waiver environment.

DCS VISION
Children will live in safe, healthy, and supportive families and communities.
FFPSA VISION
DCS will use the tools in FFPSA to preserve families in their home of origin when it is safe to do so, focus on improving outcomes across the child welfare system, ensure appropriate residential treatment use only when children demonstrate the clinical need for such care, and thrive financially in a post-Title IV-E Waiver environment.

As part of the DCS FFPSA vision of keeping families in their home of origin, DCS will use IV-E funding to expand home-visiting programs through Healthy Families America/Indiana (HFA/HFI) to serve more families with children who could be at risk of entering foster care. Indiana has invested in these specific well-supported evidence-based home-visiting and skill-building programs so families can remain safely together. Investments in HFI further our prevention efforts by supporting high risk families pre-emptively rather than reactively. In order to strengthen internal prevention efforts, DCS has created Indiana Family Preservation Services (INFPS). This model supports a holistic family assessment and provides a framework of services and concrete supports for children and families so families can remain in the home together. This per-diem model allows providers to choose an evidence-based program that best fits the needs of the family that addresses the family's underlying needs, keeps children safe, and mitigates risks to child safety. For families receiving INFPS, the family will have both a Family Case Manager (who is an employee of DCS) as well as an INFPS provider (who works closely with the FCM in monitoring child safety and providing services).

A. Introduction

FFPSA is a milestone in efforts to transform the child welfare system. Indiana will use FFPSA as a tool to further transform the child welfare system in Indiana and make the prevention of child abuse and neglect a top priority for families who reside in Indiana. DCS conducted a gap analysis in order to understand the current state of DCS operations. While conducting the gap analysis to determine the future state of DCS, DCS identified six ways we can better devote resources and improvement efforts so that families can thrive with the supports found in FFPSA. They are:

- Prioritizing the use of evidenced-based programs (EBPs) and support primary and secondary prevention services based on the needs of children, families and communities.

- Establishing and implementing a more structured, consistent process for making placement decisions within residential facilities.

- Properly assessing the availability and readiness of residential providers to become Qualified Residential Treatment Program (QRTP) providers.

- Jointly establishing outcomes and targets for the children and families DCS serves through collaboration with providers while considering best practices, child and family service reviews and other federal measures.

- Ensuring a continuous quality improvement environment within the Indiana child welfare system.

- Developing and enhancing financial processes that align with the needs of Indiana children and families and ensure federal funds are maximized.

FFPSA KEY PRINCIPLES FOR INDIANA
Clear Communication: FFPSA implementation workgroups will promote reliable, accurate, transparent, consistent and timely communication among child welfare stakeholders.
Data: FFPSA implementation will be done in a data-driven manner, ensuring services developed and provided are informed by outcomes and improved when necessary.

Child Welfare System Teamwork: Cross-level, cross-functional, cross-system staff will work together to identify strengths, gaps, root causes and major action areas to improve child welfare practice in Indiana.
Continuous Monitoring: The FFPSA implementation plan will be continually monitored and adjusted to meet emerging or changing needs and updates to the plan will be communicated on a regular basis to stakeholders.

In this prevention plan, we are seeking approval for our utilization of EBP's in the context of our prevention program INFPS. INFPS itself will be submitted to the Title IV-E Clearinghouse, and we do not seek approval for INFPS under the prevention program. Descriptions of INFPS are meant for context and legibility of our prevention plan.

B. Agency Framework for Monitoring Child Safety

Child Abuse and Neglect Prevention efforts are pre-emptive and not reactive by definition. A framework for pre-emption exists in the combined use of safety and risk assessment tools. While safety refers to the immediate conditions facing the child, risk refers to the possible future conditions facing the child. When the possible future conditions that the child faces cause concern, efforts to prevent those conditions are needed unless the immediate conditions faced by the child preclude the child's ability to remain in the home. We know there are children in homes with true future risk for adverse conditions. The risk assessment is utilized during case planning to identify a family's specific risks and the specific service interventions needed to address those risks. DCS' Risk Assessment can be seen in Appendix X. While DCS services are designed to eliminate that future risk, we do not lose sight of the child's safety conditions in the meantime. Below we have outlined the measures taken to ensure the safety of the child, when they are receiving prevention services from HFI outside of DCS purview, when they have an open DCS case, and when they have an open prevention case more specifically.

DCS Risk and Safety Assessments

DCS assesses risk and safety for all families who have had a report of abuse or neglect screened in. It is important to note that this requirement applies to all families involved with DCS – those with out-of-home cases and those with in-home cases including those receiving prevention services. As required by DCS Policy 4.18 in Appendix V, DCS will complete an initial safety assessment within 24 hours of the initiation of every assessment of child abuse and neglect received through the Indiana Child Abuse and Neglect Hotline. The purpose of the formal safety assessment is to help assess whether any child is likely to be in immediate danger of serious harm/maltreatment that requires a protecting intervention and determine what interventions (protective factors/safety responses) should be initiated or maintained to provide appropriate protection. The content of the safety assessments

A subsequent safety assessment (DCS policy 4.38 Assessment Initiation in Appendix VII) will be completed when there are:

1. Changes in family circumstances.
2. Changes in information known about the family.
3. Changes in the family's ability to utilize protective factors to mitigate safety threats.
4. Changes at the point of a case juncture.

(continued)

DCS will identify protective factors (e.g., nurturing and attachment to the child, knowledge of parenting and of child and youth development, parental resilience, social connections and concrete supports for parents) that mitigate safety concerns. DCS will work with the family and CFT to identify safety responses and write a comprehensive safety plan. In addition to the safety assessment tool, the Family Functional Assessment (FFA) tool should be utilized when working with self-identified lesbian, gay, bisexual, transgender and/or queer/questioning (LGBTQ) youth. Safety assessment questions helpful in determining the safety of LGBTQ youth can be found in the FFA tool.

DCS will continually reassess a child's safety based on the most current information available by completing subsequent safety assessments at the junctions previously specified. Adjustments to the safety plan will be completed as needed and reviewed/approved by the FCM, FCM supervisor and service provider during supervision. Additionally, DCS will identify and communicate safety concerns with the child and family team and work with the INFPS provider to mitigate safety issues (regardless of whether safety concerns are identified by the INFPS provider or DCS FCM).

i. Safety of children served outside of DCS by Healthy Families America/Healthy Families Indiana (HFI)

An important aspect of Indiana's prevention efforts is the work that happens outside of DCS. Healthy Families Indiana provides prevention supports to high-risk families in Indiana. Where DCS is inherently reactive to reports of suspected child abuse and neglect, HFI's efforts, where successful, preclude the need for DCS involvement by getting families what they need when they need it. If safety concerns are present and the HFI site suspects child abuse or neglect, a report is made to the DCS hotline in accordance with Indiana statute and DCS contract with HFI. DCS then initiates contact with the family if the report is screened in for an assessment. It is important to note that failure to meet this contracted obligation can result in a corrective action plan, termination of the contract altogether, or restriction of the terms of the contract to exclude specific HFI employees out of compliance.

DCS alone does not dictate HFI's safety efforts—their own safety policies can be viewed in Appendix XV and XVI. HFI oversees multiple sites across the state, to which these policies apply. Each local site develops its own policies and practices within the parameters set by HFI statewide policies and HFA national policies. HFI requires orientation training for staff to include "Orientation to child abuse and neglect indicators and reporting requirements. (10-2.D)." While local sites are able to determine their own procedures around child abuse and neglect, they must include:

- "Any individual who has a reason to believe a child is a victim of abuse or neglect has the duty to make a report."

About Healthy Families Indiana and Safety

Healthy Families Indiana (HFI) utilizes the FROG tool to assess factors associated with increased risk for child maltreatment or other adverse childhood experiences. HFI home-visiting staff members use the responses to create a service plan to organize the risks, concerns and needs identified by families with the activities, interventions and supports provided by the family support specialist to help ameliorate family risk. This service plan meets the requirements of a child specific prevention plan as defined in legislation. In addition, HFI completes screening for maternal depression at various intervals during participation using the Edinburgh Postnatal Depression Scale (EPDS) or Center for Epidemiologic Studies Depression Scale (CESD) and interpersonal violence (IPV) on all primary caregivers and makes referrals for resources when necessary.

HFI policy requires home-visiting staff to educate families on the following safety topics:

- Car seat installation: within 1 month of birth
- SIDS/Back to sleep/safe sleep/co-sleeping: first visit
- Shaken baby: first visit
- Blunt-force trauma: first visit
- Post-partum depression: within 4 weeks of birth
- Fire: within 1 month of birth
- Water temperature: within 2 months of birth
- Poison: within 6 months of birth
- Water safety (drowning): within 6 months of birth
- Appropriate caregivers: within 1 month of consent

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- "Without lapse of time (immediate) notification of the program manager and/or supervisor when abuse or neglect is suspected."
- "Sites are required to document the date and time of the call reporting child abuse or neglect was made, and date and time the supervisor/manager was notified."
- "Annual training on reporting child abuse and neglect must be provided to all staff."

The entirety of these requirements can be viewed in Appendix XVI.

Staff members are required to make every effort to educate anyone who cares for the child (spouse, boyfriend/girlfriend, grandparents, other household members) on safety topics. These topics are covered again with subsequent pregnancies or when new caregivers or household members are identified.

HFI home-visiting staff members observe parent child interaction during each home visit and document their observations (following the CHEERS memory aid: Cues, Holding, Expression, Empathy, Rhythm/reciprocity, and Smiles). They subsequently complete the CHEERS check-in tool, used to assess parent/child interaction, at multiple intervals throughout the duration of services. The CHEERS check-in tool must be completed at least once per year.

If at the conclusion of the 12-month child-specific plan the child is still deemed to be a foster care candidate, Indiana will not automatically remove the child from the home unless there are safety risks that cannot be mitigated through service provision. Instead, Indiana will terminate the initial plan, re-evaluate the child and family's needs, and create a new child-specific prevention plan in order to continue to provide prevention services with the goal of keeping the child safely in their home and preventing entry into foster care.

A list of HFI's tools and table displaying the timing of their utilization by HFI staff is presented in Appendix XXV.

HFI staff are trained on all tools prior to use. For the Family Resilience and Opportunity for Growth Scale (FROG) HFA certified trainers train the assessment workers on how to use the tool and how to document the assessment. This occurs during what is called FRS/FAW Core Training. HFA certified trainers also provide FSW/FSS Core, which has to be completed within 6 months of employment. During this training the direct service staff receive additional training on all of the tools used, training on how to create/monitor the service plan/prevention plan. (This service plan meets the requirements of a child specific prevention plan as defined in legislation.) For home visiting staff that will be working with families prior to attending Core, each HFI site is required to offer what they call Stop Gap training that uses HFA training materials. HFI staff are also trained on child abuse and neglect and reporting during both Core trainings, it is also a required training for all DCS contracted providers. DCS also provides a training session on signs of CA/N and reporting at our Biannual Institute for Strengthening Families Conference.

ii. Safety of Children Receiving Prevention Services through a DCS Case (in home and out of home)

In addition to DCS safety assessments, children receiving prevention services have a particularly robust framework for safety assessments. As part of the INFPS service-delivery model, DCS FCMs, in addition to INFPS providers, assess safety on a regular and continuing basis (through formal and informal assessments) and review caregiver protective factors when engaging with children and families. When a provider begins working with a family, they have 7 days to create a safety plan in collaboration with both the family and the DCS FCM. Formal safety assessments are conducted by the FCM on a bi-annual basis at minimum and weekly by the provider. Please see Table 1 below for clarity.

Table 1. Safety Assessment Responsibilities

Safety Assessments	DCS FCM	INFPS Provider
Informal	Monthly at minimum	Ongoing during contact with the family
Formal	Bi-annually at minimum	Weekly at minimum

As part of a comprehensive assessment of children and families and in collaboration with DCS FCMs and INFPS providers, DCS will ensure children who receive prevention services receive an initial safety assessment, as well as formal and informal safety assessments throughout DCS' involvement. If safety issues are identified, DCS will determine whether the children can remain safely at home with prevention services in place.

Indiana's Definition of Title IV-E Prevention Candidacy

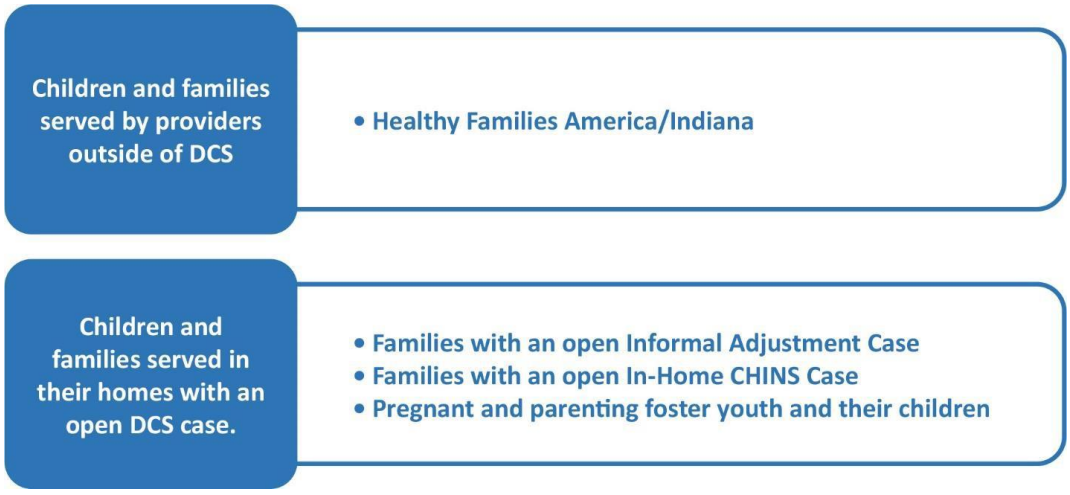
Indiana defines Title IV-E Candidacy as any child that is actually removed or any child at imminent risk of removal. DCS Policy 15.10 can be read in Appendix XIII. In the context of prevention, in which the goal is to maintain the child in the home of origin, the relevant definition of Title IV-E Candidacy is children at imminent risk of removal, which DCS further defines in DCS Policy 7.1, which can also be read in its

entirety in Appendix XIV. The specific clauses granting eligibility for the relevant prevention populations reads as follows:

> "The Indiana Department of Child Services (DCS) will make an initial determination as to whether an individual child is at imminent risk of removal and therefore a candidate for placement in out-of-home care."
>
> "The following are examples of criteria, based on federal guidance, for a child who is at imminent risk of removal and therefore a candidate for out-of-home placement:
> 1. Substantiated assessment of abuse or neglect;
> 2. Open IA or In-Home CHINS; and
> 3. Child and/or family will receive or is currently receiving services to prevent the need for removal while the child is living in his or her home."

Families receiving HFI are incidentally considered eligible for Title IV-E services because by definition they are receiving services to prevent the need for removal. Their eligibility for those services is determined on an individual basis through HFI's screening process.

C. Target Populations and Eligibility for Prevention Services



In Indiana, prevention services are delivered to the following target populations: families served outside of DCS by HFI providers, families engaged with DCS via either an informal adjustment or child in need of services (CHINS) in-home services case, and pregnant and parenting youth in foster care. Eligibility and relevance are explained below by target population.

Families served outside of DCS using HFI: This level of service is appropriate when there is low risk to the child and the family is not able to manage risk factors using its own strengths and

resources. HFI determines eligibility for its services using an eight-item screen, which can be seen in Appendix XVII.

DCS involvement is limited to working with community partners and stakeholders who can link the family with those prevention services and community resources that effectively and safely address its needs. DCS will continue to be responsible for the final IV-E prevention eligibility determination for HFI-involved families. In terms of determining eligibility for HFA/HFI, DCS will require HFI providers to meet all requirements of IV-E prevention planning before determining that a child and family are eligible for IV-E prevention fund claiming. The eligibility determination date is the last date when each of the following has occurred:

- the Service/Prevention Plan is completed with the family[1],
- on the date of birth of the child, and
- any necessary safety and risk assessments have been completed.

These dates are captured in the Comprehensive Child Welfare Information System (CCWIS) as data points and will be used as the start date for service eligibility and claiming. If the HFA/HFI service/prevention plan begins before the child is born, DCS will use the latter of the service/prevention plan start date or the date of birth as the start date for service eligibility and claiming.

DCS will retain the determination of eligibility Title IV-E Prevention Plan candidacy. If the family remains engaged and in need of HFA/HFI services in order to reduce the risk of removal after 12 months from the date the first service/prevention plan is completed (and after the child has been born), DCS will work with HFA/HFI providers to ensure that services, eligibility, and claiming continue as appropriate. Again, if at the conclusion of the 12-month child-specific plan the child is still deemed to be a foster care candidate, Indiana will not automatically remove the child from the home unless there are safety risks that cannot be mitigated through service provision. Instead, Indiana will terminate the initial plan, re-evaluate the child and family's needs, and create a new child-specific prevention plan in order to continue to provide prevention services with the goal of keeping the child safely in their home and preventing entry into foster care.

Families Served by DCS

Table 2. Monthly Snapshot Case Counts by Case Type

Date of Snapshot	Informal Adjustment (IA)	IA + In-Home CHINS	In-Home CHINS
7/1/2020	3,082	7,439	4,357

[1] HFA, as an evidence-based model that has received a well-supported rating on the Title IV-E Prevention Services Clearinghouse, can be provided to a family prior to the birth of a child. DCS recognizes that Title IV-E Prevention funds can be claimed only for children who have been born. DCS will claim only the costs of HFA for children who meet at Title IV-E prevention plan requirements and who have been born.

8/1/2020	3,000	7,293	4,293
9/1/2020	2,874	7,175	4,301
10/1/2020	2,916	7,179	4,263
11/1/2020	2,923	7,160	4,237
12/1/2020	2,919	7,050	4,131
1/1/2021	2,896	6,980	4,084
2/1/2021	2,951	6,924	3,973
3/1/2021	2,847	6,741	3,894
4/1/2021	2,771	6,649	3,878
5/1/2021	2,705	6,453	3,748
6/1/2021	2,426	6,108	3,682

Families served through an informal adjustment (IA): Families with an IA have had an assessment of child abuse and neglect allegations and are formally involved with DCS. Families with an IA can have risk levels ranging from moderate to very high, but coercive intervention of the court is not needed. DCS works with the family to develop the terms of the IA, monitor participation in services and regularly evaluate the child's safety. The court must approve the IA and monitors the IA through DCS documentation rather than court hearings.

Families served through an IA are eligible for Title IV-E funding according to DCS Policies 15.10 and 7.1. From DCS Policy 7.1:

"The Indiana Department of Child Services (DCS) will make an initial determination as to whether an individual child is at imminent risk of removal and therefore a candidate for placement in out-of-home care … A child is at imminent risk of removal when a substantiation of abuse or neglect is made by DCS, as documented by an approved substantiated Assessment of Alleged Child Abuse or Neglect (311) (SF113), an Informal Adjustment (IA), or In-Home Child in Need of Services (CHINS) case is opened, and reasonable efforts are made to prevent the child's removal from his or her home."

Families served through child in need of services (CHINS) cases in which the child or children are not removed: DCS may file an in-home CHINS petition for children in families where the risk level is high or very high and coercive intervention of the court is needed to ensure the child's safety and well-being. The court monitors the case, including the case plan and permanency goal. Families and children engaged in an in-home CHINS will receive Indiana Family Preservation Services in addition to other services that are identified by the family case

Who are we serving?

DCS utilizes Child and Adolescent Needs Assessments to identify the services of the family, but an important step in identifying the services needed is understanding the challenges the family faces. More than 17% of children with a prevention case have adjusted to trauma in a way that is causing problems for the child. An additional 60% are identified as "sub-threshold," meaning that a child's maladaptation to trauma does not currently but could eventually warrant intervention. This typically occurs when the child either has a history to which they may regress or the child displays maladaptive behaviors to be monitored. The CANS Assessment measures several emotional/behavioral aspects of the child. Adaptation to trauma is the most common challenge children with in home cases face, but certainly not the only challenge:

- 8% of children with in home cases struggle to control their anger in ways that cause problems.
- 10% struggle with anxiety and 11% struggle with depression.
- Many others struggle with conduct (5%), delinquency (3%), intentional misbehavior (4%) and opposition (7%).
- 7% struggle with impulsivity or hyperactivity.

The CANS Assessment also includes items that relate to the child's caregiver and family environment:

- 60% of children with in home cases are experiencing family functioning issues in the household.
- 58% are experiencing family stress.
- 44% have parents needing parenting knowledge, 34% have parents struggling with organization, and 36% with safety needs.
- 43% have parents that need to be more involved in the care of their child.
- 48% have parents that struggle to supervise appropriately and 16% have parents that struggle to access child care.
- 37% have parents struggling with substance use.
- 44% have parents lacking social resources, 25% lack residential stability.

manager and family team.

DCS internal reports demonstrate that 3,297 families had an open In-Home CHINS as of Dec. 1, 2021. Monthly reports are summarized in Table 2, demonstrating a snapshot count of families with IA's, In-Home CHINS, and the total of both, demonstrating the population to be served through Indiana Family Preservation Services (INFPS). These monthly reports are accessible to the public at any time from the following link: https://www.in.gov/dcs/reports-and-statistics/practice-indicator-reports/. Reports can be selected by month first, then by report. The report demonstrating In-Home and Out-of-Home cases is "Safely Home Families First by County."

Children with In-Home cases (In-Home CHINS or IAs) both receive family preservation services and are the primary target population of this prevention plan. The feature below describes what else is known about this population.

The CANS Assessment items in the feature above let us know not only the challenges that the child faces but also the challenges the child's parents face that may be impacting the child directly. In-Home cases largely revolve around neglect related issues. 84% of children with substantiated allegations have a substantiated allegation of neglect. In a child welfare context, allegations of neglect are treated as a threat to the safety and well-being of the child. Inadequate attention has been applied to the child and the needs of the child, but it's important to note that neglect does not assume voluntary inadequacy on the part of the caregiver. In many cases of neglect it is not the intention of the caregiver not to meet the needs of the child, but rather a natural consequence of a lack of knowledge or ability on the part of the caregiver. An example respectively of knowledge and ability challenges comes from the CANS: 44% of children with in-home cases have caregivers that lack the knowledge necessary to parent the child, and 25% of children with in-home cases have caregivers struggling with residential stability. Services have been selected based on the needs of this population. Rationale for each service's selection can be found in section F of this document.

Pregnant/parenting youth in foster care: DCS has included pregnant and parenting youth in foster care within the population to be served by IV-E prevention services. Pregnant and parenting youth are eligible for Title IV-E dollars because they are in the custody of DCS. DCS has embraced a two-generation approach to case management for pregnant and parenting youth. DCS offers targeted and relevant prevention-based services to pregnant and parenting youth in foster care. Providing an array of prevention services further support our youth and their children and reduce generational entry of youth into foster care. Pregnant or parenting youth in care themselves are eligible for Title IV-E Prevention Services because by definition they are in state custody.

Because youth can remain in care up to age 23, it's important for child welfare agencies to strengthen their ability to prepare youth for living independently as adults and, sometimes, as parents (Fernandes-Alcantara, 2019). A study of foster youth in the Midwestern U.S. found that female foster youth are twice as likely to become parents as their peers who are not in foster care: 50.6% of young women in foster care had at least one child by age 19 compared to 20.1% of the general population (Dworsky and Courtney, 2010). In 2019, Indiana evaluated a change to its treatment of parenting youth in care. The population distribution of parenting youth in care by age of the parent at birth of the child demonstrated that the most common ages Indiana's foster youth become parents are ages 15 through 17 (DCS Internal Reports, 2019). Parenting foster youth are particularly young parents and therefore are subject to higher risks. Children of young parents are at higher risk of experiencing child maltreatment including death

(Phipps et al., 2002). Yet youth who become parents while wards of the state must face the challenges of approaching independence, parenting and navigating the foster-care system from both the perspective of a child and a parent all at once. A study of Illinois' child welfare data demonstrated that youth in care who had children struggled not only with parenting skills (reported for 38% of youth) but also with educational and job skills, especially if the mother had two or more children (Leathers and Testa, 2006). In 2019, Indiana's data on parenting youth indicated that, since 2012, 85% of parenting youth in care had a child removed from them. For this reason, parenting youth in care are a target population for prevention services.

DCS Target population: Who are we trying to serve and why?

On June 1, 2021, DCS was serving 6108 children on prevention cases, and 9113 children on out of home cases. Improvements are coming but we know that prevention is critical for reducing the number of children that need to be placed in out of home care. When it comes to prevention and preservation, DCS takes safety as the number one priority. We looked at data about which children are being removed, and why? How did they come to be in our system to begin with? We find that the younger the child, the more likely they are to have a report, assessment, case, and removal. Older children have knowledge and abilities that infants and toddlers do not have protect them from unsafe circumstances. Nearly 40% of all children removed in 2021 were 3 or under (DCS Internal Reports, 2021). Even more specifically than this, DCS removed more infants under 1 year of age last year than any other age—and more than twice the number removed between ages 1 and 2. Parenting newborns and infants is not easy, and infant safety is knowledge that not every parent has. The most common substantiated allegation against children under 4 is that the environment endangers the health or life of the child (DCS Internal Reports, 2021). Many parents do not have the resources or support to access what their child needs. In fact, the majority of substantiated allegations in our system are neglect allegations, many of which are not related to inappropriate behavior of a parent but rather to their lack of knowledge, first hand experience, or abilities. Ninety-seven percent of substantiated allegations for babies under 1 are neglect allegations. Substantiated allegations of neglect of babies under 1 account for about 22% of all substantiated allegations.

Each family's service needs are identified by a qualified service provider, but what we know is that we are serving Indiana families in prevention cases because according to the CANS:

- Caregivers are struggling to safely parent very small children because they do not know how or do not have the resources and support they need.
- 60% of children with DCS Prevention cases experience challenges at home with family functioning. 16% have parents struggling to get child care, and 44% have parents who demonstrate inadequate parenting knowledge.
- Caregivers are struggling to support their families adequately.
- 25% of children with DCS Prevention cases live with a caregiver who struggles with residential stability.

D. Agency Framework for Prevention Services

DCS has both external and internal components to our prevention plan. Allegations to the Indiana Child Abuse and Neglect Hotline begin the process of eligibility for internal components of our prevention plan. However, many families access prevention services without ever being involved with DCS, because of our long-standing partnership with Healthy Families America/Indiana.

i. Healthy Families Indiana

DCS has collaborated with Healthy Families America/Indiana (HFA/HFI) to expand home-visiting initiatives in Indiana. HFA has been designated a well-supported practice by the Title IV-E Prevention Services Clearinghouse. Indiana has invested in these evidence-based home-visiting and skill-building programs so families can remain safely together and parents can gain the skills needed to keep their children safe long after services have ended. HFI has a documented history of keeping children and families safe and improving outcomes. Utilization of HFI is an important prevention effort to reduce families with DCS involvement altogether. HFI's support of Indiana families precludes the need for DCS involvement in some cases. Further investments in HFI, particularly when a DCS FCM is not involved in the case, are therefore an integral part of DCS' Title IV-E prevention strategy of keeping children and families thriving in their own home.

In accordance with the Child Welfare Policy Manual question 8.6C, DCS will contract with HFA/HFI providers to complete the "administrative activities necessary for the administration of the title IV-E prevention program … Examples of Title IV-E administrative activities that may be contracted out include developing and maintaining the child's prevention plan, activities

associated with meeting the requirements in section 471©(5)(B)(ii) of the Social Security Act (the Act) to monitor and oversee the safety of children receiving prevention services, and other activities that comport with or are closely related to the examples provided in 45 CFR 1356.60(c)(2)." (See the Child Welfare Policy Manual, question 8.6C). DCS will "supervise the activities performed by the contracted agency … and make the determination that a child is a candidate for foster care." (CWPM, question 8.6C). HFI providers will engage, assess for risks and plan for safety and services with their HFI families on a regular basis. Additional information on how HFI assesses safety can be found in section B.i. of this document.

ii. Indiana Family Preservation Services

DCS has built a framework of services and outcome expectations for Indiana Family Preservation Services (INFPS). DCS has built a comprehensive service standard designed to properly identify, assess, engage and provide appropriate evidence-based programs to children and families in an effort to keep families thriving together safely in their own home. It is important to note that DCS is not requesting approval of INFPS through this prevention plan. We are seeking approval for our utilization of EBPs in the context of our prevention program INFPS. INFPS itself will be submitted to the Title IV-E Clearinghouse, and we do not seek approval for INFPS under the prevention plan. Descriptions of INFPS are meant for context and legibility of our prevention plan.

INFPS services are designed to work with families that have had an incident of abuse and/or neglect when DCS believes the child(ren) can safely remain in the home with their caregiver(s) with the introduction of appropriate services to the family. When such families are identified, the FCM caseworker refers the family to the INFPS provider. The INFPS referral must begin with a holistic assessment of the family resulting in an appropriate service and treatment plan that is based on the assessed need as determined by the INFPS provider. The goal for these services is to preserve the family and avoid removal of the child(ren), provided it is safe for the child(ren) to remain with their identified caregivers. It is important to note that the primary distinctions between the previous and current approaches to serving families are:

- The family is seen in most cases by one provider instead of several, which reduces confusion for families and ensures that the INFPS provider can focus on the delivery of the service as outlined in the model's service standard (the program's manual). This also allows the department to better identify each INFPS agency's impact on families through provider-level outcome tracking that has been ongoing since the program's launch. The only exception would be if an INFPS provider who was already working with a family determined that it did not have staff qualified to meet a newly identified service need of the family. For example, if a young family's presenting needs upon assessment lead to an INFPS referral to a provider with expertise in parent-education models such as Healthy Families America, but, after beginning their work with the family

and making progress, substance abuse is identified as a presenting issue. If the existing INFPS provider does not feel they have the expertise to treat the newly identified substance-abuse concern, but the child and family team involved with the family feels the INFPS provider is making progress with their parent-education-focused interventions, the team may decide to bring in an additional provider to work on the substance-abuse concerns. It should be noted, however, that INFPS providers have the ability to deliver comprehensive services to families, including services that address substance use disorder. However, since these families are most often new to DCS, concerns not previously identified can emerge over time, and child and family teams have the ability to address them by either changing the INFPS provider to ensure all of the family's needs are met, or they can bring in an additional provider as DCS does continue to contract for all previously available services. The goal, however, is to serve families as often as possible with one provider who is well matched to the needs of the family and who is in place quickly. This helps ensure the benefits of INFPS, including the provision of evidence-based models and concrete supports, are available to families when they are needed, and that INFPS providers can focus on the program's goals of keeping families together and children safe.

- The responsibility of designing a treatment plan shifted from the DCS FCM to the INFPS Provider best acquainted with the family's clinical needs, clinical options available and the fit between the two.
- Both the FCM and the INFPS Provider are assessing safety both informally and formally.

Services must be comprehensive and individualized to families' unique needs. All services delivered under this standard must have as a foundation at least one evidence-based practice (EBP) that is classified at a minimum as a promising practice on the California Evidence-Based Clearinghouse (CEBC) (http://www.cebc4cw.org/). These services must be home-based and must monitor and address any safety concerns for the child(ren).

As part of the Title IV-E Prevention Plan, DCS will use Title IV-E prevention dollars to fund certain EBPs that are on the IV-E Prevention Services Clearinghouse and included in the case plan for the child and family. For children and families that have a DCS family case manager (FCM) along with an INFPS service provider, the date that the case/prevention plan is completed is the date of eligibility for IV-E prevention claiming purposes for the child and

family. The start date of the case/prevention plan is a date currently in the Comprehensive Child Welfare Information System. DCS will retain the determination of eligibility Title IV-E Prevention Plan candidacy. Additionally, safety and risk assessments (whether formal or informal) will continue to be monitored by DCS FCMs and INFPS service providers on a regular basis. Children and families receiving INFPS have an FCM and a service provider, both of whom jointly assess for risks and plan for safety with the family on a regular basis while the DCS case remains open. For clarity on the roles and responsibilities of the DCS FCM versus the INFPS Provider, please see Table 3 on the next page.

Outcome Based Contracting in Indiana

Prior to the development of Indiana Family Preservation Services (INFPS), DCS primarily reimbursed contracted service providers using a fee-for-service approach. Under the previous approach, providers could only provide the services for which they received a specific referral from a DCS Family Case Manager (FCM). Family Case Managers, who are not clinicians, juggled many responsibilities on each case, including being expected to understand the scores of individual service referrals that could be made for each family. This approach led to a lack of flexibility for service providers treating families as they could only deliver the specific service for which they were referred, and, often, there would be multiple provider agencies involved with each family delivering specific, non-comprehensive services at the same time. An example would be a family simultaneously receiving home-based therapy, home-based casework, substance use disorder outpatient treatment, and parent education services, each delivered by a different provider resulting in four different provider agencies working with them. This resulted in a lack of care coordination, increased confusion for the family, and challenges following the DCS practice model which calls for regular teaming of cases, and there was no ability for the department to really understand the impact of each agency's work. In addition, with fee-for-service, if a family was unable to keep a scheduled appointment with a provider, the provider would not receive any reimbursement for that time resulting in providers canceling referrals for families who were not engaging well in their services. INFPS, with its shift to per-diem-based reimbursement and one provider delivering comprehensive services to each family, allows providers to use their clinical expertise to identify each family's presenting issues and develop treatment plans and evidence-based interventions to address them, as well as ensure they have resources to keep trying to engage initially-resistant families. INFPS providers know the clear goal for all of these cases is to safely preserve the family whenever possible, and they are able to focus on achieving these outcomes without having to be concerned with billable time. They are, however, still very focused on delivering quality interventions and supporting families as they know that provider-level outcomes related to repeat maltreatment and children who have experienced removals are tracked and updated often (daily, on a Tableau report that is available to all Family Case Managers), with these outcomes influencing to which agency INFPS referrals are sent. Providers are also given regular reports for their specific agency so that they can understand how they are impacting families and develop continuous quality improvement practices, which is a requirement that is included in every INFPS provider contract.

Table 3. Roles and Responsibilities, DCS FCM versus INFPS Provider

DCS Family Case Manager (FCM) Roles and Responsibilities	INFPS Provider
The FCM is required to conduct initial assessments of safety and risk at the opening of any case. These assessments allow the FCM to identify an appropriate case plan for the family and to determine the eligibility of the family to receive INFPS.	Responsibilities do not begin until a referral for INFPS has been processed.
The FCM refers an eligible family to an INFPS Provider for INFPS Services.	
INFPS Services Begin	
The FCM has put together a case plan with the family that specify a set of treatment goals towards case closure. The FCM works with the family and provider on a safety plan.	INFPS provider assesses the service needs of the family and determines treatment plan. INFPS provider is responsible for ongoing assessment of family's progress and adjusting the treatment plan as needed. The provider creates a safety plan with the family and DCS FCM.
The FCM continues to manage the progress of the DCS case including facilitating and communicating around permanency and progress.	INFPS provider performs all services or supplements the family's treatment plan with additional referrals billed to Medicaid through the INFPS provider.
The FCM continues to manage the progress of the DCS case including monitoring the family's progress in services and facilitating movement towards permanency.	INFPS provider is required to submit monthly reports to the DCS FCM. Reporting requirements are covered in the EBP Fidelity section on page 21 of this document.
The FCM continues to conduct monthly in person visits and safety assessments with each child on the INFPS referral for the duration of their DCS case.	INFPS conducts ongoing safety assessment including one weekly formal safety assessment.

a. EBP Effectiveness in INFPS

It is not in the interest of DCS nor the children and families we serve to refer and pay for services that are not helpful to a family's progress towards permanency. There are guardrails against DCS providing irrelevant or unhelpful services. In the case of prevention services, the progress of each family is closely monitored by the INFPS provider and by the DCS FCM. Both parties share responsibility in identifying the appropriateness and effectiveness of services received throughout the duration of the referral. If a service provided is not a good fit for the family or is not leading to the expected outcomes, it is the responsibility of the INFPS provider to identify and make adjustments to the family's treatment plan. Notification of recommended changes to the family's treatment plan are reported to the DCS FCM within the monthly report at the very least (please see the INFPS Service Standard in Appendix III). The FCM utilizes this monthly report to understand the progress of the family in pursuit of

their case and treatment goals. A sustained lack of relevant outcomes has immediate and broader consequences for the provider. On the case level, an FCM who do not see relevant progression of the family would end the referral with the provider. At the highest level, ongoing failed referrals and poor outcomes would lead to DCS terminating the contract with that provider.

Every INFPS provider has a contract with DCS which specifies that "All service plans must include goals that address issues of child safety and the family's protective factors. Monthly reports … must outline progress towards goals identified in the service plans." A Family Preservation Service contract can be read in its entirety in Appendix II. All DCS contracts are available to the public at https://fs.gmis.in.gov/psc/guest/SUPPLIER/ERP/c/SOI_CUSTOM_APPS.SOI_PUBLIC_CNTR_FL.GBL?&. This contract obligates providers to create treatment goals that are relevant to the case goals set by DCS. Moreover, the progress of the family towards those treatment and case goals needs to be documented and tracked thoroughly by the provider and delivered to the FCM.

b. EBP Fidelity in INFPS

In order to ensure that Indiana children and families receive evidence-based programs that are served to fidelity, DCS has several processes in place for all services provided, including prevention services. INFPS Providers are subject to the content of their contracts with DCS, which itself requires compliance with EBP model holders and a number of attachments including the Family Preservation Services Standard (Appendix III) and relevant assurances (Appendix IV).

The INFPS contracts obligate the provider to submit reports that "must contain all of the information requested by the State and must conform to the format and content of the reporting procedure specified by the State." The INFPS Service Standard explains in detail the expectations of providers' monthly reports:

"Monthly reports are due by the 10th of each month following the month of service provision, unless requested earlier by DCS. Case documentation shall show when report is sent and include: a) Provider recommendations to modify the service/treatment plan b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress."

Details of these fidelity reports can be found below in the feature "INFPS Fidelity Checks."

Lastly, DCS monitors fidelity by conducting audits of every contracted service provider once

every four years. The case record documentation required for these audits is detailed in the INFPS Service Standard – the entirety of Section VIII in the INFPS Service Standard can be found in Appendix III of this document. A more concise description of these requirements can be found in the Assurances presented with the RFP for INFPS: "The provider agrees to maintain all case records indicating time spent with the clients, documents provided to the referring Department of Child Services and referral forms that authorize services." These assurances can be reviewed in their entirety in Appendix IV of this document.

Contractors of the EBP's for which we seek approval are also subject to fidelity tracking from the model holder of the EBP. The only service that is not constantly monitored by a model holder is Motivational Interviewing. Details on how model holders determine fidelity for each service can be seen in each service's fidelity section under F. Service Description and Oversight.

INFPS Fidelity Checks

To ensure that INFPS is used to fidelity, Indiana has worked with service providers to properly document EBPs being used with families receiving Family Preservation. This process involves three independent steps. First, by the 12th of each month, providers enter all EBP information into a SurveyMonkey link. The provider will enter each EBP used with a family in the monthly reporting period for each focus child on the Family Preservation referral. The provider will enter case IDs, referral IDs and child IDs for all cases that received services the prior month. Furthermore, providers will enter in the date that they first received the referral and the first date of contact with the family. When entering EBPs, the provider will be asked a series of fidelity questions tied to the specific model being used. Depending on the model, there are two or three fidelity components tied to the participants the model is being used with, the amount of time the model was used with a participant in a given period of time, and that the model was used by an individual with the proper education or training experience. The EBP fidelity components were taken directly from the California Evidence Based Clearinghouse (CEBC) website.

The second step to ensure INFPS fidelity is to verify all information entered by the provider in the SurveyMonkey. From February 2021 to May 2021, survey responses were downloaded once each month; from June 2021 onwards, survey responses were downloaded every other month. The survey responses were then cross validated with monthly reports that that the providers upload into the DCS case management system. If a provider entered that they used Motivational Interviewing with two children in a given month, two things would be checked. First, the two children must be verified as focus child on the referral/case. Second, the monthly document must clearly document the usage of Motivation Interviewing. If the information was entered correctly, the provider would not have to take additional action on the specific case. However, if there were any errors identified, such as a missing child needing entry or an EBP that was used in a monthly period, but not entered into the survey, the provider would be asked to resubmit the missing information. Notes were kept and tracked by DCS research analysts to make sure that any information (continued on next page)

requested of providers could be followed up with. Every other month DCS would send providers individual status updates with cases/referrals that need to be corrected.

The final stage to ensure INFPS fidelity is to clean all data entered and track individual fidelity measures in *R Studio.* Due to providers entering data on a monthly basis, it is critical to make sure that all data entered for each case is entered uniformly. This process includes checking all ID numbers and dates entered in the SurveyMonkey and make sure they are uniform across all entries. If a date field or ID number was entered incorrectly, DCS research analysts would change the field to the correct value. After checking data for each case was entered correctly, the three fidelity measures could be tracked and monitored accurately. The three measures include: 1) Are providers with an INFPS referral only using evidence-based services ranked as promising practice or higher on the CEBC? 2) Are providers with an INFPS referral using evidence-based services according to the individual model's service standard set by the CEBC?; and 3) Do families accepted for an INFPS referral receive a face-to-face contact within three days of the accepted referral date?

E. Prevention Services

i. Selection Process

DCS has consulted with internal and external stakeholders across the state. Specifically, DCS has collaborated with other state agencies including the Family and Social Services Administration (FSSA) and the Indiana Department of Health (IDOH). Each of these state agencies administers health programs including mental health and substance abuse prevention and treatment services in Indiana. DCS has collaborated with other public and private agencies (including community-based organizations) with experience administering child and family services to foster a continuum of care for children, parents and caregivers receiving prevention services. Select executive staff traveled the state in 2019 to discuss FFPSA vision and planning with stakeholders including community members, court personnel, service providers, court appointed special advocates, foster parents, community mental health providers, juvenile probation officers, Indiana legislators and youth/families with experience with the system.

Prevention services provided for or on behalf of a child and the parents or kinship caregivers of the child will be coordinated with other child and family services provided to the family under the state title IV-B plan. DCS partners with Healthy Families Indiana, as well other prevention services providers, through Indiana Family Preservation Services. These services are part of a strategic plan to maximize resources supported by Title IV-B and TANF funds, prevention services funding and public health funding.

DCS created an FFPSA workgroup that met throughout 2020 and 2021. The following members discussed FFPSA implementation and identified gaps in FFPSA compliance throughout 2020 and 2021. The workgroup was integral to tracking and adjusting needs and closing the identified gaps in Indiana's child welfare system.

Table 4. FFPSA Workgroup Participants

FFPSA Workgroup		
FFPSA Workgroup Coordinator: Heather Kestian		
Name	**Representative**	**Agency/background**
Angela Reid-Brown	Indiana Office of Court Services	Judiciary
Baily Truelove-Cargal	Parent	Member with lived experience
Cassondra Kinderman	Home-visiting program manager	Indiana Department of Health
Christina Commons	First Steps director	Family and Social Services Administration
Demetrice Hicks	Lived expertise with foster care	Member with lived expertise
Elena De La Cruz	Prevention services provider	Bowen Center
Elisabeth S. Wilson	Evaluation planning	DCS
Gael Deppert	Magistrate, Marion County (Indianapolis)	Judiciary
Hannah Robinson	Prevention services manager	DCS
Harmony Gist	Staff training and development staff	DCS
Jessica Deyoe	Nurse-family partnership administrator	Indiana Department of Health
Karen Hayden-Sturgiss	Kinship care/field operations staff	DCS
Karen Mikosz	Pokagon Band Citizen	Pokagon Band of the Potawatomi Tribe
Kara Riley	Office of Data Management	DCS
Kelly Broyles	Field operations	DCS
Kim Spindler	Legal	DCS

Kyle Horine	Probation service consultant	Juvenile Justice
Liz Day	Prevention services provider	Lifeline Inc.
Matt Gooding	Residential licensing coordinator	DCS
Melissa Norman	Prevention services provider	Choices Coordinated Care Inc.
Michelle Madley	Gibault	QRTP provider
Rachel Fisher	Community-based provider (service continuum)	Community Mental Health Center
Todd Fandrei	Administrative services	DCS

In January 2021, a draft of the IV-E Prevention Plan was shared broadly with internal and external stakeholders. DCS gathered feedback through email and virtual meetings. DCS shared and discussed the IV-E Prevention Plan with the Pokagon Band of the Potawatomi leadership in February 2021. Through this meeting, DCS and the Pokagon Band of the Potawatomi Tribe will further discuss a Title IV-E Tribal Agreement so that children and families who are Pokagon citizens can access services through Indiana's Title IV-E Prevention Plan. Changes were made to the IV-E Prevention Plan to address feedback and adapt the plan to better meet the needs of Hoosier families. Indiana is committed to continually reviewing feedback on the IV-E Prevention Plan to improve service delivery and outcomes for children and families.

Rationale for service selection incorporated the Indiana families we want to target, the service needs of Indiana families, and the populations for which the service produces positive outcomes. Table 5 on the subsequent page demonstrates each of these per EBP for which Indiana seeks approval.

Table 5. Target Population Alignment per EBP in Alignment with Indiana's Evaluation Waiver Requests

Evidence Based Program	Indiana's Target Population	Populations for which the EBP has Demonstrated Effective and Relevant Outcomes
HFA	High Risk families with young children (0 to 5).	- High risk families in Hawaii (Duggan, 2004) - High risk families in New York (Mitchell-Hertzfeld, 2005) - First time mothers (DuMont, 2008)
FFT	Families with disruptive youth ages 11 to 18.	- Delinquent youth ages 10-18 (Humayun, 2017) - Delinquent youth mean age approx. 15 (Celinska, 2013) - Court involved youth (Celinska, 2018) - Runaway youth (Slesnick, 2009) - Delinquent youth (Baglivio, Jackowski, Greenwald, & Wolff, 2014)

TF-CBT	Children with trauma and their parents.	- Sexually abused preschool children (Cohen, 1996) - Children age 8-14 years old with sex abuse related PTSD (Cohen, 2004) - Children age 7-17 years with trauma (Goldbeck, 2016) - Children age 10-18 with trauma (Jensen, 2017) - Children age 3-6 with trauma (Scheeringa, 2011) - Children with trauma (Smith, 2007)
MI	Families in which a caregiver has substance use disorder.	- Heavy drinking students, mean age approx. 19 (Carey, 2006) - Adults with alcohol dependence (Freyer-Adam, 2008) - Adults with alcohol dependence (Gentilello, 1999) - Incoming college freshmen below age 19 (Marlatt, 1998) - Young adults ages 16 to 24 (Diaz Gomez et al., 2019) - Nonpregnant adult women, mean age approx. 29 (Rendall-Mkosi, 2013) - Adults with substance use disorder (Saitz, 2014) - Women age 18-24 with reported use of marijuana (Stein, 2011)
PAT	High Risk families with young children (0 to 5).	- High risk families including CPS referred families at approx. 21% (Chaiyachati, 2018) - High risk families (Wagner, 2001) - Low-income parents and children (Wagner, 2002)

Rationale for service selection also incorporated how the service needs of Indiana families align with the proven outcomes produced by the EBP. Table 6 below demonstrates each of these per EBP for which Indiana seeks approval.

Table 6. Indiana Needs and EBP Outcome Alignment in Alignment with Indiana's Evaluation Waiver Requests

Evidence-Based Program	Indiana's Service Needs Met by the EBP	Evidence that the Program Meets that Need
HFA	Indiana families demonstrate the need for basic parenting education and support. 60% of families assessed for HFA set unrealistic expectations for their child. Indiana families demonstrate a need for this program at a volume over twice that of current capacity.	A third party evaluation of HFI showed improvement in many relevant areas (Healthy Families Indiana 2020 Evaluation Report, 2020). Parents became more responsive to their children (95.7%), understood their child's development more (95.1%), became more involved in their child's life and care (90.3%), organized (88.3%), and created appropriate home environments for their children (76.5%). Parents also addressed poor behaviors on the part of the child and parent (65.6%), became more effective parents (58.3%), learned to mobilize resources (71.2%) and problem solve (62%), as well as strengthened their own social supports (58.5%). The evaluation can be viewed in its entirety in Appendix XXI.

FFT	Indiana families demonstrate the need for help parenting children with unmet behavioral needs. CANS assessments of In Home children reveal that many of these children experience challenges with Adjustment to Trauma (92%), Anxiety(37%), Depression (36%), Oppositional [Behavior] (24%), Anger Control (23%), Conduct (20%), Impulsivity or Hyperactivity (20%), Intentional Misbehavior (13%) and Delinquency (10%).	FFT has been shown to improve children's behavioral health (Celinska, 2013; Humayun, 2017; Celinska, 2018). Studies of FFT's impact on delinquent youth have found improvements in depression symptoms, substance use, delinquent behaviors and negative consequences and reconvictions for delinquent youth (Slesnick, 2009). FFT has also been shown to support the child's environment through improving family conflict skills and reducing verbal aggression (Slesnick, 2009).
TF-CBT	Indiana families demonstrate the need for specialized services for children who have experienced trauma. In a child welfare context, trauma services are especially important due to the traumatic nature of experiencing child abuse and neglect. In 2021, 17% of children with In-Home cases had CANS assessments indicating confirmed maladaptation to trauma, and an additional 65% had CANS assessments indicating the child's response to trauma needs to be monitored.	TF-CBT has been shown to improve child functioning for children who have experienced trauma in accordance with the intended and proven treatment effect(Cohen,1996; Cohen, 2004; Goldbeck, 2016; Jensen, 2017; Jensen, 2018; Sheeringa, 2011, Smith, 2007). TF-CBT has also been found to improve caregiver empathy and understanding of their children who have experienced trauma to prevent repeat maltreatment and allow for the child to remain in the home in accordance with the intended and proven treatment effect (Cohen, 2004).
MI	Indiana families demonstrate the need for substance use treatment. 25% of reports to DCS involve substance use disorder. 64% of removals are at least in part due to caregiver substance use disorder.	The Title IV-E clearinghouse lists the following studies demonstrating the effectiveness of MI in treating caregivers specifically for substance use: Carey, 2006; Freyer-Adam, 2008; Gentilello, 1999; Marlatt, 1998; Rendall-Mkosi, 2013; Saitz, 2014; and Stein, 2011.
PAT	Indiana families demonstrate the need for basic parenting education and support. 60% of children with DCS Prevention cases experience challenges at home with family functioning. 16% have parents struggling to get child care and 44% have parents who demonstrate inadequate parenting knowledge.	In particular, families including non-latina mothers became more organized, responsive to their children, utilized more appropriate discipline, and were more accepting of their child's behavior (Wagner, 1999). A recent study found that families receiving PAT were 22% less likely to have substantiated allegations of maltreatment (Chaiyachati et. al 2018). PAT was particularly effective in reducing substantiated allegations of neglect.

DCS Prevention Service Descriptions

F. Service Description and Oversight

DCS, in partnership with service providers, will assess children and their parents or kin caregivers who live in Indiana to determine eligibility for the appropriate use of Title IV-E prevention services. DCS will provide access to several evidence-based programs in a concerted effort to keep families together. In determining which evidence-based programs to offer as part of the Title IV-E Prevention Plan, DCS consulted with providers, stakeholders, court partners, DCS employees and families/youth with lived expertise as described in section E.i. of this document to determine a comprehensive service array that would meet the needs of children, families and kin in Indiana. Table 5 below presents each of those programs, the program category for which Indiana seeks the EBP's approval, the EBP's rating in the Title IV-E Clearinghouse, and expected outcomes in Indiana.

Table 7. Indiana's Prevention Services

Prevention Program Categories	Indiana Evidence-Based Programs	Title IV-E Prevention Services Clearinghouse Rating	Expected Improvement in Outcomes in Indiana
	Functional Family Therapy (FFT)	Well-supported	Reduce risk of repeat child maltreatment through improved family functioning for families in which there is disruptive youth behavior. Improved parenting and family functioning so the youth can safely stay in the home.

Mental Health Treatment	Trauma-Focused Cognitive Behavioral Therapy (TF- CBT)	Promising	Improved child functioning for children who have experienced trauma. Improved caregiver empathy and understanding of their children who have experienced trauma to prevent repeat maltreatment and allow for the child to remain in the home.
Substance Abuse Treatment and Prevention	Motivational Interviewing (MI)	Well-supported	Facilitate positive change with individuals and within families to address problems that present safety risks to children so the child can remain safely in the home and avoid repeat maltreatment.
In-home, Skill-based ParentingPrograms	Healthy Families America (HFA)	Well-supported	Improve child safety through focusing on healthyattachment and bonding between parents and their young children.
	Parents as Teachers (PAT)	Well-supported	Prevent child abuse and neglect through increased parent knowledge of early childhood development andimproved parenting practices.

Many families receive important prevention services before ever reaching DCS in the form of a report or referral. Indiana seeks approval for HFI in Indiana as a Title IV-E Prevention program. Where involvement cannot be avoided due to safety concerns, DCS has an important family preservation program INFPS, which is designed to provide all that could be needed to support a family – concrete supports and any EBP the family could need in order to maintain the child or children safely in the home. Indiana does not request approval for INFPS or Concrete Supports as part of this prevention plan. Indiana

seeks approval for FFT, TF-CBT, MI and PAT as prevention services, all of which are EBP's offered to families with in-home cases under the umbrella of INFPS.

Healthy Families America (HFA)/Healthy Families Indiana (HFI)

Indiana seeks approval for HFA/HFI in Indiana as a Title IV-E Prevention program for in-home, skill-based parenting programs.

Service Description

Healthy Families America (HFA) is rated as well-supported with the Title IV-E Prevention Services Clearinghouse. HFA is a home-visiting program for first-time parents and their children with services being provided from before birth up to age 5. HFA is designed to promote child and parent health as well as reduce risk by supporting positive parent-child relationships, healthy attachment and improved family functioning. This occurs through a variety of services including child development, access to health care and parent education. The program also advocates for positive, nurturing, non-violent discipline of children.

The goals of Healthy Families Indiana are to:

- Systematically engage families with multiple stressors in home-visiting services prenatally or at birth.
- Sustain community partnerships.
- Promote safe environments for children and families.
- Cultivate and strengthen nurturing parent-child relationships.
- Promote healthy childhood growth and development through parent engagement.
- Enhance family functioning by reducing risk and building protective factors for optimal childhood outcomes.
- Provide staff with the training and support needed for their professional well-being.

Please see the Healthy Families Indiana web page for more information on HFI in Indiana, https://www.in.gov/dcs/2459.htm.

Program Model

Best practice shows that providing education and support services to parents around the time of birth and continuing afterward significantly reduces the risk of child maltreatment. Indiana will use the following manual for HFA/HFI: Healthy Families America. (2018) *Best practice standards*. Prevent Child Abuse America; Healthy Families America. (2018). *State/multi-site system central administration standards*. Prevent Child Abuse America.

Healthy Families America has supportive services that can begin prenatally[2] and continue until the child is 5 years old. For the first six months after birth or enrollment (whichever is later), families are offered at least one in-home visit per week, approximately an hour in duration. After six months, families may move to less frequent visits (biweekly and then monthly). Movement to less frequent visits depends on the needs and progress of the family, and in times of crisis, visit frequency can increase to properly address the needs of the family, ensure safety, and mitigate risks.

The HFI Eligibility Process

To be eligible for HFI, families must be referred either before or shortly after the birth of the target child. Families can refer themselves or can be referred by another entity, including DCS. Once referred to HFI, a family must be identified as at increased risk for child maltreatment as determined by the FROG (Family Resilience and Opportunities for Growth Scale) in order to receive services. Referred families are initially screened by HFI assessment staff using the eight-item screen rating. A positive screen on the eight-item screen is one part of the determination for eligibility for services. If a family screens positive on the eight-item screen, the FROG is offered to the family. The FROG includes an in-depth conversational interview by a HFI family resource specialist with expectant or new parents to learn about their individual experiences, competencies and strengths. HFI staff members are trained to engage the family conversationally, weaving in 14 areas of focus (The Family Environment, Perception of the Child, Infant and Child Development, Plans for Discipline, Child Protective Service, Positive and Stressful Childhood Experiences, Behavioral Health, Mental Health, Stress Level, Social Connections, Intimate Partner Support and Conflict Management, and Concrete Support Services). After the assessment interview, the HFI assessment staff and supervisor review the results. Those families determined to be high risk are offered HFI services.

Target Population

Indiana's target population for HFA is high-risk families with young children. Indiana trends with the United States generally in that young children and infants enter care at higher rates

[2] DCS is aware that Title IV-E prevention funding and claiming is available only to children who have been born or to current foster youth who are pregnant/parenting. As such, DCS will claim Title IV-E funding only for those children who have been born or for current foster youth who are pregnant/parenting and whose families have otherwise met all other Title IV-E prevention plan requirements. DCS will claim only when the child and family have been determined to be Title IV-E prevention plan program candidates. (See also the Service Description and Oversight section of the Indiana Title IV-E Prevention Plan above for more information.)

than older children because of their vulnerability (DCS Internal Reports, 2021). Programs focusing on young children like HFA, with the goal of maintaining children safely in the home, are important to ensure safety and reduce the need for and precipitation of removals. Families of children with increased risk for maltreatment or other adverse childhood experiences are one of the target candidates for HFA. HFI provision to DCS involved families is addressed at the end of this section. Outside of DCS involvement, the target population is identified by HFI using an eligibility process that incorporates a combination of several assessments and can be read in detail in the below feature "The HFI Eligibility Process."

We know quite a bit about the population of parents receiving HFI. Below Table 6 displays the distribution of families served by the primary parent's age. These numbers will not sum to 100% because some parents' ages are unknown. Nearly 60% of families served by HFI in 2020 were in a single parent household.

Table 8. Distribution of HFI Families by Parent Age		
AGE	**Number of Families**	Percentage
13-19	889	12.14%
19-29	4,438	60.62%
30-39	1,809	24.71%
40+	162	2.21%

While about a quarter of families served by HFI are employed, only about 14.11% of families have a primary parent employed full time. Table 7 below demonstrates the most common employment status for primary parents is unemployment.

Table 9. Employment Status of HFI Families		
Employment Status	**Number**	**Percentage**
Not Employed	1,674	22.87%
Employed Full Time	1,033	14.11%
Unemployed Not Seeking Work-Barriers	891	12.17%
Employed Part Time	728	9.94%
Unemployed Seeking Work	504	6.88%

While the assessment of parents provides a great deal of context for what families receiving HFI are experiencing, referrals HFI makes for more specific services can help us better understand

the needs of these families. In 2020, 6,524 referrals were made to provide food to the family, another 2,796 for emergency assistance and 2,295 for financial support.

61.69% of families receive services post-natally, meaning at least one child is in the home. 40% of families served by HFI are first-time parents and may lack the knowledge needed to parent appropriately. In fact, many of these parents have poor examples of parenting appropriately, themselves having a history of child abuse at a rate of 34.18%, 24.46% of which reportedly have a "history of being beaten as a child." HFI's assessments indicate that nearly 60% of parents have rigid, unreasonable expectations for their child (DCS Internal Reports, 2021). In 2020, HFI also found that 17.37% of families punished their child harshly. While 9.01% of families have had an incident of interpersonal violence in the year prior to assessment, most of the concerns identified by HFI regard knowledge of appropriate parenting.

Unmet Community Needs: Expanding HFI with Title IV-E Dollars

- In 2020, nearly 36,000 Indiana families were referred to HFI. Of these, only 15,507 were able to be contacted and screened.
- In 2020, 96.2% of families screened had a "positive" screen, indicating that parents struggled one of the items on the 8 item screen.
- However, only 7321 (less than half) of those were subsequently assessed, and 6,510 were offered services.

HFI's impact on Indiana families is limited by the funding available to the program. Currently the program is funded in part by TANF (for TANF-eligible families), MIECHV and Indiana's state budget. Local sites are careful to serve the number of families that they can with the resources they have. Our intention is to reach and in the meantime approach meeting the total need of Indiana families for the HFI program.

A Note on Enrolling Child Welfare Involved Families in HFI up to 24 Months

HFA has allowed enrollment of children up to age 24 months since 2018 if the child is involved with child welfare. According to HFA's website:

"HFA sites that utilize the protocols for working with families referred from child welfare are able to extend enrollment for families with a child up to 24 months of age referred by the child welfare system. This is in keeping with the model's original design to offer services up to the time the child is 5 years of age. Consistent with HFA requirements, voluntary services will be offered for a minimum of three years, regardless of the age of the child at intake, and support will be tailored to the unique needs of each family." Additional information can be found here: Protocols for Working with Families referred from Child Welfare (healthyfamiliesamerica.org).

Easterbrooks' 2013 study of HFA found outcomes effective for a sample that at T2 (12 months post-enrollment) included children who were on average 12.05 months old with a standard deviation of 5.27 months, indicating enrollment after birth to be common and appropriate. Easterbrooks' 2019 study of HFA included a sample with child welfare involved families. Children in the HFA group who received 1 CPS report were less likely to receive a second report compared to the control group, and when they did have a second report there was a longer period of time between the initial and second CPS report. This study was conducted on child welfare involved children after the implementation of the CW protocol, indicating the effectiveness of this program for children enrolled in HFA between ages three months and twenty-four months as allowed by the child welfare protocol. Lee's 2018 evaluation of Healthy Families New York also found that a subgroup of families involved with CPS at HFA enrollment experienced significant reduction of maltreatment recurrence.

Implementation Plan

HFA has been delivered in Indiana for many years and is a critical aspect of prevention in Indiana. Healthy Families Indiana (HFI) celebrated 25 years of service in 2019. HFA is available in all 92 Indiana counties (see the Prevention Services Dashboard, which is available here) from 31 local HFI providers to parents of children birth to 3 years old. HFI has a close relationship with HFA as an accredited Multi Site that is centrally administered. HFI has an established, positive image among Indiana families. HFI served 6,510 Indiana families in 2020.

Indiana will use adaptations to HFA when children and families are involved in the child welfare system. Therefore, when a family has been assigned an FCM and have an open DCS involvement, the HFA child welfare protocol (CWP) will be used. DCS has 11 HFI agencies that are contracted for Indiana Family Preservation Services and serve child welfare families using the HFA CWP. When using the HFA CWP, families can enroll in HFA with their children who are between birth and 2 years old at the time of initial enrollment. Infants and toddlers through age 24 months are the most vulnerable to abuse and neglect because of their level of need. In Indiana and the U.S. more generally, infants and toddlers younger than 2 are more likely to be confirmed victims of abuse or neglect, removed from the home, and experience a fatality or near fatality ("The AFCARS Report FY2019", 2020, DCS Internal Reports, 2021). Indiana's goal through HFA is to maintain a child safely in their home of origin, and our expansion to 24 months is appropriate in this context because this age group is particularly vulnerable and

more likely to enter foster care (DCS Internal Reports, 2021). It is also important to note that the CEBC lists HFA as a program for parents and caregivers of children up to age 5 (CEBC, 2019). Indiana child welfare has followed the direction of HFA regarding its expansion to 24 months in HFA's official adaptation protocol for the field of child welfare. According to HFA, "Consistent with HFA requirements, support services will be offered for a minimum of three years, regardless of the age of the child at intake, and as a model originally designed to support families with children through age 5; this allows sites to enroll families referred by child welfare up to age 24 months." (See https://www.healthyfamiliesamerica.org/protocols-child-welfare/). The expansion of enrollment to 24 months also allows for a full dosage (three years) of HFA treatment to families involved in child welfare. This maximizes eligibility of Indiana families while remaining in compliance with the standards set by HFA.

Fidelity

HFI is accredited by Healthy Families America as a multi-site state-wide program and is overseen on an ongoing basis by HFA. The HFA Standards for Multi Site Central Administration such as in Indiana can be read in their entirety in Appendix XVIII. Indiana's HFI sites are subject to two separate sets of standards (single site standards and multisite central administration standards), as well as HFI standards and individual site policies. HFI and HFA conduct annual site visits to each HFI site and provide a site summary report to show any standards in or out of adherence for the last year. HFI is contracted with a consulting group to conduct Quality Assurance with each individual site on the individual standards not met. A redacted sample of a site summary report can be read in Appendix XIX, and the QA plan for HFI can be read in Appendix XX.

HFA accreditation occurs on a cycle. Indiana will be re-accredited in 2022. Changes resulting from the accreditation process and other upcoming improvements will require a resubmission of this document. We intend to resubmit if any changes are made to the QA plan or to any HFI policies. HFI's intake tool is expected to change in April 2022 and we will resubmit at that time.

Outcomes

Recent evaluations of HFA have demonstrated its strengths in the child-welfare context. The most immediately relevant findings are that children of parents in the program have been found to receive fewer reports and after more time had passed (Easterbrooks et al., 2019), as well as fewer substantiated reports of physical abuse or neglect (Lee et al., 2018). Parents were found to parent less harshly (Rodriguez et al., 2010), and utilize less physical and psychological aggression (DuMont et al., 2008).

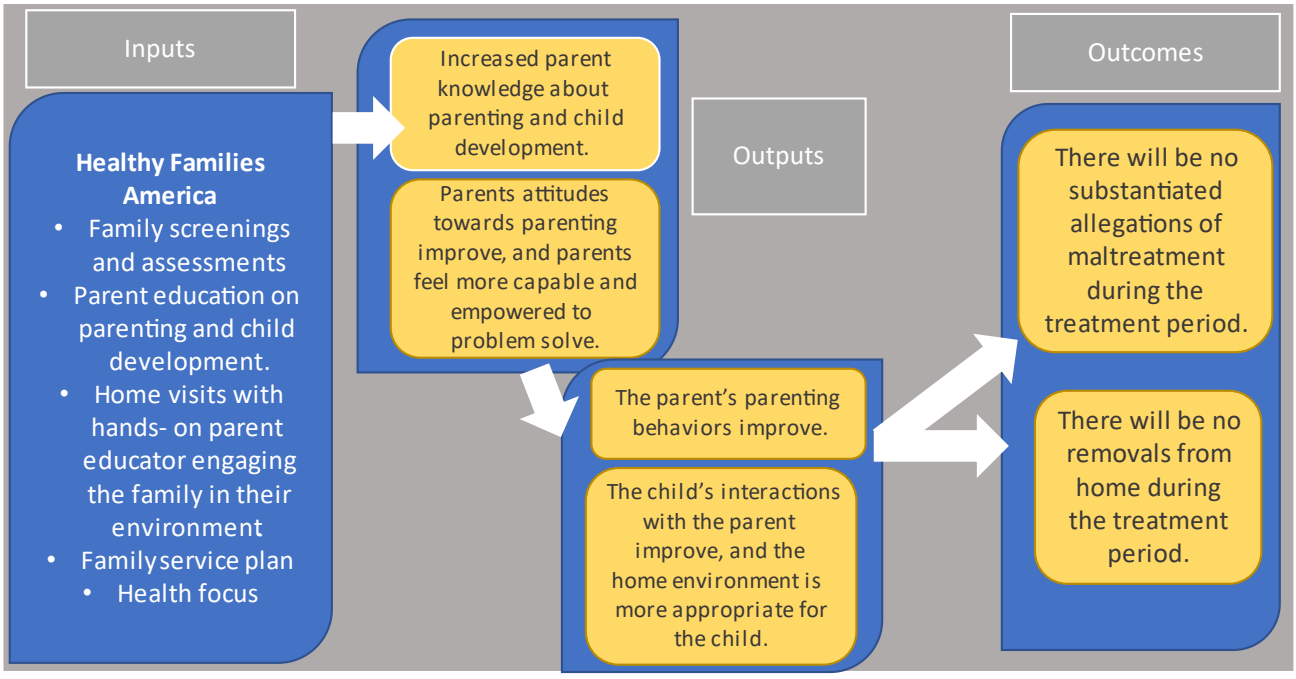
HFI itself was evaluated in 2020, covering performance of HFI from 10/1/2019 to 9/30/2020. This evaluation demonstrated that:

- Families' HOME Organization subscale scores improved over time in the program (88.3% of families).
- Families' Home Environments improved beyond classification as an Area of Concern (76.5% of families).
- Parent/Child Behavior improved beyond classification as an area of Concern (65.6% of families).
- Parenting Efficacy improved beyond classification as an area of Concern (58.3% of families).
- Responsivity of parents on the HOME scale improved (95.7% of families).
- Learning Materials and Involvement subscales on the HOME improved (95.1% and 90.3% respectively).
- Social Support Subscale of HFPI improved beyond classification as an area of Concern (58.5% of families).
- Mobilizing Resources improved beyond classification as an area of Concern (71.2%).
- Problem Solving improved beyond classification as an area of Concern (62%).

The evaluation can be read in Appendix XXI. HFA has proven outcomes in Indiana and an ongoing process for improving those outcomes as well as the processes to reach them.

Indiana's logic model for understanding the pathways leading to positive outcomes for HFI served families can be viewed below in Figure 2.

Figure 1. HFA Logic Model



Indiana Family Preservation Services (Not Yet Rated, Evaluation Pending)

Indiana is not requesting approval for claiming Title IV-E dollars in the provision of INFPS at this time.

DCS has built a framework of services and outcome expectations for Indiana Family Preservation Services (INFPS). DCS has built a comprehensive service standard and per-diem model designed to properly identify, assess, engage and provide appropriate evidence-based programs to children and families in an effort to keep families thriving together safely. Indiana Family Preservation Services are services designed to work with families that have had an incident of abuse and/or neglect, where DCS believes the child(ren) can remain in the home with their caregiver(s) with the introduction of appropriate services to the family. The service shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need. The goal for these services is to preserve the family and avoid removal of the child(ren), provided it is safe for the child(ren) to remain with their identified caregiver(s). Services must be comprehensive and individualized to families' unique needs. All services delivered under this standard must have as a foundation at least one evidence-based practice that is classified at a minimum as a promising practice on the CEBC (http://www.cebc4cw.org/). These services must be home-based and must monitor and address any safety concerns for the child(ren).

Concrete Supports (Bundled with INFPS)

Indiana is not requesting approval for claiming Title IV-E dollars in the provision of Concrete Supports at this time.

Concrete supports are a pivotal piece of INFPS and multiple evidence-based family preservation programs (Fraser et al., 1997). In 2019, DCS used Title IV-E funds to conduct an evaluation of concrete support services in Indiana (as required by the IV-E Waiver Demonstration Grant). The evaluation found the use of concrete-support spending increases placement stability (Winters et al., 2020). This finding was used to support the addition of concrete supports as a part of INFPS as an evidence-based approach that has been shown to effectively stabilize Indiana families.

Providers of this service will be expected to address any concrete supports the family has if failing to address these needs would result in the child(ren) having to be removed from the home in coordination with the child and family team as dictated by the INFPS Service Standard.

Examples of concrete assistance are:

- Solving housing issues such as overdue rent when the family is facing an eviction.

- Resolving past-due utilities that could result in electricity and/or gas to the homebeing suspended, creating an unsafe or unsuitable living condition for the child(ren) (e.g., lack of heat during winter months, or water service being shut off).
- Providing access to essentials such as food and clothing.
- Connecting with other concrete supports as needed to keep the family intact (e.g.,transportation assistance).

Concrete supports will be evaluated under the INFPS evaluation through two key outcome questions: how does the use of concrete supports on an INFPS referral impact the number of children removed and how does the use of concrete supports on an INFPS referral impact the number of children with a subsequent substantiated allegation of abuse or neglect? While the evaluation relies on administrative data, this administrative data is the most likely to be accurate. The tracking of families who receive concrete supports is completed by providers who are asked to complete a form each month. These forms are sent monthly to ChildWelfarePlan@dcs.in.gov. The Regional Services Consultants are available to help clarify when the usage of concrete assistance is required and assist with recording it on the form to ensure accuracy. DCS has the ability to measure the specific amount of concrete assistance that specific families receive during the course of their involvement with INFPS.

Indiana seeks approval for the remaining services in this section under the Title IV-E Prevention plan. Please see the table below for a summary of DCS EBP target populations, client needs addressed by the EBP, proximal outcomes and distal outcomes expected from the EBP.

Table 10. Alignment Table for Program Populations and Outcomes

Model	Target Populations; Age Ranges	Client Need	Proximal Outcomes	Distal Outcomes*
A Logic Model has been included for each of the following EBP's. These logic models can be found on the pages accompanying the model name in this table.				
FFT, p45	Families with disruptive youth; Youth ages 11 to 18	Youth needs behavioral health services.	Youth's behavior improves. Parent skills improve	Children in the home do not experience a removal or

		Parent needs parenting skills training.	managing youth behaviors.	repeat maltreatment.
TF-CBT, p49	Children with trauma and their parents; 3 to 18	Child needs mental health treatment. Parent needs trauma-informed parenting skills training.	Child skills improve managing trauma responses. Parent skills improve managing trauma responses.	Children in the home do not experience a removal or repeat maltreatment.
MI, p52	Families in which a caregiver has substance use disorder	Parent needs support addressing substance use.	Parent substance use is no longer a relevant safety concern.	Children in the home do not experience a removal or repeat maltreatment.
HFA, p38	High risk families; 0 to 5	Parent needs support reducing risks and increasing protective factors in the home.	Risks to the child are eliminated or the parent has the skills to manage the risk.	Children in the home do not experience a removal or repeat maltreatment.
PAT, p57	High risk families; 0 to 5	Parent needs support reducing risks and increasing	Risks to the child are eliminated or the parent has	Children in the home do not experience a removal or

		protective factors in the home.	the skills to manage the risk.	repeat maltreatment.

*Distal Outcomes are our measured outcomes.

b. Child Welfare Services to Support Mental Health in Indiana

Functional Family Therapy

Indiana seeks approval for FFT in Indiana as a Title IV-E Prevention program for mental health treatment.

Service Description

Functional Family Therapy (FFT) is rated as well-supported by the Title IV-E Prevention Services Clearinghouse. Functional Family Therapy (FFT) is a family intervention program for youth experiencing dysfunction with disruptive, externalizing problems.

Program Model

In addition to its well-supported rating by the Title IV-E Clearinghouse, the California Evidence Based Clearinghouse has also rated the program as well supported as a disruptive behavior treatment, as well as supported as a treatment for substance abuse, as a behavioral management program for adolescents, and as an alternative to Long-Term Residential Care Programs ("FFT", 2020). Research on FFT signals a robust comprehensive treatment for older children and their families.

Families receiving FFT meet with a therapist face to face for 60 to 90 minutes each week, plus over the phone as needed up to 30 minutes weekly. Families tend to complete treatment within three to six months, receiving an average of eight to 14 sessions in that time. One continuous feature of FFT delivery is the ongoing attention to risk and protective factors, making it a model that works well within the existing child safety framework in DCS. There are five phases of FFT delivery: Engagement, Motivation, Relational Assets, Behavior Change and Generalization. The Engagement, Motivation and Relational Assets phases preceding, as well as the Generalization phase following, each support the over-arching goals set in the Behavior Change phase. This phase addresses the behavioral health of the child, resets the mindset of the parents with regard to the child and their behaviors, and introduces skills for both parties moving forward. Risk and Protective Factors addressed in the Behavior Change phase include for example:

- Youth temperament.
- Parental pathology.
- Conflict resolution/negotiation skills.

- Peer refusal skills.

In this way, the needs of the child and parent are addressed together in the context of their relationship and family environment.

Target Population

The target population for FFT is 11- to 18-year-olds with concerns such as conduct disorder, violent acting out and substance use disorder. As stated previously, Indiana supports 1,253 children (DCS Internal Reports, 2021) of 11- to 18-year-old children with in-home cases where FFT could potentially be utilized. To drill down further to the needs of this population, we have displayed below relevant CANS items and the percentage of Indiana's In-home population that has been identified as currently causing problems or has the potential to start problems.

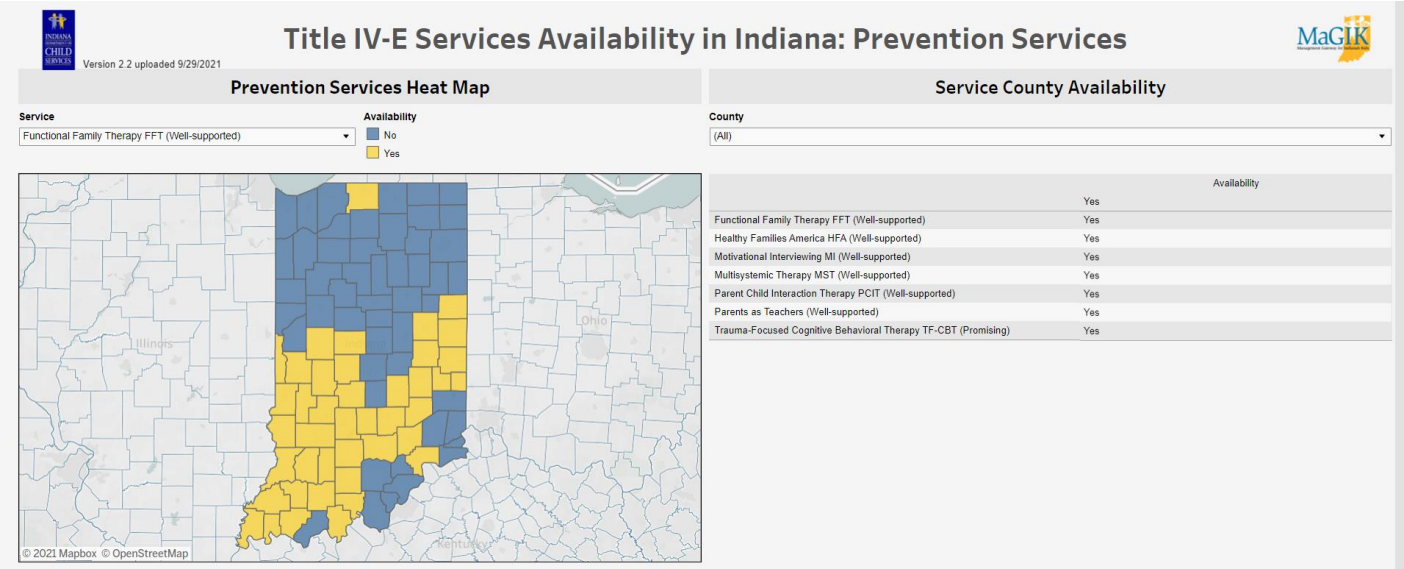
Table 11. Percent of In-Home Children to which FFT Relevant CANS items Apply

CANS Item Causing Problems or Needing Monitoring for the Child/Family	Percent of In-Home Children to which the CANS item Applies
Adjustment to Trauma	92%
Anger Control	23%
Anxiety	37%
Depression	36%
Conduct	20%
Impulsivity/Hyperactivity	20%
Oppositional	24%
Intentional Misbehavior	13%
Delinquency	10%

Implementation Plan

DCS will utilize the FFT manual, Family Therapy for Adolescent Behavioral Problems and will not use any adaptations to the FFT model (Alexander, Waldron, Robbins, & Need, 2013). FFT has been in use in Indiana prior to implementation of INFPS in 2020. FFT is available in 38 of Indiana's 92 counties. FFT providers are concentrated in the southern half of the state. The specific counties served can be found on Indiana's Title IV-E Services Availability Dashboard, shown in Figure 2 below or at this link: Workbook: Title IV-E Services Availability in Indiana. FFT has been offered to families under the INFPS umbrella since INFPS was implemented in June 2020.

Figure 2. Title IV-E Services Availability in Indiana: Family Functional Therapy



Fidelity

FFT providers are subject to fidelity monitoring by both DCS and by the model holder of FFT. DCS fidelity measures are covered fully in section D.ii.b. of this document on page 21. FFT providers must have a contract with DCS to provide FFT. A sample contract is attached in Appendix II. These contracts bind the service provider to:

- Ensure that FFT is provided to families only by employees qualified to provide FFT
- On the case level, provide monthly reports to the FCM which include:
    - Provider recommendations to modify the service/treatment plan
    - Overall progress related to treatment plan goals including specific examples to illustrate progress

Providers are also subject to audits every four years, which are described in depth in section D.ii.b on page 21.

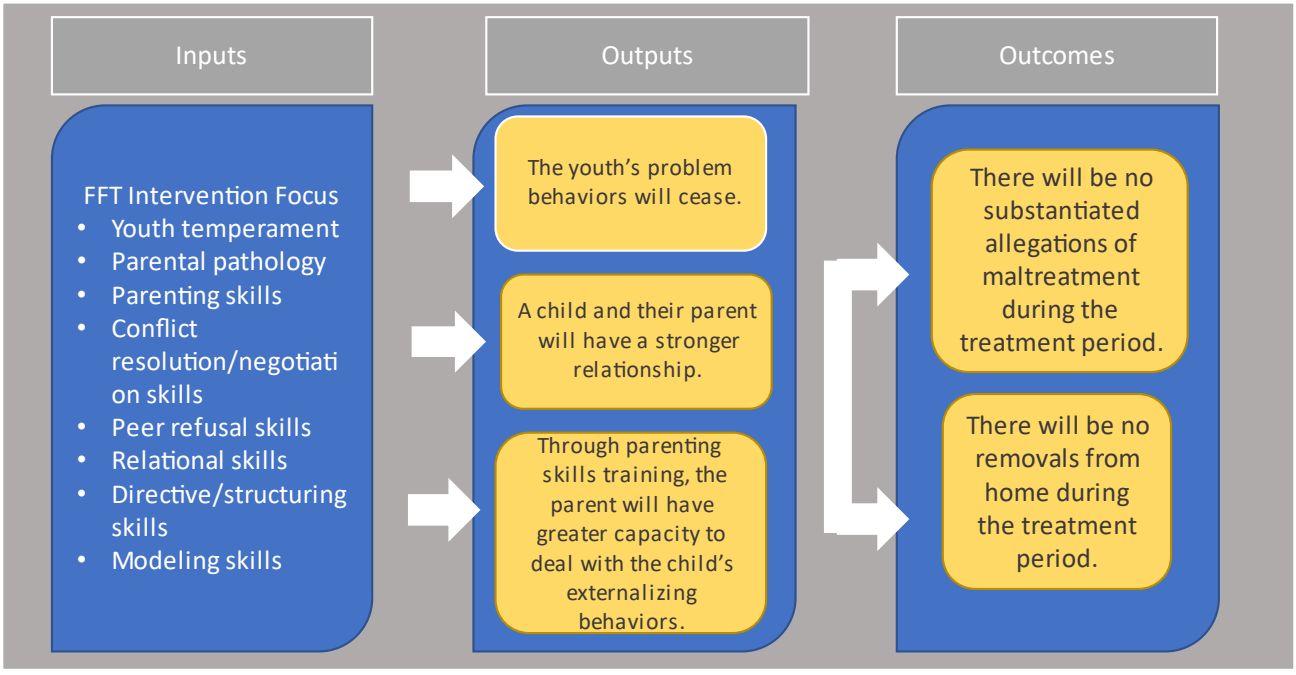
In addition to the measures taken by DCS to ensure the model is executed to fidelity, the model holder of FFT intensively monitors the quality of providers' implementation of FFT. At the conclusion of an FFT site receiving certification, each site is assigned an FFT National Consultant. This consultant supports the site in delivering FFT to fidelity. Weekly supervision checklists are utilized by clinical supervisors at the case level to ensure fidelity. Three times a year, clinical supervisors report the fidelity of their therapists to FFT. These are also used as a way to provide feedback and set goals with therapists providing FFT. The FFT Certification Map details the support and accountability of FFT sites in depth and can be found in Appendix XI.

Outcomes

FFT aims to treat children with high- need behavior disorders. FFT has been shown to improve children's behavioral health (Celinska, 2013; Humayun, 2017; Celinska, 2018). Studies of FFT's impact on delinquent youth have found improvements in depression symptoms, substance use, delinquent behaviors and negative consequences, and reconvictions for delinquent youth (Slesnick, 2009). FFT has also been shown to support the child's environment through improving family conflict skills and reducing verbal aggression (Slesnick, 2009). The effectiveness of FFT is also lasting –it has been shown to decrease recidivism (Baglivio, Jackowski, Greenwald, & Wolff, 2014).

FFT is expected to reduce disruptions associated with the high need behavior disorders FFT is designed and proven to treat. FFT is also expected to improve parenting and family functioning so the youth can safely stay in the home. FFT is therefore expected to reduce risk of repeat child maltreatment through improved family functioning for families in which there is disruptive youth behavior.

Figure 3. FFT Logic Model



Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Indiana seeks approval for TF-CBT in Indiana as a Title IV-E Prevention program for mental health treatment.

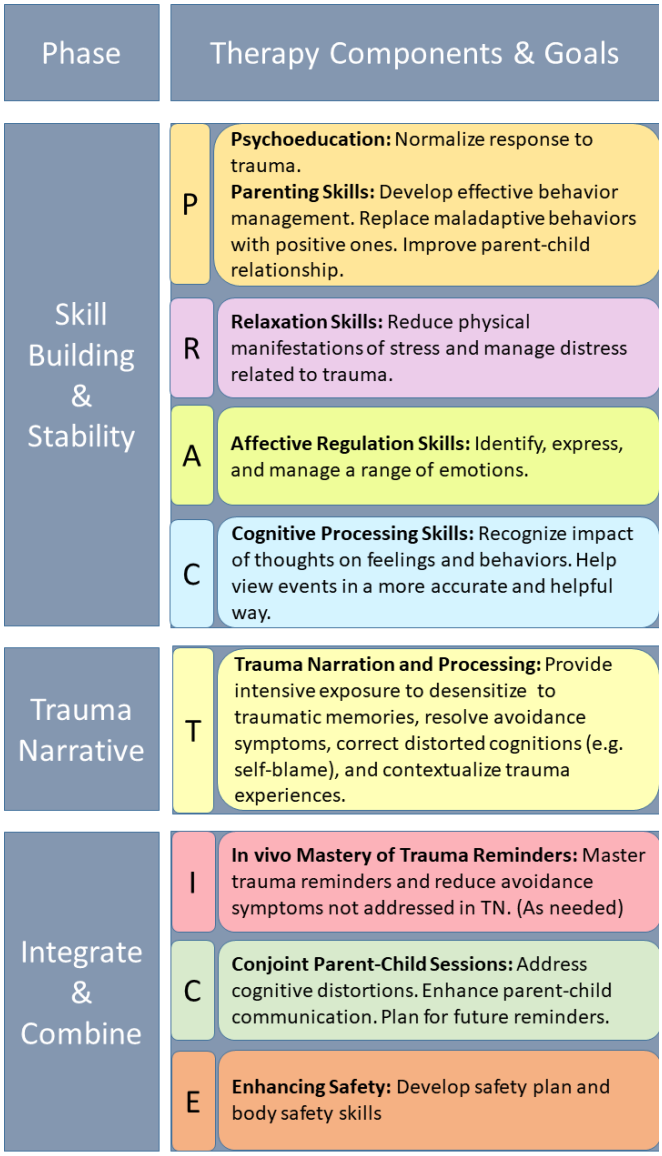
Service Description

TF-CBT is a conjoint child and parent psychotherapy model for children experiencing significant emotional and behavioral difficulties related to traumatic life events. TF-CBT is rated as well-supported and high for child-welfare relevance per the CEBC.

Program Model

TF-CBT is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family and humanistic principles. TF-CBT is usually administered in 12 to 16 sessions but can be delivered in as few as eight. Indiana will use the following manual for TF-CBT: Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* Guilford Press. DCS will not use any adaptations to TF-CBT. TF-CBT's PRACTICE Components and goals can be seen below in Figure 4.

Figure 4. TF-CBT PRACTICE Components and Goals



(Penn State University, n.d.)

Target Population

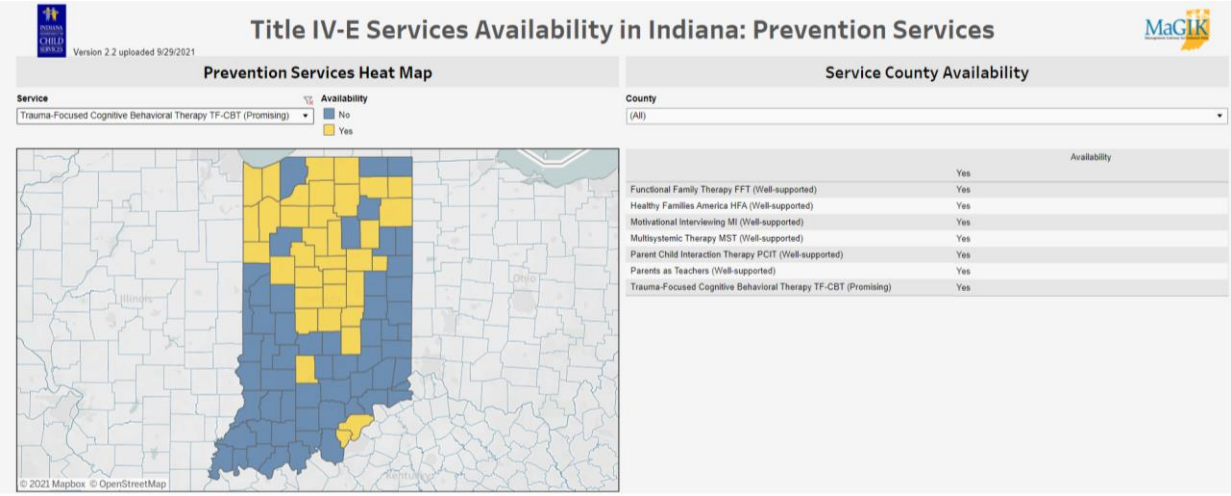
The target population for TF-CBT is families with children ages 3 to 18 who are experiencing significant challenges due to trauma, whether or not they meet full diagnostic criteria. This target population is appropriate in a child welfare context due to the trauma resulting from incidence of child abuse and neglect. Every child with a prevention case may or may not have substantiated allegations of abuse. In 2021, 17% of children on prevention cases were identified as either actively struggling with adjustment to trauma according to their CANS (Child and Adolescent Needs and Strengths Assessment) (Internal DCS Reports, 2021).

Implementation Plan

TF-CBT is already being utilized on prevention cases in Indiana. Below, Figure 5 demonstrates the 35

Indiana counties that house TF-CBT providers. Families in counties with no TF-CBT providers will be able to access the service from the provider most closely located to them.

Figure 5. Title IV-E Services Availability in Indiana: Trauma-Focused Cognitive Behavioral Therapy



Fidelity

TF-CBT providers are subject to fidelity monitoring by both DCS and by the model holder of TF-CBT. DCS fidelity measures are covered fully in section D.ii.b. of this document on page 21. TF-CBT providers must have a contract with DCS to provide TF-CBT under the umbrella of INFPS. A sample contract is attached in Appendix II. These contracts bind the service provider to:

- Ensure that TF-CBT is provided to families only by employees qualified to provide TF-CBT
- On the case level, provide monthly reports to the FCM which include:
    - Provider recommendations to modify the service/treatment plan
    - Overall progress related to treatment plan goals including specific examples to illustrate progress

Providers are also subject to audits every four years, which are described in depth in section D.ii.b on page 21.

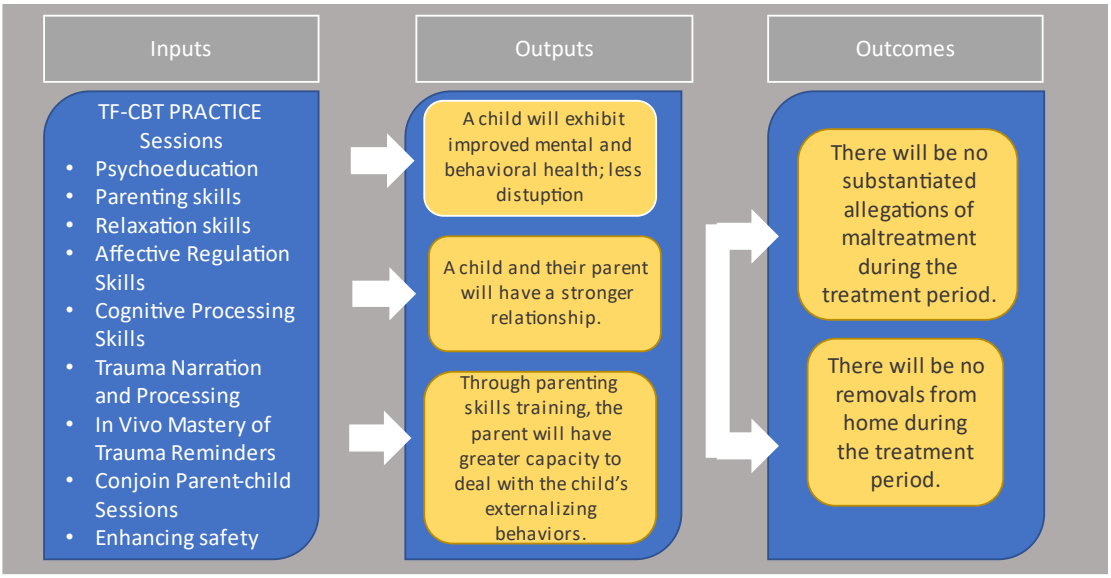
In addition to the measures taken by DCS to ensure the model is executed to fidelity, the model holder of TF-CBT intensively monitors the quality of providers' implementation of TF-CBT. According to the Title IV-E Clearinghouse, "In order to receive certification for TF-CBT, individuals must attend two consecutive days of training, complete three treatment cases, score at least 80% on a certification exam, and participate in follow-up supervisory consultation with trainers for 6-12 months." TF-CBT's model holders provide a fidelity tool for clinicians to use on their own or with supervisors called the TF-CBT Brief Practice Checklist. This checklist can be viewed in its entirety in Appendix XII at the end of this document, but what's important

to note is its basis on Figure 4's Practice Components and Goals.

Outcomes

TF-CBT has been shown to improve child functioning for children who have experienced trauma in accordance with the intended and proven treatment effect(Cohen,1996; Cohen, 2004; Goldbeck, 2016; Jensen, 2017; Jensen, 2018; Sheeringa, 2011, Smith, 2007). TF-CBT has also been found to improve caregiver empathy and understanding of their children who have experienced trauma to prevent repeat maltreatment and allow for the child to remain in the home in accordance with the intended and proven treatment effect (Cohen, 2004).Treatment focus on both child and parent allows for fewer trauma-related disruptions on the side of the child and more skills to manage such disruptions on the side of the parent. The logic model for our TF-CBT evaluation is pictured below in Figure 6 as an aid to understanding how TF-CBT facilitates positive change for children and families in Indiana.

Figure 6.TF-CBT Logic Model



Indiana will be conducting a full evaluation of TF-CBT's performance in Indiana under the umbrella of INFPS. Indiana currently seeks approval for TF-CBT in Indiana as a Title IV-E Prevention program for mental health treatment.

c. Child Welfare Services to Support Substance Abuse Treatment and Prevention in

Indiana

Motivational Interviewing (MI)

Indiana seeks approval for MI in Indiana as a Title IV-E Prevention program for substance use treatment and prevention.

Service Description

Motivational interviewing is a method of counseling clients designed to promote behavior change and improve physiological, psychological and lifestyle outcomes. Motivational Interviewing (MI) is rated as well-supported with the Title IV-E Prevention Services Clearinghouse and the CEBC. MI is specifically effective treating parents or caregivers with substance-use disorders. The goals of the program include increasing internal motivation to change, reinforcement of that motivation and development of a plan to follow through with the change.

Program Model

MI aims to identify ambivalence for change and increase motivation by helping clients progress through five stages of change: pre-contemplation, contemplation, preparation, action and maintenance. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors might conflict with attainment of those goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible. These clinical strategies include the use of open-ended questions and reflective listening. MI can be used to promote behavior change with a range of target populations and for a variety of problem areas. MI is typically delivered over one to three sessions with each session lasting about 30 to 50 minutes.

Target Population

MI focuses on illicit substance and alcohol use/abuse among youth and adults and nicotine/tobacco use among youth under 18. MI was last reviewed in November 2019 by the Title IV-E Clearinghouse. Because favorable outcomes were consistently found when MI was applied to parent or caregiver substance use, this is the use for which Indiana seeks approval.

MI is an important treatment for Indiana children and families to have access to. Indiana families have a significant service need for MI because of the prevalence of substance use disorder. About 25% of all reports to DCS involve substance use disorder (DCS Internal Reports, 2021). Moreover, 64% of removals are at least in part due to caregiver substance use disorder (DCS Internal Reports, 2021). Indiana parents' needs clearly align with the strengths of this model. The utilization of MI to address substance use disorder among caregivers is critical for

enabling change and reducing the number of child welfare involved families across Indiana.

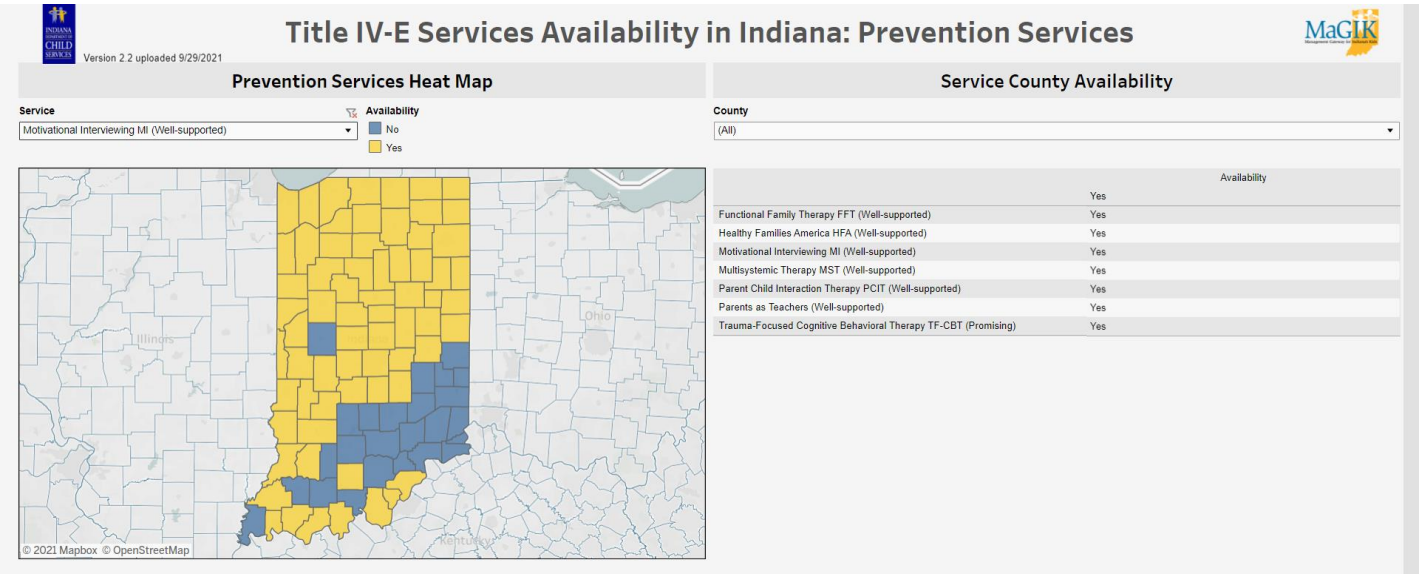
Because sessions are often used prior to or inconjunction with other therapies or programs, INFPS is a particularly useful prevention framework for providing this service.

Implementation Plan

Fortunately, MI is already in use in Indiana and has been for many years. MI is used by INFPS providers located in 68 of 92 Indiana counties (see the Prevention Services Dashboard below in Figure 6). On the ground, this means that 71 DCS counties are able to refer to a provider within their county, and another 25 counties are able to refer to a provider most closely located to the home county of the family.

MI was provided prior to FFPSA, and it has been provided through Indiana's program INFPS implementation in June 2020. During the INFPS evaluation period, 1,236 children on 614 cases were served MI through INFPS referrals to providers. Implementing MI as a prevention treatment was not burdensome on the existing system and providers and presents no current challenges.

Figure 7. Title IV-E Services Availability in Indiana: Motivational Interviewing



Fidelity

MI providers must have a contract with DCS to provide MI under the umbrella of INFPS. A sample

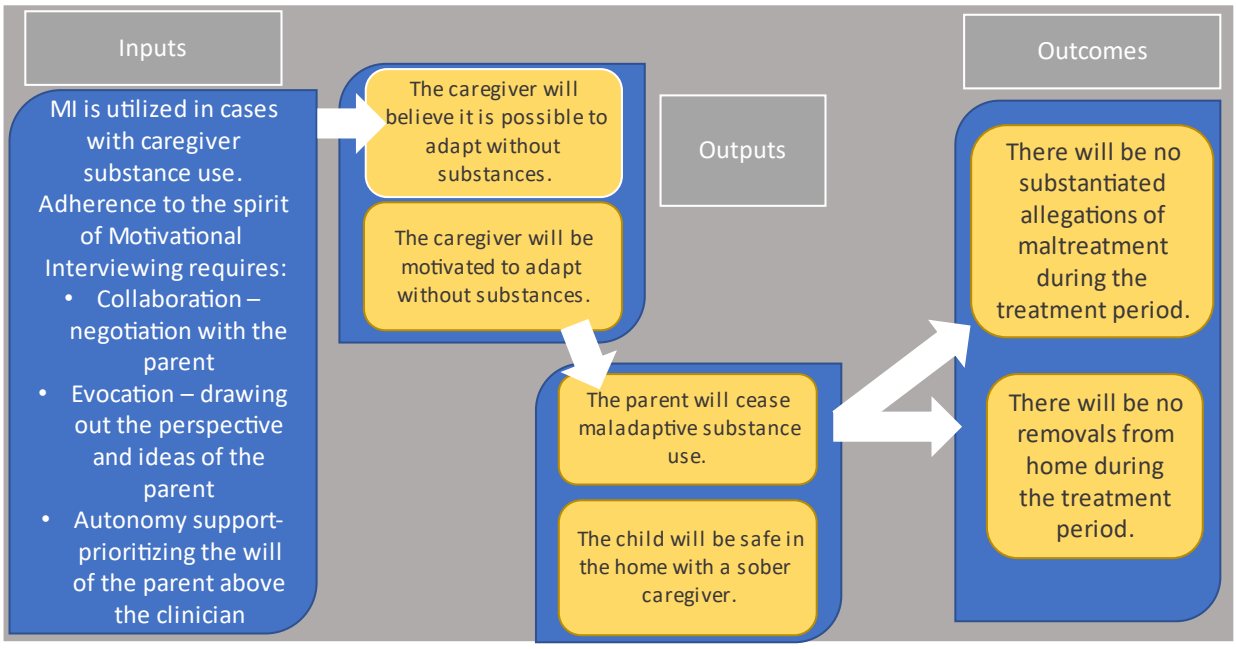
contract is attached in Appendix II. These contracts bind the service provider to:

- Ensure that MI is provided to families only by employees qualified to provide MI
- On the case level, provide monthly reports to the FCM which include:
    - Provider recommendations to modify the service/treatment plan.
    - Overall progress related to treatment plan goals including specific examples to illustrate progress.

Providers are also subject to audits every four years, which are described in depth in section D.ii.b on page 21. Indiana will use the following manual for MI: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press. DCS will not use any adaptations to MI.

Unlike the other evidence-based models for which DCS seeks approval, MI does not have a model holder that tracks fidelity to the model. MI has no minimum qualifications and no recommended trainings. DCS's outcome-based contracting is essential in this context because it allows DCS to ensure effective service delivery. Contracted providers of MI manage fidelity to MI through resources they select. An example can be seen on page 51.

Figure 8. MI Logic Model



MI Provider Fidelity

A MINT-certified practitioner at one Indiana provider directs the training and development of staff providing the service. The provider is a certified member of MINT (Motivational Interviewing Network of Trainers) and only utilizes training exercises that have been approved by MINT. Practitioners begin training by attending one full day training on MI basics. Afterwards, they begin honing their skills in the field and return a month later for a second full day training on advanced skills in MI such as identifying opportunities to practice change talk in the moment. Following this second training, clinicians have a 12-week continuation of teaching and follow-up with both their trainer and supervisor who is already trained in MI. This 12-week curriculum is the same for all trainees, and when training is complete the 12-week rotation begins again and continues as long as the clinician is providing MI. Each 12-week cycle is guided by the areas the clinician may need support on or growth in that are identified in ongoing supervision. One year into a clinician's MI delivery, they are observed and given formal feedback.

Clinicians providing MI must speak to and provide evidence of their adherence to MINT standards as described below. These clinicians create this evidence in their case notes, which their supervisor uses during supervision to ensure fidelity. Staff notes must name specific Key Techniques listed below that they have used and give examples in their case notes. Supervisors review these notes to ensure that if a clinician notes use of MI, there are detailed descriptions of what Key Techniques the clinician utilized in their delivery of MI to the family. Staff must also be able to name the specific Major Concept that the clinician is working on with each family at any given time. This is also reviewed by and discussed with the supervisor as each case progresses.

MINT Major Concepts include enhancing confidence, importance of change, maintaining new status quo, resolving ambivalence, solidifying commitment, and working through a change plan. MINT Key techniques include:

- Amplify ambivalence
- Change talk
- Collaboration
- Decisional matrix
- Develop discrepancy between goals and values
- Envisioning/miracle question
- Evocative questions for change
- Exploring and resolving ambivalence
- Exploring values
- Information sharing
- OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
- Offering concerns
- Readiness ruler
- Roll with resistance and sustain talk
- Scaling questions
- Selectively reinforcing elements focused on change
- Support autonomy
- Support self-efficacy

Outcomes

MI seeks to increase the importance of change from a client's perspective (Burke et al. 2003). MI focuses on a client's readiness for change through the importance and confidence the client has that change will occur (Burke et al 2003). The utilization of MI has shown to have lasting effects on individuals with both substance and alcohol use-related problems (D'Amico et al. 2018). Specifically, in the context of caregiver substance use, the goal of MI would be for the caregiver to be invested in treatment and sobriety. The Title IV-E clearinghouse lists the following studies demonstrating the effectiveness of MI in treating caregivers specifically for substance use: Carey, 2006; Freyer-Adam, 2008; Gentilello, 1999; Marlatt, 1998; Rendall-Mkosi, 2013; Saitz, 2014; and Stein, 2011.

Families receiving MI as part of their prevention case would be receiving it because a caregiver's substance use has presented as a safety concern to the children. A caregiver's commitment to their sobriety, then, eliminates a safety concern facing children in the household. Successful treatment in this context leads to the proximal outcomes of caregiver sobriety and child safety, as well as the distal outcomes that are implicated by the ongoing safety of the child in the absence of substance use as a risk factor. These distal outcomes include our expectation that families receiving this treatment will experience fewer removals (meaning that children will be assessed to be safe in the immediate future) and fewer re-entries (meaning that children will not re-enter the system due to another reported incident). For clarity, please see our logic model for MI in Figure 8 on the previous page.

Given the intended and proven strategies of MI, MI is expected to facilitate positive change with individuals and within families to address caregiver substance use that presents safety risks to children so the child can remain safely in the home and avoid repeat maltreatment.

Parents as Teachers (PAT)

Indiana seeks approval for PAT in Indiana as a Title IV-E Prevention program for in-home, skill-based parenting programs.

Service Description

PAT is a home-visiting model designed to educate parents on child development and improve parenting practices for new parents of kids ages 0 to 5. PAT focuses on reducing risk by building protective factors. PAT builds protective factors by educating parents on child development and on positive parenting practices, focusing particularly on activities parent and child can do together and activities that support the child in being ready for school.

Program Model

Parents as Teachers (PAT) is rated as well-supported with the Title IV-E Prevention Services Clearinghouse. (Parents as Teachers National Center, Inc. (2016). The PAT Model centers around home visits, but also includes screenings and a group connection component. Home visits occur at least monthly depending on the needs of the family. New and expectant parents, starting before the birth and continuing until theirchild reaches kindergarten, may participate in PAT. DCS will utilize the PAT manual f*oundational curriculum.* Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten.* DCS will not use any adaptations to PAT.

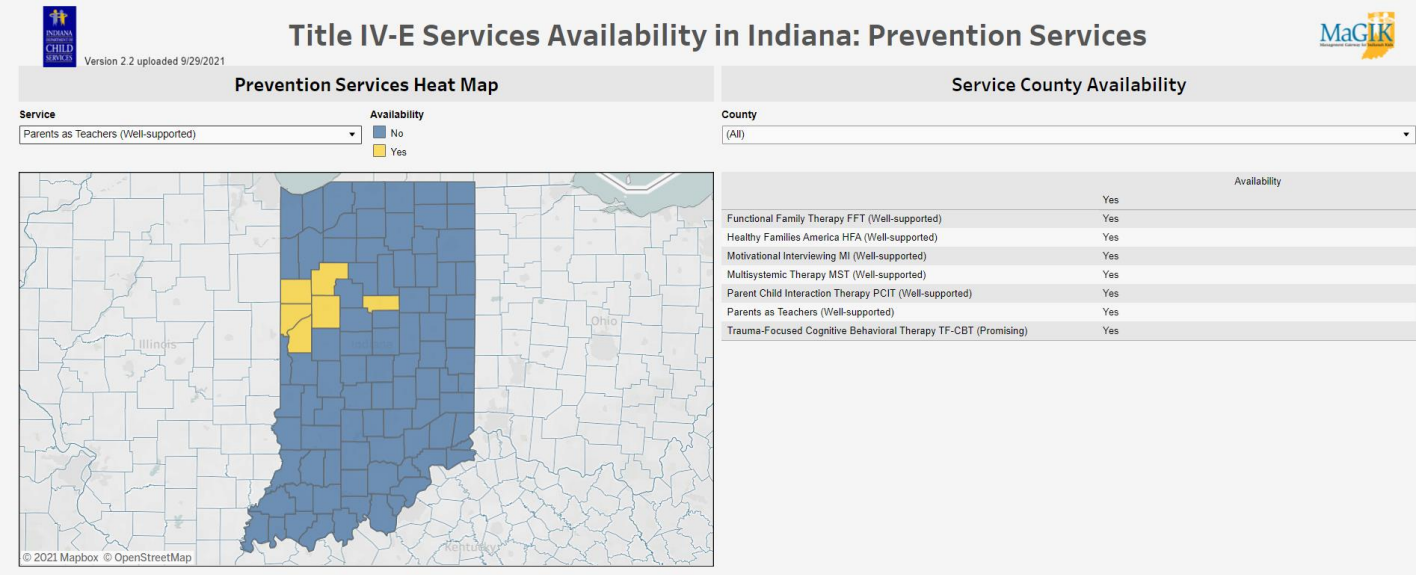
Target Population

Indiana trends demonstrate that young children and infants enter care at higher rates than older children due to their vulnerability. Programs focusing on young children, with the particular goal of maintaining children safely in the home, are important to ensure safety and prevent and reduce the need for removals of children from their home of origin. Please see Section C for more information on the Target population for this prevention plan.

Implementation Plan

PAT is currently available in six Indiana counties, as shown in the figure below from the Prevention Services Dashboard, which is available here.

Figure 9. Title IV-E Services Availability in Indiana: Parents As Teachers



Fidelity

PAT providers must have a contract with DCS to provide PAT under the umbrella of INFPS. A sample contract is attached in Appendix II. These contracts bind the service provider to:

- Ensure that PAT is provided to families only by employees qualified to provide PAT.
- On the case level, provide monthly reports to the FCM which include:
    - Provider recommendations to modify the service/treatment plan/
    - Overall progress related to treatment plan goals including specific examples to illustrate progress.

Providers are also subject to audits every four years, which are described in depth in section D.ii.b on page 21. Indiana will use the following manual for PAT: f*oundational curriculum.* Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten* DCS will not use any adaptations to PAT.

In order to deliver PAT to fidelity as an evidence-based model, a site can elect to be a PAT affiliate, through which PAT monitors the fidelity and quality of services provided by the affiliate. The affiliation process for organizations and the certification for individuals are distinct. Individuals with certification are not subject to the same support or oversight as those operating within a PAT affiliate.
Parent educators must attend a three-day foundational training incorporating over 40 hours of training. They must also attend a two-day model implementation training that covers strategies used to implement PAT. Quality standards for PAT can be viewed in Appendix XXII. Affiliates are expected to deliver PAT to fidelity, and PAT utilizes an annual Affiliate Performance Report to oversee implementation at Affiliate sites. The PAT Affiliate Performance Report can be viewed in Appendix XXIII.

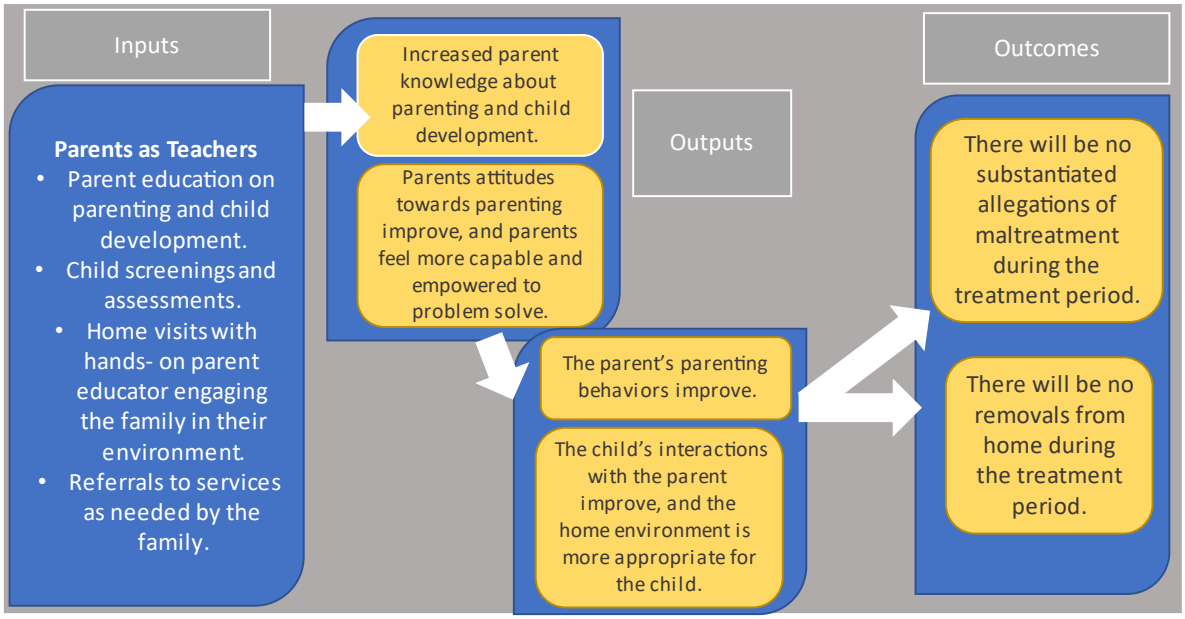
Outcomes

PAT has been an established home visiting program for many years. The Title IV-E Clearinghouse website includes findings from an RCT conducted in 1999 which demonstrates the particular improvements of interest in our context. In particular, this study found that families became more organized, responsive to their children, utilized more appropriate discipline, and were more accepting of their child's behavior (Wagner, 1999). A recent study found that families receiving PAT were 22% less likely to have substantiated allegations of maltreatment (Chaiyachati et. al 2018). The same study found that the program reduced PAT families' risk scores as well, accompanied by a nonsignificant downward trend in out-of-home placements for families receiving PAT.

PAT's model holders have a publicly available logic model which can be accessed from the Title IV-E Website. This framework is more broad than specifically relevant to child welfare. Indiana has also developed its own logic model for how PAT works to create the desired outcomes. This

logic model can be viewed below in Figure 10. The relevant aspects of PAT's framework to the child welfare context begin with the identification of child needs. PAT provides the knowledge and framework for parents to understand what is developmentally normal for children and what signs may point to unmet needs of their child. PAT supports parents in completing various screens on the child to ensure identification of child needs. In the household visits, PAT clinicians are able to redirect problematic parenting, reinforce positive parenting skills, and promote positive parent-child interactions and relationship. Families with these skills and a strong positive relational foundation have what DCS would define as important protective factors in preserving the child in the home, including more appropriate parenting behaviors in the caregiver but also generally a more appropriate home environment for the child at their developmental level. These protective factors either eliminate or qualify risks that previously existed in the household, ultimately empowering the family to function safely and without oversight.

Figure 10. PAT Logic Model



G. Evaluation Strategy

FFPSA changes how Title IV-E funds can be used in child welfare. In order to draw funding, a program must be rated as at least "promising" by the Title IV-E FFPSA Clearinghouse. As part of supporting and building the evidence base of interventions and programs within child welfare, each jurisdiction must include a well-designed and rigorous evaluation strategy for each service if the state intends to draw IV-E prevention funds to cover some of the costs of providing the prevention service. Indiana's IV-E Prevention Plan describes an evaluation of Indiana's

Trauma- Focused Cognitive Behavior Therapy (TF-CBT) and Indiana Family Preservation Services (INFPS) along with concrete supports and services provided under INFPS.

a. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)

Trauma-focused cognitive behavioral therapy (TF-CBT) is an intervention for children and adolescents ranging in age from 3 to 18 years who have been exposed to an identified trauma and exhibit trauma-related emotional or behavioral health symptoms (Deblinger et al., 2006). Initially designed to treat trauma related to sexual abuse, TF-CBT has been applied for trauma related to physical abuse and neglect (Deblinger et al, 2011). The intervention aims to reduce the child's maladaptive emotional and behavioral health symptoms and seeks to strengthen parenting skills and the parent-child relationship (Deblinger et al, 2011). TF-CBT blends social-learning theory and cognitive-behavioral principles into a comprehensive intervention administered to both the affected child and a non-offending parent or caregiver (Deblinger et al., 2006).

Designated as a promising practice by the Title IV-E Prevention Clearinghouse and well-supported by the CEBC, this evaluation seeks to add to the evidence base to support or improve TF-CBT's current designation of promising. The evaluation will compare a group of children who receive TF-CBT to a similar group of children receiving other therapeutic modalities. DCS will evaluate TF-CBT's impact on the following three outcomes for children and families served in Indiana:

- Behavioral health CANS scores.
- Rate of repeat maltreatment.
- Rate of child removals from their home.

DCS will use a quasi-experimental design (propensity score-matching to evaluate the intervention's impact on the treatment group and control group children). The evaluation's findings will inform DCS' internal operations and will serve as a basis for DCS to draw Title IV-E funds. A full copy of the evaluation of TF-CBT that satisfies the necessary evaluation requirements is attached as Attachment 10.

b. Indiana Family Preservation Services (INFPS)

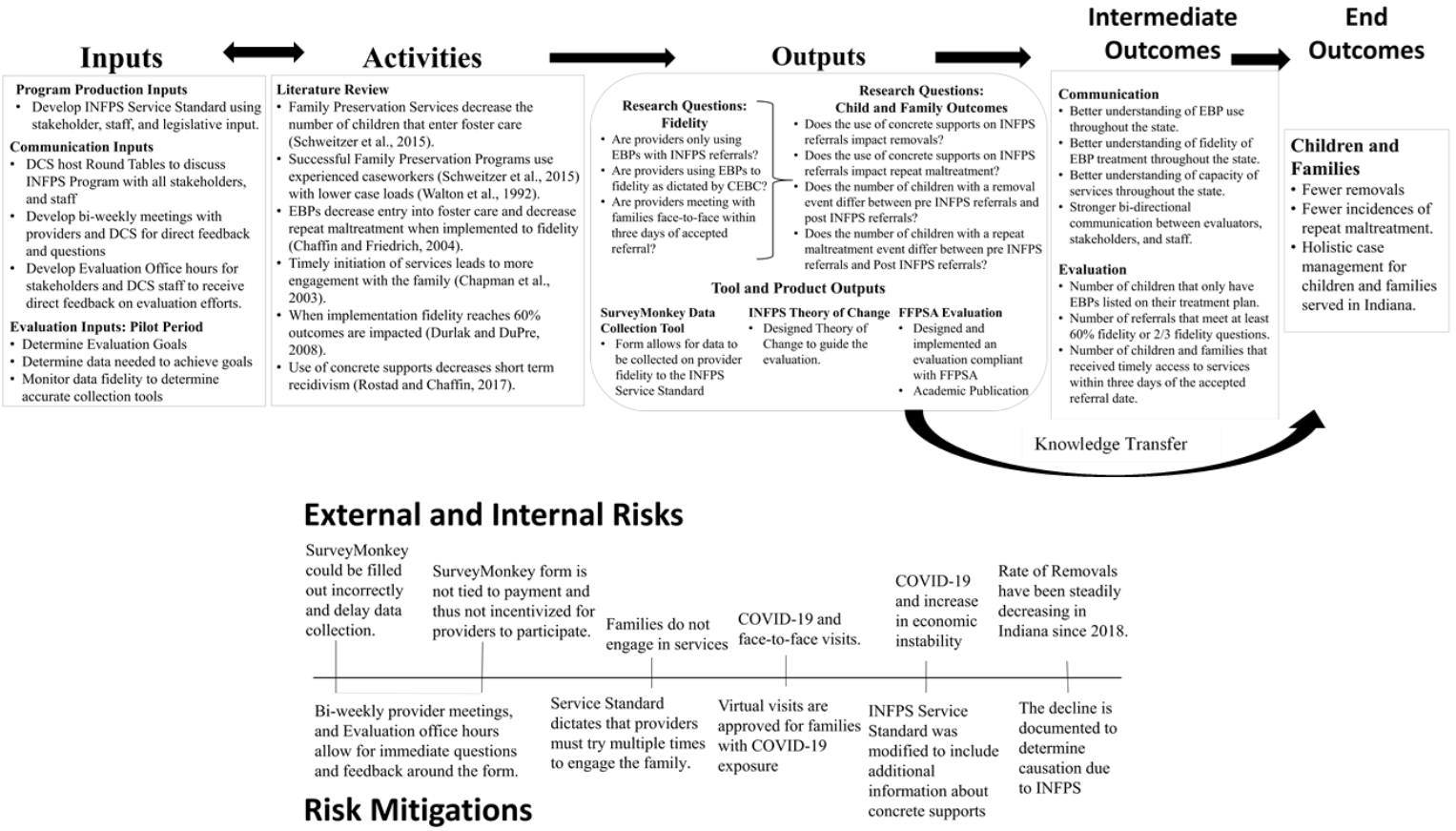
FFPSA prioritizes prevention over foster care entry and the use of evidence-based programs to assist in child abuse and neglect prevention. As such, Indiana intends to support Indiana Family Preservation Services (INFPS) and use intensive home-based services by working with both

children and parents through increasing education and keeping children from entering foster care (Schweitzer et al., 2015). Intensive family preservation services (IFPS) are a service category in child welfare that became prominent in 1980 to decrease the number of children entering foster care (Schweitzer et al., 2015). IFPS as a category of services hinges on relationships between child welfare professionals and the families they serve, as families must be receptive to the support they receive from child welfare to effectively build life-long skills (Duppong Hurley et al., 2019). Multiple states have implemented their own programs based on the service provisions defined by IFPS (Schweitzer et al., 2015).

DCS has created its own service model called Indiana Family Preservation Service Standard (INFPS). The description of the service standard is described in the policy manual under the section titled "Service Standard Indiana Department of Child Services Family Preservation Services (Per Diem Model)" (Service Standard Indiana Department of Child Services Family Preservation Services Per Diem Model, 2020). The INFPS manual dictates that INFP services "are designed to work with families that have had a substantiated incident of child abuse/or neglect, where DCS believes they can remain in the home with their caregiver(s) with appropriate services" (Service Standard Indiana Department of Child Services Family Preservation Services Per Diem Model, 2020). The manual further dictates that evidence-based services ranked by the CEBC of promising or higher be used by providers to support these families (Service Standard Indiana Department of Child Services Family Preservation Services Per Diem Model, 2020). The following evaluation aims to build existing literature around INFPS and provide evidence that the INFPS model decreases entry into fostercare and has the same positive or better outcomes previously found of IFPS services.

The results of the evaluation's findings will be used to improve DCS practice. A full copy of the evaluation of INFPS that satisfies the necessary evaluation requirements is attached as attachment 11. Figure 11 below contains the logic model for INFPS. It also addresses the confounds of the evaluation by identifying risks and their associated mitigations.

Figure 11. INFPS Logic Model



c. Concrete Supports and Services

Concrete Supports are bundled with INFPS as a per diem service for DCS used Title IV-E Waiver evaluation dollars to evaluate whether concrete supports keep families and children stable in their home. In our previous evaluations, DCS found that concrete services are effective in preventing removals (Hall et al., 2017) and when children were removed, concrete supports decreased the number of placements (Winters et al., 2020). As such, DCS has requested that concrete supports and services be rated as a promising practice by the IV-E Prevention Services Clearinghouse considering the evidence that concrete supports aid Indiana families.

This evaluation will analyze outcomes associated with the provision of concrete services to families receiving in-home services through DCS. The Indiana Family Preservation Service Standard directs service providers to offer concrete services to families when children would otherwise be removed from the home because of unmet basic needs under the INFPS service standard. The INFPS Service Standard has been approved as a modification of the Chapter 16 Section 3 Policy Manual by the owners. Considering the successful outcomes experienced by

Indiana Families under the Winters et al., 2020, and Pierce et al., 2017 studies, Indiana has used this research to inform the standards of the Indiana Family Preservation Program. This addition of concrete supports and family preservation is very common among evidence-based in-home family preservation programs and identified as a common characteristic among family preservation programs (Fraser et al., 1997), which argues the combination of INFPS with concrete supports will be the most supportive program for Indiana families.

Concrete assistance may include direct payments for rent, utilities, etc.; connecting families to community support such as local food banks; or assisting families with applications for federal assistance including Medicaid or the Supplemental Nutrition Assistance Program (SNAP).

Previous research demonstrates that concrete services are effective in preventing removals (Hall et al., 2017), increasing parent skills (Berry, 1992) and engagement in services (Littell & Tajima, 2000; Rostad et al., 2017) and lowering the odds of future child maltreatment (Chaffin et al., 2001; Pelton, 2008; Rostad et al., 2017; Ryan & Schuerman, 2004). DCS will use this study to build on the existing body of literature by evaluating the effectiveness of concrete services using the following two outcomes under the INFPS Service Standard:

- Child removals.
- Repeat maltreatment.

Concrete services will be evaluated using a quasi-experimental design with four treatment groups. The control groups will compare children under the previous in-home CHINS and IA referral system who received concrete supports to those who did not receive concrete supports under the previous referral system. These groups will then be compared to the treatment group of children who received concrete supports under the new INFPS program compared to children who did not receive concrete supports under the new INFPS program. Through using four treatment groups, we will be able to understand how the use of concrete supports impacts children and families separate from the referral system the families experienced. The use of concrete supports is monitored through both the billing department and DCS service consultants. The results of the study will inform DCS' efforts to provide evidence-based prevention services to children and families. A copy of the evaluation of concrete services that satisfies the necessary evaluation requirements can be found in attachment 11 (included within the INFPS evaluation).

H. Indiana's Request to Waive the Rigorous and Well-Designed Evaluation Requirement for Well-Supported Programs

DCS is requesting a waiver for those evidence-based programs rated as well-supported by the Title IV-E Clearinghouse. **This request is consistent with section 471(e)(5)(C)(ii) of the act because the Clearinghouse itself has determined that the evidence of the effectiveness of each program is compelling.** DCS has included a separate evaluation waiver request for each evidence-based program that is rated as well-supported using attachment II(See attachments two through six).

Table 12. Prevention Programs and Ratings for which Indiana seeks an Evaluation Waiver

Prevention Program Categories	Evidence-Based Programs	Title IV-E Prevention Services Clearinghouse Rating
Mental Health Treatment	Functional Family Therapy (FFT)	Well-supported
Substance Abuse Treatment and Prevention	Motivational Interviewing (MI)	Well-supported
In-home, Skill-based Parenting Programs	Healthy Families America (HFA)	Well-supported
	Parents as Teachers (PAT)	Well-supported

Please see Tables 5 and 6 under section

a. Continuous Quality Improvement Framework for Well-Supported Programs

Again, families receive prevention services both inside and outside of DCS involvement. First we will explain the CQI process for HFI, indicating the CQI process for families served by HFI with no open DCS involvement. The subsequent section will address CQI for all services provided under INFPS to families with open DCS cases.

Healthy Families Indiana Continuous Quality Improvement

A monthly report matches children removed to children served by HFI. DCS will review the report that matches children against monthly DCS data and tracks thepercentage of children who are free of substantiated abuse and/or neglect. The match population includes HFI children in families "fully engaged" with at least 12 home visits since program enrollment.

The Healthy Families data is obtained from the home-visiting information and tracking system. The HFI data is stored in Enlite, which is accessible to DCS to support ongoing monitoring of HFI model fidelity requirements as well as contract compliance and claiming/eligibility determination for funding sources. The Child Protective Services (CPS) data is obtained from

the DCS case management system.

A fully engaged family in the HFI program is defined as an enrolled family who has received a minimum of 12 visits postpartum. For example, a family with four visits a month for the first three months of a child's life meets the definition of fully engaged. Visits would continue at the level appropriate for the family. Within the fully engaged family, DCS will track the child of focus defined as the baby or child for whom the family is receiving HFI services.

Each month, additional children who have reached the milestone of 12 visits and therefore are fully engaged will be tracked. No other children in the HFI family will be tracked.

All the unique fully engaged children of focus identified for tracking will be matched to the latest month of CPS records starting with July data. A match is defined as the HFI child of focus being the victim of substantiated abuse or neglect in the CPS report. Children who are matched are counted only once.

Logic Model on Matching

- Once the family of a child of focus has had 12 visits (or more), they have been fully engaged.
- The match will be reported in the first month the abuse/neglect is substantiated.
- Once a match involving a child of focus is found, no further matching occurs for that child (to avoid distorting the count). The child will continue to be counted in the cumulative cycle-to-date total.

Denominator

- Total number of unique HFI children of focus who are fully engaged (12 or more visits) in the system as of the most current report month.
- This number will increase each month as more children of focus meet the milestone of the 12^{th} visit and are deemed fully engaged in the program.

Numerator

- Total number of HFI children of focus who are the victim of substantiated abuse.
- Total number of HFI children of focus who are the victim of substantiated neglect.
- Total number of HFI children of focus who are the victim of both substantiated abuse and neglect.

Once abuse and/or neglect are observed for a child of focus, no further matching is done. That child will not be included in subsequent monthly calculations (numerator, denominator).

DCS is the governing body for the HFI program, which is accredited as a multi-site statewide system. A multi-site statewide system must have a central administration entity that provides support to the individual HFI sites, delivers policy, training, quality assurance, technical assistance and evaluation of the system to ensure standards for model fidelity are met. HFI Central Administration is also granted the authority by HFA to affiliate and disaffiliate sites within the system. HFI's Central Administration has regular direct contact with the HFA National Office. The HFI Central Administration consists of the DCS prevention team, HFI quality assurance/technical assistance/training contractor, HFI database contractor and the chairs of the leadership committee. Additional committees with the HFI statewide system include the HFI advisory committee, think tank, policy committee, QA/TA committee, evaluation workgroup, database committee, forms workgroup and training committee. The leadership committee consists of the chairs of the other individual committees. All committees meet at least quarterly and have representation from the QA/TA/training contractor as well as DCS prevention staff. The committee chairs report updates to the leadership committee and make recommendations that are voted on by leadership. DCS is not a voting member of the leadership committee since DCS has to review and give final approval to all policy, training, plans, and forms approved by leadership before implementation or use.

The QA/TA committee develops a quality-assurance plan each year that identifies what HFA best practice standards (BPS) will be reviewed by the QA/TA contractor during the annual site visit. This plan must be reviewed and approved by DCS prior to site visits occurring. This ensures that HFI sites are meeting model fidelity. DCS reviews the quality assurance plan and supports this review of HFI as part of CQI and fidelity monitoring efforts. Sites visits are used to monitor adherence to HFA best practice and prepare the sites for accreditation. Technical assistance is provided to sites to address any standards found to be out of adherence during the site visit. If needed, the QA/TA contractor works with the site to develop a plan to address the item(s) out of adherence. Any significant concerns identified during a site visit are brought to the DCS prevention manager's attention immediately. DCS and the QA/TA committee review the visit summary report quarterly to look for trends. If there are standards that multiple sites are struggling to meet, DCS or the QA/TA committee will recommend training for the multi-site system. This training will be provided during a program managers' meeting or during the bi-annual Institute for Strengthening Families Conference.

Continuous Quality Improvement for All Services Provided within a DCS Prevention Case

DCS submits additional continuous quality-improvement requirements included in section 471(e)(5)(B)(iii)(II) of the act regarding each evidence-based program. DCS will implement a continuous quality improvement (CQI) process including outcomes measured by both DCS and providers to monitor activities provided under the Title IV-E Prevention Plan. This CQI process will ensure participants are provided quality services that continually promote the safety and health of every child and family. The process will also determine the impact of those services on child- and family-level outcomes and functioning. DCS will coordinate and monitor the CQI framework with each provider approved to provide services under the Title IV-E Prevention Plan.

Since INFPS service delivery began in June 2020, DCS has met with INFPS providers on a regular and continuing basis. DCS engaged with INFPS providers via virtual platforms to discuss expectations, provider questions or concerns, data and outcomes, and remove barriers to implementation of INFPS. All meeting agendas and minutes are posted to the DCS FFPSA website for providers to be able to review on an as-needed basis. As part of regular meetings with providers, DCS has shared data and outcomes with providers in an attempt to understand and improve practice and outcomes in real time.

Per the INFPS contract and service standard, INFPS providers are required to follow the fidelity practices of the evidence-based practice interventions they have chosen. As services are delivered, providers must implement fidelity-monitoring procedures for each program as part of their service contract. Providers must submit a written report noting the model that was used for each child and family. The written reports are due monthly on the 10th of the month to report information from the previous month. DCS reviews these reports and monitors service delivery.

Fidelity review documentation will be assessed by DCS through random sampling. For children involved with DCS who have an open case, the random sampling process will include a sample of 5% of open cases of INFPS providers each month. As cases are sampled, the provider will receive a survey to complete that reviews fidelity to the EBP chosen for the family for the sampled month. If there are error rates in the random sample greater than 25%, then an additional 5% of cases will be randomly pulled for additional DCS review. If fidelity issues are found, DCS will utilize the clinical consultants in the child welfare services division who will review the treatment modalities and EBP fidelity measures and create a plan for improvement

for the provider to address fidelity issues or concerns. The review cycle will continue until fidelity issues at the provider level improve and sustained fidelity to the use of EBPs is sufficiently demonstrated. In addition to this fidelity review, fidelity is also incorporated into DCS quality-assurance processes including but not limited to practice-model reviews (PMR) and safe-system reviews (SSR).

PMR reviews also track service delivery and outcomes, which are tied very closely to the child and family service review (CFSR) requirements. The specific items for Indiana's PMR include but are not limited to the following:

1. Item 7: Services to the Family to Protect Child(ren) in the Home and Prevent Removal or Return into Foster Care: To determine whether, during the period under review, the department made concerted efforts to provide services to the family to prevent child(ren)'s entry into foster care or return after reunification.
2. Item 8: Risk and Safety Assessment and Management: To determine whether, during the PUR, the department made concerted efforts to assess and address the risk and safety concerns relating to child(ren) in their own homes or while in foster care.
3. Item 10: Assessing the Needs and Services of Child(ren): To determine whether, during the period under review, the department (1) made concerted efforts to assess the needs of child(ren) (both initially, if the child(ren) entered foster care or the case was opened during the period under review, and on an ongoing basis) and identify the services necessary to achieve case goals and adequately address the issues relevant to the department's involvement with the family, and (2) provide the appropriate services.
4. Item 11: Assessing the Needs and Services of Parents: To determine whether, during the period under review, the department (1) made concerted efforts to comprehensively assess the needs of parents (both initially, if the child(ren) entered foster care or the case was opened during the period under review, and on an ongoing basis) and identify the services necessary to achieve case goals and adequately address the issues relevant to the department's involvement with the family, and (2) identified underlying needs of the parents.
5. Item 12: Assessing the Needs and Services of Resource Parents: To determine whether, during the period under review, the department (1) made concerted efforts to assess the needs of resource parents (both initially, if the child(ren) entered foster care or the case was opened during the period under review, and on an ongoing basis) and identify the services necessary in order for resource parents to provide appropriate care and supervision to ensure the safety and well-being of the children in their care, and (2) provided the appropriate services
6. Item 16: Intervention Adequacy: To determine whether, during the period under review, concerted efforts were made to provide change-related interventions that (1) were timely and of sufficient frequency, duration, and intensity to produce intended results, (2) utilized

information obtained from comprehensive formal and/or informal assessments, and (3) led to progress necessary to meet safe, sustainable case closure.

7. Item 19: Resource Availability: To determine whether, during the period under review, identified services for child(ren), parents, and resource parents were available locally, timely, and available for the identified needs.
8. Item 20: Provider Quality: To determine whether, during the period under review, service providers accurately and appropriately developed a service array to meet the individual needs of the family with the correct duration, frequency and intensity, tracked and adjusted services based on case progression, and had frequent communication with the department regarding family participation and progress.

Additionally, SSRs are completed on any family or child with DCS involvement in the 12 months prior to a critical incident occurring (e.g. fatality or near fatality) or for families who were involved in HFA/HFI even if DCS had no prior involvement. These reviews are done in a psychologically safe manner and completed in an effort to understand system-level issues that impact repeat maltreatment. The SSR team aggregates the trends and focuses on improvement opportunities as part of a continuous quality improvement cycle.

INFPS providers must also collect and report on the goals/outcomes defined below:

Goal #1: Preservation of the referred family while ensuring the safety of the child(ren).

Objective: Providers will have clearly developed treatment plans that target any apparent safety concerns including supervision and appropriate discipline.

Goal #2: Family will have protective factors in place that keep children safe.

Objective: To ensure providers discuss and target the development of these protective factors, providers must complete the Protective Factors Survey, 2nd Edition (PFS-2) within 30 days of receiving the Family Preservation Services referral, and every three months thereafter, for as long as the provider is working with the family under the Family Preservation Services referral.

Goal #3: The concrete needs of families will be met, preventing the need to remove the child(ren) from the home because of lack of housing, food, transportation, clothing, etc.

Objective: Families will learn to meet their own concrete needs with the help of the contracted provider.

Objective: Before removing a child(ren) related to the concrete needs of a family, the child and

family team will discuss the best course of action for that family given the presenting circumstance.

Goal #4: Children will be safe during and after the provision of Family Preservation Services.

Objective: 91.33% of families that actively engage in treatment for at least three months will not be the subject of a new substantiated report of abuse or neglect during service provision (while their DCS case is open).

Objective: 91.5% of families that actively participated in and successfully completed services will not be named in a new substantiated report of abuse or neglect 12 months post discharge.

Healthy Families Indiana within a Family Preservation (INFPS) Case

HFA is provided to child welfare involved families through use of HFA's Child Welfare Protocol (CWP). There are 11 HFI agencies contracted to provide HFA CWP through INFPS. All HFI sites conduct two family outcomes measures. The Healthy Families Parent Inventory (HFPI) and the Home Observation for the Measurement of the Environment (HOME) Inventory, are completed on all enrolled families. The HFPI is a 63-item inventory with nine subscales designed to assess parent change related to the overarching goals of Healthy Families—the development of healthy parenting skills and behaviors that will in turn reduce child abuse and neglect. The HOME Inventory is designed to measure the quality and extent of stimulation available to a child in the home environment. Additionally, DCS will monitor removal episodes for HFI target children by reviewing the HFI Removal Episode Matching Reports on a regular and continuing basis.

Ongoing Monitoring by DCS

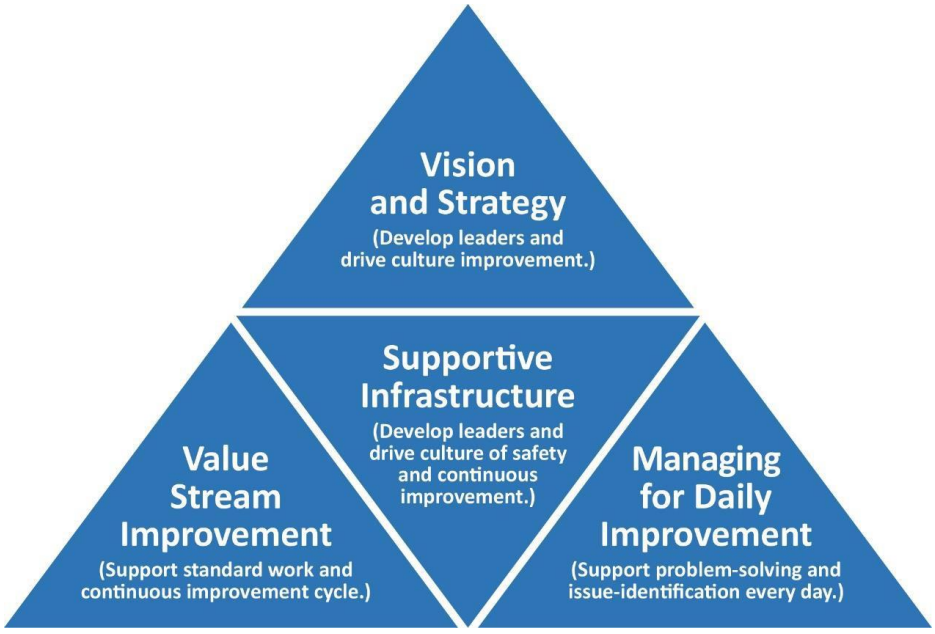
DCS will monitor and review outcomes submitted by providers. If outcome measures are not achieved as expected, the provider could be required to submit an action plan that will be reviewed and monitored by DCS. As part of the CQI process and ongoing monitoring, DCS will develop a review of programs and services to help identify the impact the services have on child/family outcomes/functioning to determine the effectiveness of current processes and systems. This information is used to identify strengths and needs in implementation within and across providers to support improved outcomes for children and families. DCS will meet regularly to review and evaluate CQI outcomes and will communicatewith stakeholders and decision makers to improve practices and policies.

DCS utilizes Lean methodologies and principles to identify and eliminate waste and support

efficiencies. Lean thinking and the application of lean principles are a team approach to culture change and problem solving.

Lean principles include:

- Allowing customers to define value.
- Delivering value to the customer on demand.
- Standardizing to solve and improve.
- Fostering transformational learning.
- Enabling mutual respect and shared responsibility, resulting in higherperformance.



Through the use of Lean principles, DCS will demonstrate respect for people, embrace continuous-improvement opportunities, and relentlessly identify and eliminate waste. DCS has embarked on a Lean journey and has built a framework including vision and strategy, supportive infrastructure, value-stream improvement, and management for daily improvement as core requirements of a Lean system that supports continuous improvement of services to children and families.

I. Child welfare workforce support

DCS is at the forefront of child welfare workforce support and training. The Indiana Partnership for Child Welfare Education and Training between DCS and the Indiana University School of Social Work (Indiana Partnership) provides high-quality, competency-based training for DCS staff 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.

As part of FFPSA workforce training and support, providers and DCS employees received the same computer-assisted training developed with the Indiana Partnership. DCS also hosted DCS staff and provider roundtables to ensure clear communication, support and training for the entire workforce. The training is available here, along with the full question-and-answer list from the roundtables. Additionally, DCS has hosted trainings for public defenders, CASAs, judges and legal staff.

Provider meetings have been held to discuss implementation of INFPS. Provider meetings started before the launch of INFPS and occur every two weeks. Meetings with providers continue with the minutes and a Q&A list from each meeting posted following each meeting. These meetings address service issues and model fidelity monitoring, as well as review needs and questions of providers with the DCS child welfare services and research and evaluation team members. DCS is fully invested in supporting a well-trained and well-supported workforce, which includes providers as well as FCMs.

a. Staff training overview

DCS supports and designs curricula to enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services. All training incorporates the practice of cultural humility. Courses related to the Indiana DCS Practice Model include the principles of teaming, engaging, assessing, planning and intervening (TEAPI) and have been incorporated into new worker training. All curricula have been updated to reflect the Indiana DCS Practice Model. Continuous feedback from the qualitative service review process, the training evaluation process and legislative or policy changes is reflected in curriculum revisions.

Prior to pre-service training, family case managers are assigned a peer coach within their region to train them to facilitate child and family team meetings. Following a prescribed shadowing, observation and mentoring program, peer coaches support these family case managers so they can lead child and family team meetings independently. Debrief feedback forms are completed and supervisors quarterly complete observation forms to maintain fidelity to the model. Twenty-one regional peer coach consultants monitor progress and provide additional information and trainings as necessary including fidelity monitoring.

During pre-service, all family case managers 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 that align with the classroom coursework have been developed for the transfer-of-learning days.

The field mentor also completes skill assessment scales at the time of graduation. These are behaviorally anchored scales to assess the trainees' skills in 52 areas. Supervisors receive a copy of this assessment and can use it to strengthen their staff's skills. Three months after graduation, the new employee's supervisor also completes the skill assessment scales evaluation to assist the staff development division with determining additional training needs during the pre-service period.

This feedback 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 practice.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 modify new worker curriculum.

The pre-service training for newly hired FCMs comprises classroom time, computer-assisted trainings (CATs), transfer-of-learning (TOL) activities in the FCM's base county, and graduation from the institute. The pre-service training is designed as learner-based facilitation and focuses on the development of critical-thinking skills needed for FCMs. Pre-service training activities are enhanced by small and large group discussions using real-life examples. Transfer of learning (TOL) includes working with the assigned supervisor, assigned mentor, and peer coach to review CATs, observe/shadow in the office, make court/field visits and more. Historically, FCMs completed all classroom training before beginning transfer-of-learning activities. Now, each day is split equally between the two to maximize the opportunity for hands-on experience.

Prior to graduation from the pre-service training, new cohort members are certified as child and family team meetings (CFTM) facilitators. Twenty-one peer coach consultants located throughout the state monitor the regional peer coaches as they train new cohort members to facilitate CFTMs.

All new field staff must complete pre-service training, including pre-tests and post-tests, prior to receiving a caseload. This is monitored through the statewide case management database. The Training Year-end Report of 2019 indicates the partnership collected 36 cohorts' pre-tests and post-tests. Participants improved 10.1% on average from pre-test to post-test, with 96.1%

of trainees showing improvement (n=742, 96.1%). Trainees improved by at least 20% on skills and knowledge related to getting to know DCS, case planning and intervening. Skills and knowledge related to the following areas improved by at least 10%: legal overview, child maltreatment assessments, laptop use, effects of abuse and neglect and worker safety.

DCS mandates all staff complete annual training hours (see https://www.in.gov/dcs/files/GA-10-Internal-Training.pdf). For example, FCMs are required to complete 24 annual hours (12 of which may be online). Family case manager supervisors (FCMS) and other field management staff must complete at least 32 hours (16 of which may be online).

b. Ensuring development of appropriate prevention case plans and conducting risk assessments for children receiving prevention services

FCMs receive training on the creation of case plans, including prevention strategies, as well as conducting risk and safety assessments. DCS Case Planning and Intervening for Permanence is a three-day course on planning and implementing case plans that promote safety, stability, permanency, and well-being. It teaches new workers to engage families in the service-planning and delivery process, identify necessary services and revise judgments in the best interest of the child throughout a case.

FCMs also receive training on safety planning and safety/crisis planning to help families identify and mitigate safety risks. Safety Planning is a training that helps FCMs understand safety planning in the field. Trainees analyze scenes from the movie “The Glass Castle” and complete a mock safety assessment, risk assessment, and safety plan, applying their learning to situations they might encounter in the field.

During safety/crisis planning training, FCMs learn how social service workers and mental health clinicians can create effective family safety/crisis plans with high-risk families. High-risk adolescents and their families face obstacles that might seem impossible to manage. FCMs receive a sample crisis/safety plan to support improved safety planning with children and families. This ensures staff are qualified to provide services consistent with evidence-based programs.

Healthy Families Indiana oversight and employee qualifications: HFI providers are required to review staff background checks and ensure training requirements are met at each annual site visit. There is required training for contracted providers in addition to HFA/HFI training requirements.

Indiana Family Preservation Services oversight and employee qualifications: DCS requires providers to adhere to the evidence-based programs they are using and demonstrate that staff:

- Are properly trained in the model being utilized.
- Possess any certification or credentials required by the model, state and/or federal law.
- Carry appropriate caseloads (no member of the treatment team may carry a caseload greater than what is allowed by the model being delivered, provided the caseload is no greater than 12.

Providers must document fidelity to the model.

Supervisors engaged in INFPS caseload oversight must possess a current license issued by the Indiana Behavioral Health and Human Services Licensing Board (or be consistent with model expectations for supervision). Additionally, they must possess a master's or doctoral degree in at least one of the following:

- Social work.
- Psychology.
- Marriage and family.
- Related human service field.

Supervision shall occur at least semi-monthly for at least one hour. At least one supervision session must be one on one between worker and supervisor. The remainder may occur in a group. If the EBP in use requires a different frequency or format of supervision, fidelity to the model must be demonstrated.

J. Child welfare workforce training

DCS trains and supports caseworkers to help them assess what children and their families need, build engagement skills, access and deliver trauma-informed and evidence-based services, and oversee/evaluate the continuing appropriateness of the services. DCS offers the following trainings for caseworkers:

i. Child and Family Team Facilitation: The FCM learns to use child and family team meetings (CFTMs) to oversee and evaluate services to determine if services need to be adjusted to address the underlying needs of the family.Tracking and adjusting services is a part of the Indiana DCS Practice Model and should be completed by the child and family team on a regular and continuing basis.

ii. Peer coaching: A peer coach receives additional training on CFTM facilitation and demonstrates enhanced engagement skills when working with children and families. As part of the Indiana Program Improvement Plan (PIP), DCS committed to training every FCM supervisor to be a peer coach. In 2019, the Indiana DCS Practice Model was relaunched across the agency. All divisions utilize the Indiana DCS Practice Model in their daily work. In 2019, family case manager supervisors began being trained as peer coaches. By the end of 2019, there were 234 supervisors successfully trained as peer coaches. In 2020, the practice consultant and peer coach consultant expectations were updated to reflect additional support to field and sustainability of the practice model. All FCM supervisors are trained to be a peer coach. The 21 peer coach consultants, practice model supervisors and the practice model manager respond to the practice needs identified by the practice model review (PMR), permanency roundtable process and/or the executive team. This is the practice model unit for the state that helps field operations staff apply our practice model to each case and with one another in the agency. Each peer coach consultant is assigned to a region to support the trained peer coaches and help local management identify training needs and practice advancement.

iii. Evidence-Based Programs and Services: This is a three-hour classroom training on the following topics:

    i. The importance of evidenced-based programs and services.
    ii. How to access evidenced-based programs and services.
    iii. How evidenced-based programs and services improve outcomes and how this applies to DCS cases.
    iv. Model fidelity.
    v. Case manager oversight and continued assessment of the appropriateness of theevidence-based services that are in place.

iv. Motivational Interviewing: This four-hour course teaches strategies for client counseling.

v. Trauma-Informed Treatment for Children with Challenging Behaviors: Staff learn to help severely traumatized children regulate emotions and manage behaviors.

vi. DCS Practice Model rollout (including prevention services updates): As part of the Indiana Program Improvement Plan (PIP), DCS provided practice model training to all DCS employees. DCS also provided practice model training to service providers, foster parents, CMHC staff members, licensed child-placing agency (LCPA) employees,

members of the judiciary and other external stakeholders.

vii. Indiana Family Preservation Computer-Assisted Training: DCS has reimagined service delivery for children receiving in-home services. DCS developed Indiana Family Preservation services, which are designed to align with the expectations of FFPSA while serving children and families in their home of origin. This training covers the service standards for this service. In addition, information is disseminated by the DCS communications division.

viii. FFPSA Joint Training: This 2.5-hour virtual training is a joint training partnership between DCS and the Indiana Office of Court Services. The FFPSA Joint Training was created to share information on FFPSA implementation and vision for DCS employees, Court Appointed Special Advocates (CASAs), juvenile probation officers, service providers, judicial and court partners among other child-welfare system stakeholders. The event focused on all aspects of FFPSA implementation in Indiana from prevention planning to Qualified Residential Treatment Programs (QRTPs). A recorded version of this training is available here.

ix. FFPSA Computer-Assisted Training: This computer-assisted training gives internal and external stakeholders a foundational understanding of FFPSA. It includes a high-level overview of systemic changes to DCS processes resulting from this legislation.

K. Prevention caseloads

The prevention caseload standard is determined by the particular evidence-based program model. DCS and DCS service providers adhere to those standards.

Families served by Healthy Families America/Healthy Families Indiana: The caseload size for HFI is calculated on a point system determined by the number of families being served on each level.

Families served by DCS: The Indiana Legislature recently changed the statute that codified caseload sizes and types. As of July 1, 2019, FCMs may serve no more than 12 families whose children remain in the home. Each of the 18 regional managers and their local office directors are responsible for managing FCM caseloads.

L. Assurance on Prevention Program Reporting and Trauma-Informed Service Delivery

DCS reports to the secretary of the U.S. Department of Health and Human Services any information the secretary requires with respect to the Title IV-E Prevention Plan, including information and data necessary to determine performance measures. DCS is adding the necessary data points as part of the Indiana Comprehensive Child Welfare Information System (CCWIS). DCS provides this signed assurance as Attachment 1.

DCS will provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing,and responding to the effects of trauma using a trauma-informed approach and trauma-specific interventions to facilitate healing. DCS provides this signed assurance as Attachment 8.

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M. Attachments

1. Evaluation Strategy for Trauma-Focused Cognitive Behavior Therapy

AN EVALUATION OF TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY
An Evaluation submitted to ACF-Children's Bureau

By
Aubrey Kearney, Mike Poletika, Brian Goodwin, Heather H. Kestian, Elisabeth S. Wilson
April 1st, 2020
Indianapolis, Indiana

2. Evaluation Strategy for Indiana Family Preservation Services and Concrete Supports

RIGHT FAMILY, RIGHT TIME, RIGHT SERVICES: EVALUATION OF INDIANA DCS

FAMILY PRESERVATION SERVICES PROGRAM

An Evaluation submitted to ACF-Children's Bureau

By

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Indianapolis, Indiana

N. Appendixes

Note: Each Appendix item can be opened from this document.

Appendix I. Healthy Families Indiana Contract

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PROFESSIONAL SERVICES CONTRACT

Contract #00000000000000000000046371

This Contract ("Contract"), entered into by and between the Indiana Department of Child Services (the "State" or "DCS") and The Villages of Indiana, Inc. (the "Contractor"), is executed pursuant to the terms and conditions set forth herein. In consideration of those mutual undertakings and covenants, the parties agree as follows:

1. Duties of Contractor.

A. Purpose: The Contractor, which must be accredited by the national Healthy Families America, shall provide certain home visitation and related services as part of the Healthy Families Indiana ("HFI") program (the "HFI Services"). HFI, which is modeled after the national Healthy Families America, is a voluntary multi-faceted home visitation program locally designed to promote healthy families and children through services which include child development, access to health care, parent education, family incentives, staff training, and community coordination and education. The program model includes screenings, assessment, and home visiting activities that begin for eligible families either prenatally or at the time of birth. The goal of HFI and of the HFI services described herein is to promote healthy families and children to help prevent child abuse through intensive early intervention services to families who have been identified at-risk and who voluntarily participate in home visitation services with trained providers. Thus, the purpose of this Contract and all other HFI Services provider contracts is to select HFI vendors and providers that can satisfy the DCS need for the provision of prevention services to all ninety-two (92) counties in the state of Indiana (the "Scope of the Contract").

B. Contractor's role as an HFI provider is to conduct screening and assessment of families in targeted areas throughout the state of Indiana. HFI service entry points include Women, Infants, and Children ("WIC") programs (WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children), OB Navigation Initiative (ISDH's Mom's helpline), health clinics, and local hospitals. Parents are screened using a validated, standardized instrument: the 8-Item Screen or any successor screening tool. Positive screens do not assess the risk of child abuse and neglect, but indicate a need to conduct a more in-depth discussion with the family. Families with positive screens are then assessed using a standard validated instrument: the Parent Survey. HFI staff use a standardized rating scale to score the survey; families meeting certain criteria and with a score within a certain range are offered the opportunity to participate in a voluntary home visiting program tailored to their individual needs.

C. All HFI staff, including Family Resource Specialists and Family Support Specialists, Supervisors, and Managers employed by local Healthy Families sites, must complete forty (40) hours of Core Training within the first six (6) months of employment. Staff that have not yet completed forty (40) hours of Core Training must complete "Stop Gap" training (as defined by Healthy Families America Best Practice Standards) prior to providing services to families. All newly hired HFI staff must complete an orientation program prior to providing services to families and must complete the ongoing trainings required at three (3), six (6), and twelve (12) months following their date of hire, as well as any additional training required by Healthy Families America in accordance with Healthy Families America Best Practice Standards.

Appendix II. INFPS Contract

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FAMILY PRESERVATION SERVICES
PROFESSIONAL SERVICES CONTRACT
CONTRACT #00000000000000000000042386

This Contract ("this Contract" or "Contract"), entered into by and between the Indiana Department of Child Services (the "State" or "DCS") and CHILDREN'S BUREAU INC. (the "Contractor") is executed pursuant to the terms and conditions set forth herein. In consideration of those mutual undertakings and covenants, the parties agree as follows:

1. Duties of Contractor.

A. Background and Purpose: "Family Preservation Services" are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. Family Preservation Services grew out of recognition that children need a safe and stable family and that separating children from their families is traumatic for them, often leaving lasting negative effects. These Services build upon the conviction that many children can be safely protected and treated within their own homes when parents are provided with services and support that empower them to change their lives. Such services are designed to promote safe and stable families, support family strength and stability, enhance parental functioning, and protect children. The DCS, in accordance with its State Plan, requires multiple child welfare services in all eighteen (18) regions and ninety-two (92) counties across the state of Indiana. Thus, the purpose of this Contract is to set forth the terms by which the Contractor provides Family Preservation Services to its designated region(s) corresponding local DCS Local Offices.

B. Definitions. As used in this Contract, the following terms are defined as follows:

1) **Child In Need of Services ("CHINS")** has the meaning set forth in IC § 31-34-1.

2) **Family Preservation Request For Proposal ("Family Preservation Services RFP")** means the regional or other Community-Based Family Preservation Services Request for Proposal to which the Contractor responded which was issued by the State on or after December 16, 2019. The Family Preservation RFP, all of its attachments, and any and all necessary supplemental Request(s) for Proposal(s) ("Supplemental RFPs") and attachments are incorporated by reference into this Contract.

3) **Contractor's RFP Response** means the Contractor's Response to the Family Preservation Services RFP (which includes the Contractor's RFP Response to any necessary Supplemental RFPs), as refined based on any subsequent Contractor agreement to services or rates (including any differential (if applicable)), which was submitted by the Contractor in accordance with the specifications of the Family Preservation Services RFP. Contractor's RFP Response is incorporated by reference into this Contract.

4) **DCS Child Welfare Principles** means the most current version of DCS Child Welfare Principles. The DCS Child Welfare Principles are modified/updated from time to time by DCS but always available in their most current form at the following link (or any designated successor website):

https://www.in.gov/dcs/files/Attachment_F_Principles_of_Child_Welfare_Services.pdf

Appendix III. INFPS Service Standard

SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

FAMILY PRESERVATION SERVICES (Per Diem Model)

I. Service Description

A. Family Preservation Services are services designed to work with families who have had a substantiated incident of abuse and/or neglect, where the Indiana Department of Child Services (DCS) believes the child(ren) can remain in the home with their caregiver(s) with the introduction of appropriate services to the family.

1. "Caregiver" is broadly defined to include:
   a) Birth parent(s)
   b) Adoptive parent(s)
   c) Relative caregiver(s)
   d) Fictive kinship caregiver(s)
   e) Other caregiver(s) who has been providing care and housing to the child(ren) and who has been deemed to be appropriate by DCS.
2. These services may also be utilized in the absence of a substantiated abuse or neglect allegation if the case is an in-home CHINS or Informal Adjustment (IA). This service shall be for the entire family.

B. This service shall be for the entire family.

1. The service shall include assessment of child/parent/family resulting in an appropriate service/treatment plan that is based on the assessed need.
2. The clear goal for these services is to preserve the family and avoid removal of the child(ren), provided it is safe for the child(ren) to remain with their identified caregiver(s).

C. All services delivered under this standard must have as a foundation at least one evidence-based practice that is classified at a minimum as a "Promising Practice" on the California Evidence-Based Clearinghouse (CEBC) (http://www.cebc4cw.org/).

1. Models that are classified on the CEBC as "Supported" or "Well-Supported" may also be used.
2. No practice that is classified as "Fails to Demonstrate Effect" or "Concerning Practice", or that is not listed at all on the CEBC may be utilized, except for concrete assistance which is defined below.

D. Providers ("Providers" or "Service Providers") must be able to document adherence to the evidence-based practice(s) that they are utilizing and be able to show that staff delivering these practices have had adequate training/certification/credentials (as required by the model being utilized).

Appendix IV. Assurances from Providers Responding to the INFPS RFP

Attachment G
DEPARTMENT OF CHILD SERVICES (DCS)
PROPOSAL FOR THE USE OF FEDERAL AND STATE FUNDS

Assurances

1. The provider agrees that funds requested for this program are unavailable through existing funds. The funds requested will not supplant or replace already existing funds but will be used to expand the range of services or client population.

2. The provider agrees to meet all evaluation and reporting requirements such as monthly updates, quarterly reports, and court reports as requested by the Department of Child Services.

3. The provider agrees to conform to Title VI of the Federal Civil Rights Act of 1964, as amended, and to Indiana Code 22-9-1-10, as amended, and thus assures non-discrimination in practices concerned with staff recruitment as well as in the provision of services without distinction as to color, race, religion, sex, handicap, ancestry.

4. The provider agrees to upgrade and maintain cultural knowledge base of staff regarding issues of diversity and cultural competence, particularly with primary populations being served.

5. The provider agrees that income (i.e. client fees, insurance, other public funds) generated by the program must be used to reduce the costs of the program to regional funding sources (Title IV-B I & II, SSBG, CFCIP or state and/or local funds). If the provider accepts Medicaid for payment of the unit, Title IV-B will not be billed for any part of that unit.

6. The provider agrees that if a regional funding source is paying for a group service by paying a group rate and non-DCS clients are members of the group and the non-DCS members are charged a fee, the sum of the fees collected shall be deducted from the approved group rate when processing the claim for regional funded services.

7. The provider agrees that the service for which the proposal is being written may require the appearance of the provider in court or appeals hearings. As part of its services, provider shall:
    a. Require appearance of its employees in court as required by DCS
    b. Immediately contact DCS regarding subpoenas/correspondence received, including notification of any correspondence addressed to a former employee
    c. Provide contact information for former employees, if available
    d. Provide a substitute witness for any former employee as requested by DCS
    e. Timely copy and provide records and documentation
    f. Arrange for documentation of chain of custody on tests administered to clients as part of provider's services, if requested by DCS.

8. The provider and all staff will meet the qualifications listed on the Service Standard as provided. Failure to meet qualifications could mean disqualification for payment of services rendered; therefore the grantee could have to make repayment for claims already paid. (If qualification waivers were granted during the term 7-1-06 to 12-331-09, the waiver will be honored as long as the person waived continues to work for the provider who sought the waiver.) Services will be conducted in a culturally competent that include language and behavior that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions.

9. The provider agrees that any agency treatment activity, therapy and service plan for a specific client or family will be compatible and consistent with the plan of case for the client/family that is on file with the Department of Child Services.

10. The provider agrees to maintain all case records indicating time spent with the clients, documents provided to the referring Department of Child Services and referral forms that authorize services.

11. The provider agrees that the overall service coordination or case management is the responsibility of the Department of Child Services and that DCS case plans are ultimate authority that controls the services clients receive.

12. The provider agrees to provide and maintain a drug free workplace as required by federal law (Drug Free Workplace Act of 1988-45 CFR, Part 76 subpart F). The provider agrees to sign the "STATE OF INDIANA DRUG FREE WORKPLACE CERTIFICATION".

Appendix V. DCS Policy 4.18: Initial Safety Assessment

INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY	
Chapter 4: Assessment	**Effective Date:** March 1, 2019
Section 18: Initial Safety Assessment	**Version:** 7

STATEMENTS OF PURPOSE

The Indiana Department of Child Services (DCS) will complete an Initial Safety Assessment (including a response and decision) within 24 hours of the initiation of every assessment. A subsequent Safety Assessment(see separate policy, 4.38 Assessment Initiation for additional guidance) will be completed when there are:

1. Changes in family circumstances;
2. Changes in information known about the family;
3. Changes in changes in the family's ability to utilize protective factors to mitigate safety threats; and/or
4. Changes at the point of a case juncture.

[REVISED] When child safety concerns are identified DCS will consider the viability of informal and community support services to ensure the child's safety, prior to considering involuntary removal of the child. A Safety Plan (SF 53243) will be completed with the family. The Safety Plan (SF 53243) will be reviewed for approval during safety staffing. See separate policies, 4.19 Safety Planning and 4.41 Daily Safety Staffing for additional information.

> **[NEW] Note:** When a Child in Need of Services (CHINS) petition is filed, DCS will consider an in-home CHINS if the child's safety can be ensured.

DCS will utilize the Child and Family Team (CFT) Meeting process to engage children and families throughout the assessment phase. The CFT will assist in planning for child safety while identifying the child and family's strengths, informal supports, and needs. (see separate policies, 5.7 Child and Family Team (CFT) Meetings and 4.19 Safety Planning).

DCS will explore all possible safety options for the child with the non-offending parent in domestic violence situations.

DCS will complete referrals to appropriate community services as necessary (see separate policy, 4.26 Determining Service Levels and Transitioning to Ongoing Services.

[REVISED] DCS will continually reassess a child's safety based on the most current information available by completing subsequent Safety Assessments. Adjustments to the Safety Plan (SF 53243) will be completed as needed and reviewed for approval during clinical supervison.

Change in Household Composition

If DCS determines that a temporary change in household composition will allow the family an opportunity to address the safety and risk issues present during the time of the assessment, a change in household composition may occur if it is in the best interest of the child (see separate policy, 4.37 Change in Household Composition).

Appendix VI. DCS Policy 4.19: Safety Planning (Assessment)

INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY	
Chapter 4: Assessment	**Effective Date:** May 1, 2019
Section 19: Safety Planning	**Version:** 8

STATEMENTS OF PURPOSE

The Indiana Department of Child Services (DCS) will assist the child's family with the development of a Safety Plan (SF53243) when a child's safety is dependent on defined actions. A Safety Plan (SF53243) will be developed during the assessment phase in situations including, but not limited to:

1. A safety decision of "Conditionally Safe" has been determined through the Initial Safety Assessment. See policy, 4.18 Initial Safety Assessment for additional information; or
2. An assessment finding of "Substantiated" is reached but DCS will pursue no further direct intervention.

   Note: An assessment may not be closed without further DCS intervention unless all safety threats have been resolved.

When domestic violence has been alleged, DCS will create a Safety Plan (SF53243) for the child and all family members upon initiation of the assessment. See Practice Guidance for assistance. The purpose of this plan is to:

1. Achieve immediate safety for the child and non-offending parent;
2. Begin planning for the long-term safety of the child and the non-offending parent;
3. Provide safety options for the non-offending parent and the child; and
4. Address behaviors demonstrated by the alleged domestic violence offender that pose a risk to the child's safety.

   Note: The Safety Plan (SF53243) for the non-offending parent and child should not be shared with the alleged domestic violence offender. DCS should work with the alleged domestic violence offender to develop a separate Safety Plan (SF53243).

Following the completion of the Initial Safety Assessment, a Safety Plan (SF53243) will be created as quickly as necessary to protect the safety of the child. Child safety will be reassessed regularly and the Safety Plan (SF53243) and/or Plan of Safe Care (SF56565) (if applicable) will be reviewed and modified as needed throughout the assessment phase. See Practice Guidance and policy, 4.42 Plan of Safe Care for additional information.

Code References

1. IC 35-37-6-1: "Confidential Communication" defined
2. IC 34-6-2-34.5 Domestic or Family Violence

PROCEDURE

The Family Case Manager (FCM) will:

1. Collaborate with the family and Child and Family Team (CFT) to develop a Safety Plan (SF53243). Efforts to ensure the child's safety in all settings must be considered (e.g.,

Appendix VII. DCS Policy 4.38: Assessment Initiation

INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY	
Chapter 4: Assessment	**Effective Date:** July 1, 2019
Section 38: Assessment Initiation	**Version:** 9

STATEMENTS OF PURPOSE

The Indiana Department of Child Services (DCS) will initiate every Child Abuse and/or Neglect (CA/N) assessment within the appropriate timeframe as determined by Indiana Law. In order to ensure the safety of a child and meet appropriate timeframes, assessments will be initiated regardless of the time of day or night, weekends, or holidays. **A CA/N assessment will be considered initiated upon face-to-face contact with all alleged child victims.** The parent, guardian, or custodian will be notified in person or by phone of the face-to-face contact with the alleged victim. See policies 4.5 Consent to Interview Child and 4.6 Exigent Circumstances for additional information.

> **Note**: There may be times when extenuating circumstances (see Practice Guidance) affect timely initiation. In these situations, contact with a person (other than the alleged perpetrator) who is able to provide information about the condition and safety of the alleged child victim should be attempted. **Face-to-face contact with the alleged child victim is still required to successfully initiate the assessment. Contact with any other individual will not be valid for timely initiation.**

DCS will measure the assessment response time from the time of local office notification of the intake report. Assessments will be initiated within the following timeframes: (see Practice Guidance):

1. Within two (2) hours if the allegations would cause a reasonable person to believe the child is in imminent danger of serious bodily harm;

   Note: Law Enforcement Agency (LEA) assistance should be requested on all reports that require a two (2) hour response time (see Practice Guidance).

2. Within 24 hours if the allegations involve abuse, but the conditions in item one (1) above do not apply; or
3. Within five (5) days if the allegations involve neglect, and none of the conditions in items one (1) or two (2) above apply.

For reports involving alleged domestic violence:

1. DCS will initiate the assessment within 24 hours if the parent, guardian, custodian, or child calls to report alleged domestic violence and the allegations would not cause a reasonable person to believe the child is in imminent danger of serious bodily harm; or
2. DCS will initiate the assessment within 24 hours if the alleged domestic violence occurred in the past 48 hours (regardless of the report source) and the allegations would not cause a reasonable person to believe the child is in imminent danger of serious bodily harm.

Appendix VIII. DCS Policy 5.21: Safety Planning (Case Management)

INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY	
Chapter 5: General Case Management	**Effective Date:** August 1, 2019
Section 21: Safety Planning	**Version:** 2

STATEMENTS OF PURPOSE

The Indiana Department of Child Services (DCS) will collaborate with the child's family, the Child and Family Team (CFT), and other caregivers to develop a Safety Plan (SF 53243) when a child's safety is dependent on defined actions. Child safety will be reassessed regularly and the Safety Plan (SF 53243) and/or Plan of Safe Care (SF 56565) (if applicable) will be reviewed and modified as needed throughout DCS involvement. See Practice Guidance and policy, 4.42 Plan of Safe Care for additional information. Review will occur at minimum:

1. At each Case Juncture;
2. Upon any new allegation of Child Abuse or Neglect (CA/N);
3. During each Child and Family Team (CFT) Meeting and Case Plan Conference. See policies, 5.7 Child and Family Team Meetings and 5.8 Developing the Case Plan) for more information;
4. Following the completion of each Safety and Risk Assessment (e.g., In-Home Risk and Safety Reassessment and Out-of-Home Risk and Safety Reassessment). See policies, 7.11 In-Home Risk and Safety Reassessments and 8.44 Out-of-Home Risk and Safety Assessment for more information; and
5. In conjunction with each court hearing and any new court orders.

When domestic violence is present or suspected, DCS will create a Safety Plan (SF 53243) which addresses the safety of the child and all family members. See Practice Guidance for further assistance. The purpose of this plan is to:

1. Achieve immediate safety for the child and non-offending parent;
2. Begin planning for long-term safety for the child and the non-offending parent;
3. Provide safety options for the non-offending parent and the child; and
4. Address behaviors demonstrated by the alleged domestic violence offender that pose a risk to the child's safety.

Note: The Safety Plan (SF 53243) for the non-offending parent and child should not be shared with the alleged domestic violence offender. DCS should work with the alleged domestic violence offender to develop a separate Safety Plan (SF 53243).

Code References

1. IC 35-37-6-1: "Confidential Communication" defined
2. IC 34-6-2-34.5 Domestic or Family Violence

PROCEDURE

The Family Case Manager (FCM) will:

1. Collaborate with the family, CFT, and other caregivers to develop a Safety Plan (SF 53243). Efforts to ensure the child's safety in all settings must be considered (e.g., school, extracurricular activities, out-of-home placement, in-home placement, safe sleep

Appendix IX. Safety Assessment

INDIANA DEPARTMENT OF CHILD SERVICES
SDM® SAFETY ASSESSMENT

r: 3/11

Assessment Name: _____ **Assessment #:** _____

County: _____ **FCM:** _____

Date of Assessment: _____/_____/_____ **Assessment Type:** ☐ Initial ☐ Subsequent

Names of Children Assessed:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Household Name: _____ **Were there allegations in this household?** ☐ Yes ☐ No

Factors Influencing Child Vulnerability (conditions resulting in child's inability to protect self; mark all that apply to any child):

☐ Age 0–5 years
☐ Significant diagnosed medical or mental disorder
☐ School age but not attending school
☐ Diminished mental capacity (e.g., developmental delay, nonverbal)
☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)

SECTION 1A: SAFETY THREATS

Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe safety threat is present. Mark all that apply.

Yes	No		
☐	☐	1.	Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current assessment, as indicated by the following: ☐ Serious injury or abuse to the child other than accidental ☐ Caregiver fears he/she will maltreat the child ☐ Threat to cause harm or retaliate against the child ☐ Excessive discipline or physical force ☐ Drug-exposed infant
☐	☐	2.	Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.
☐	☐	3.	Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.
☐	☐	4.	Caregiver is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
☐	☐	5.	Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.
☐	☐	6.	The family refuses access to the child, or there is reason to believe that the family is about to flee.
☐	☐	7.	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
☐	☐	8.	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
☐	☐	9.	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
☐	☐	10.	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
☐	☐	11.	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
☐	☐	12.	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
☐	☐	13.	Other (specify): _____

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Appendix X. Risk Assessment

INDIANA DEPARTMENT OF CHILD SERVICES
SDM® FAMILY RISK ASSESSMENT

r: 3/11

Assessment Name: _____ **Assessment #:** _____ **Date:** ____/____/____

County Name: _____ **FCM Name:** _____ **FCM ID#:** _____

NEGLECT — **Score**

N1. Current report is for neglect
- a. No 0
- b. Yes ..... 1 ____

N2. Prior assessments (*assign highest score that applies*)
- a. None ..... -1
- b. One or more, abuse only 1
- c. One or two for neglect 2
- d. Three or more for neglect ..... 3 ____

N3. Household has previously received child protective services *(informal adjustments/CHINS)*
- a. No 0
- b. Yes ..... 1 ____

N4. Number of children involved in the child abuse/neglect incident
- a. One, two, or three 0
- b. Four or more ..... 1 ____

N5. Age of youngest child in the home
- a. Two or older 0
- b. Under two ..... 1 ____

N6. Characteristics of children in household *(add for score)*
- a. Not applicable 0
- b. One or more present (*mark all applicable and add*)
  - ☐ Developmental, learning, or physical disability 1
    - ☐ Developmental ☐ Learning ☐ Physical
  - ☐ Medically fragile or failure to thrive 1
  - ☐ Mental health or behavioral problem ..... 1 ____

N7. Primary caregiver physical care of the child
- a. Consistent with child needs 0
- b. Inconsistent with child needs ..... 1 ____

N8. Primary caregiver has a history of abuse or neglect as a child
- a. No 0
- b. Yes ..... 1 ____

N9. Primary caregiver has/had a mental health problem
- a. None/not applicable 0
- b. One or more apply ..... 1 ____

N10. Primary caregiver has/had an alcohol and/or drug problem
- a. None/not applicable 0
- b. One or more apply (*mark all applicable*) ..... 2 ____
  - ☐ Alcohol (☐ Last 12 months and/or ☐ Prior to the last 12 months)
  - ☐ Drugs (☐ Last 12 months and/or ☐ Prior to the last 12 months)
    - ☐ Marijuana ☐ Methamphetamine ☐ Heroin ☐ Cocaine
    - ☐ Other: _____

N11. Primary caregiver has criminal arrest history
- a. No 0
- b. Yes ..... 1 ____

If yes, check either or both:
☐ Arrests ☐ Conviction

N12. Current housing
- a. Not applicable 0
- b. One or more apply ..... 1 ____
  - ☐ Physically unsafe; AND/OR
  - ☐ Family homeless

TOTAL NEGLECT RISK SCORE ____

ABUSE — **Score**

A1. Current report is for physical abuse
- a. No 0
- b. Yes ..... 1 ____

A2. Number of prior assessments
- a. None ..... -1
- b. One or more, neglect only 0
- c. One for abuse 1
- d. Two or more for abuse ..... 2 ____

A3. Household has previously received child protective services *(informal adjustments/CHINS)*
- a. No 0
- b. Yes ..... 1 ____

A4. Prior physical injury to a child resulting from child abuse/neglect or prior substantiated physical abuse to a child
- a. None/not applicable 0
- b. One or more apply ..... 1 ____
  - ☐ Prior physical injury to a child resulting from CA/N
  - ☐ Prior substantiated physical abuse of a child

A5. Number of children involved in the child abuse/neglect incident
- a. One, two, or three 0
- b. Four or more ..... 1 ____

A6. Characteristics of children in household (*score 1 if any present*)
- a. Not applicable 0
- b. One or more present (*mark all applicable*) ..... 1 ____
  - ☐ Delinquency history
  - ☐ Developmental disability
  - ☐ Learning disability
  - ☐ Mental health or behavioral problem

A7. Domestic violence in the household in the past year
- a. No 0
- b. Yes ..... 1 ____

A8. Primary caregiver employs excessive/inappropriate discipline
- a. No 0
- b. Yes ..... 1 ____

A9. Primary caregiver is domineering
- a. No 0
- b. Yes ..... 1 ____

A10. Primary caregiver has a history of abuse or neglect as a child
- a. No 0
- b. Yes ..... 1 ____

A11. Primary caregiver has/had a mental health problem
- a. No 0
- b. One or more apply ..... 1 ____
  - ☐ During the last 12 months
  - ☐ Prior to the last 12 months

TOTAL ABUSE RISK SCORE ____

SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse indices, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
☐ -1–1	☐ -1–0	☐ Low
☐ 2–5	☐ 1–3	☐ Moderate
☐ 6–8	☐ 4–6	☐ High
☐ 9 +	☐ 7 +	☐ Very High

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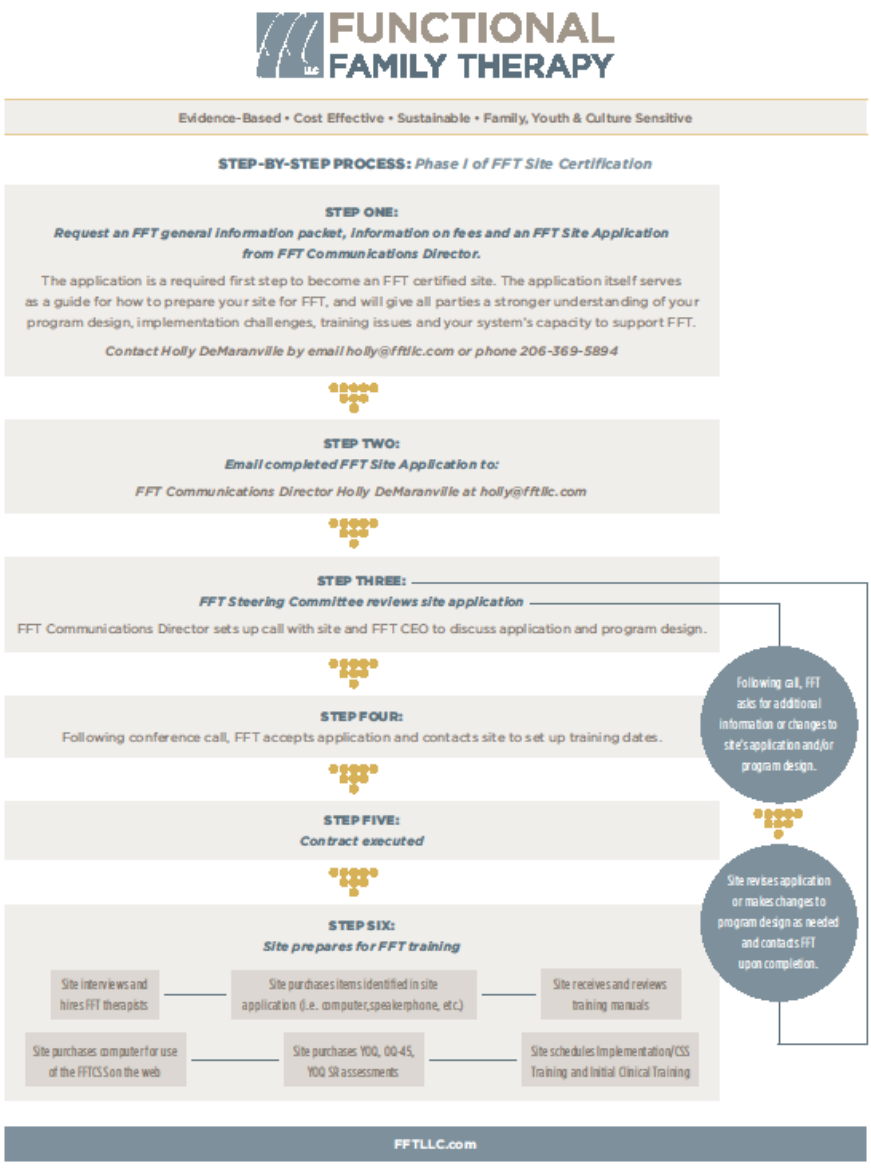
Appendix XI. FFT Certification Map



Appendix XII. TF-CBT Brief Practice Checklist

TF-CBT Brief Practice Checklist

Which PRACTICE component did you implement today? Mark only ONE component for each session.

Therapist Identifier:_____ (May also check caregiver participation for any session)

TF-CBT Treatment Component	Session #: / Date:	1 / /	2 / /	3 / /	4 / /	5 / /	6 / /	7 / /	8 / /	9 / /	10 / /
Caregiver participation: Meet with caregiver > 15 minutes											
P: Provide psychoeducation about traumatic experiences, trauma reactions, youth's symptoms and trauma reminders GE: identify trauma triggers; use proper words for traumas and body parts											
P: Provide parenting skills (praise, selective attention, time out, contingency reinforcement) GE: connect parental response and youth's behavior problems to trauma											
R: Provide individualized relaxation skills GE: Connect use of relaxation skills to youth's trauma reminders											
A: Provide affect identification and modulation skills GE: Connect use of skills to youth's trauma reminders											
C: Introduce cognitive triangle; encourage more accurate/helpful thoughts GE: Help PARENT use cognitive coping for trauma related maladaptive thoughts											
T: Develop youth's trauma narrative in calibrated increments with thoughts, feelings and worst moments. Cognitively process maladaptive cognitions. Share with parent as TN is developed GE: Re-read the TN at the beginning of *each* session											
I: GE: Develop in-vivo desensitization plan for generalized avoidant behaviors											
C: Conjoint youth-parent sessions: share youth's TN ; youth and parent Q&A; improve communication GE: Share TN with parent or address other trauma related issues conjointly											
E: Address personal safety skills and assertive communication; increase awareness of problem-solving skills and/or social skills GE: Address safety skills related to youth's trauma											
© Deblinger, Cohen, Mannarino, Murray & Epstein, 2008											

Appendix XIII. DCS Policy 15.10 regarding Title IV-E Eligibility Requirements

	INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY	
INDIANA DEPARTMENT OF CHILD SERVICES	**Chapter 15:** Eligibility	**Effective Date:** August 1, 2021
	Section 10: Continued Title IV-E Eligibility Requirements	**Version:** 4

POLICY OVERVIEW

A child's continued Title IV-E Foster Care (Title IV-E) eligibility must be determined to maintain Title IV-E funding. The child's eligibility status is reviewed periodically and whenever a change occurs that may affect the child's continued eligibility for Title IV-E funding.

PROCEDURE

The Indiana Department of Child Services (DCS) will determine a child's continued eligibility for Title IV-E funding. The continued eligibility criteria include the following:

1. The child must be placed in a Title IV-E eligible placement;
2. DCS must continue to have responsibility for Placement and Care (PC) of the child; and
3. Reasonable Efforts to Finalize the Permanency Plan (REPP) language must be obtained timely in a written court order. See policy 6.10 Permanency Plan for the timeframe in which REPP language must be obtained.

   Exception: Youth in Collaborative Care (CC) with a Voluntary Collaborative Care Agreement between the Older Youth and the Department of Child Services are not required to meet the REPP requirement for continued eligibility for Title IV-E funding.

A child will be considered to have entered foster care (for Title IV-E purposes) on the earlier of:

1. The date of the first judicial finding that the child has been subjected to Child Abuse and/or Neglect (CA/N); or
2. The date that is 60 days after the date on which the child was removed from the home.

A child's Title IV-E continued eligibility status may change from month to month, depending upon the child's placement and the timeliness of required court order language. Updates to the eligibility status may result in changes in claiming for funding. Administrative costs may be claimed for a Title IV-E eligible child in an out-of-home care placement under the following circumstances:

1. A child is in an Eligible Placement;

   Note: Administrative costs may be claimed for a Title IV-E eligible child's placement in a Child Caring Institution (CCI) regardless of whether the placement meets the requirements for Title IV-E funding to continue beyond 14 days. See policy 15.13 Title IV-E Eligible Placements for additional information regarding eligible CCI placements.

2. A child is on runaway status from a foster care placement;
3. A child is on a Trial Home Visit (THV). Reimbursement for administrative costs may be claimed for the child for up to six (6) months (the initial three [3] months and a three [3] month extension) unless the THV is extended by order of the court. See policy 8.39 Trial Home Visits for more information;

Appendix XIV. DCS Policy 7.1

INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY	
Chapter 7: In-Home Services	**Effective Date:** September 1, 2019
Section 1: Child at Imminent Risk of Removal	**Version:** 5

STATEMENTS OF PURPOSE

The Indiana Department of Child Services (DCS) will make an initial determination as to whether an individual child is at imminent risk of removal and therefore a candidate for placement in out-of-home care. DCS will re-determine imminent risk of removal every 180 days. A child is at imminent risk of removal when a substantiation of abuse or neglect is made by DCS, as documented by an approved substantiated Assessment of Alleged Child Abuse or Neglect (311) (SF113), an Informal Adjustment (IA), or In-Home Child in Need of Services (CHINS) case is opened, and reasonable efforts are made to prevent the child's removal from his or her home.

Code References

1. IC 31-26-5-1: Child at imminent risk of placement
2. 42 USC 672 (j)(2): Administrative costs associated with otherwise eligible children not in licensed foster care settings
3. 42 USC 5106a: Grants for programs and projects

PROCEDURE

The Family Case Manager (FCM) will:

1. Complete the In-Home Risk and Safety Reassessment within 45 days of the Disposition Hearing or during the development of the Program of Informal Adjustment to make an initial determination and at least every 180 days thereafter to make a re-determination regarding a child being at imminent risk of removal. See Policy 7.11 In-Home Risk and Safety Reassessment for additional information.

   Note: A determination of imminent risk will be completed on every child with an open case type of IA or In-Home CHINS;

2. Document the initial determination of imminent risk of removal within 72 hours in the following documents (see Candidacy: Imminent Risk of Removal Fact Sheet and Related Information for further guidance):
   a. Program of Informal Adjustment for IA Cases. See policy 5.9 Informal Adjustment for additional information, and
   b. Case Plan (SF2956) for In-Home CHINS Cases. See policy 5.8 Developing the Case Plan for additional information; and
3. Make a redetermination of imminent risk of removal within 72 hours in the following documents (see Candidacy: Imminent Risk of Removal Fact Sheet and Related Information for further guidance):
   a. Progress Report on the Program of Informal Adjustment (S54336) for IA Cases. See policy 5.9 Informal Adjustment for additional information; and

Appendix XV. HFI Safety Policy 10-2.D.

Policy and Procedure Manual

Chapter: 10 Staff Training Plan	
Section: Best Practice Standards 10-2: Orientation prior to direct work with families (Note: HFA BPS 10-2.D is a **Safety Standard.**)	

POLICY

Staff (assessment workers, support workers, supervisors and program managers) receive orientation training (separate from intensive role specific training) prior to direct contact/work with families or supervision with staff to familiarize them with the functions of the HFI site. Additionally, Program Managers hired after July 1, 2014 will receive orientation training within 3 months of hire.

The topics and their associated HFA Best Practice Standards are as follows:

- **Orientation to role as it relates to the site's HFI goal**s, services, curriculum materials, policy and operating procedures, data collection forms and processes, principles of ethical practice, and philosophy of home visiting and family support. (10-2.A, B)
- **Orientation to the site's relationship with other com**munity resources. (10-2. C)
- Orientation to child abuse and neglect indicators and reporting requirements. (10-2.D)
- Orientation to issues of confidentiality. (10-2.E)
- Orientation to issues related to boundaries. (10-2.F)
- Orientation to issues of staff safety. (10-2.G)

Department of Child Services Contract References
Section 1. Duties of Contractor

C. All HFI staff, including Family Resource Specialists and Family Support Specialists, Supervisors, and Managers employed by local Healthy Families sites, must complete forty (40) hours of Core Training within the first six (6) months of employment. Staff that have not yet completed forty (40) hours of Core Training must complete Stop Gap training prior to providing services to families. All newly hired HFI staff must complete an orientation program prior to providing services to families and must complete the ongoing trainings required at three (3), six (6), and twelve (12) months following their date of hire, as well as any additional training required by HFA in accordance with Healthy Families America Best Practice Standards.

Healthy Families America (HFA) References

Appendix XVI. HFI Safety Policies GA 6.A and 6.B

Policy and Procedure Manual

Governance and Administration	
Section: HFI Local Site Policy for child abuse and neglect reporting (Note: HFA BPS GA-6A and GA-6B are Safety Standards.)	

POLICY

The HFI site has policy and procedures that are in accordance with all applicable Indiana laws and specify the following:

-criteria used to identify and determine when to report suspected child abuse and neglect (or at a minimum, policy must indicate where these criteria can be found), and
-immediate notification of the site manager or supervisor and the Department of Child Services Hotline (1800-800-5556) when abuse or neglect is suspected.

Healthy Families America (HFA) References
HFA BPS, GA-6, 10.2-D, 11.4-B

Other references
HFI Local Site Policy 10-1 Training plan
HFI Best Practice Standard 11-3.F, 11-4
HFI Multi Site System Central Administration Standard, P-5
DCS policy on Statutory Definition of Child Abuse and/or Neglect
https://www.in.gov/dcs/files/3.08%20Statutory%20Definition%20of%20CAN.pdf

Indiana Code (IC) 31-33-5
Chapter 5. Duty to Report Child Abuse or Neglect
IC 31-33-5-1
Duty to make report
Sec. 1. In addition to any other duty to report arising under this article, an individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this article. (As added by P.L.1-1997, SEC.16.)
IC 31-33-5-2
Notification of individual in charge of institution, school, facility, or agency; report
Sec. 2. (a) If an individual is required to make a report under this article in the individual's capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, the individual shall immediately notify the individual in charge of the institution, school,

Appendix XVII. Healthy Families Indiana 8 Item Screen

Healthy Families Indiana 8 item screen

8-Item Screen Rating

You should choose the best answer to the following screening questions:

1. **Single**
True, if the participant is not married.
False, if the participant is currently married and living with her/his spouse.
2. **Inadequate income/no information**
True, if the mother/father receives Medicaid, without insurance, TANF, Zero income or stated concerns by family about finances. Otherwise the answer is **False**.
3. **Income from disability**
True, if MOB's/primary caregiver income is from SSI or SSDI. **False** if not.
4. **Unstable housing**
True, if there is no home address, uncertain of family not having a home, or questionable address such as homeless shelter. Otherwise the answer is **False.**
5. **Education under 12 years**
True, if participant has less than a high school educational level.
6. **History of/current substance abuse**
True, if the mother/primary caregiver has a history of, (reported substance abuse in last 2 years) or a current problem with substance abuse. Indications of a problem could be from a positive "tox" (toxicology) test based on the presence of drugs or alcohol in the bloodstream of the mother or child at the time of birth. Otherwise, **FALSE**.
7. **History of/current psychiatric care**
True, if there are any records in the hospital or clinic charts or reported by parent/family (does not include counseling for life crises/does include treatment for depression or other mental illness.) Otherwise **FALSE**.
8. **Marital or family problems**
True, if there are any indications of discord among family members as relevant to the mother/primary caregiver. It can include the father of the baby, current boyfriend or partner. It can also include problems between the mother of the baby and her parents or the baby's paternal grandparents. Otherwise **FALSE**.

Once you have completed the screen questions, you should choose the screen status (i.e., positive, negative, first birth, not first birth, etc.).

The Screen is considered **Positive** if:
Either number 1, 2, or 3 is "True"
OR any other 2 items are "True"
0 unknowns allowed to determine eligibility
NOTE: Positive Screens indicate the need to talk with the family to obtain more information. It does not determine the family's level of risk. Some positive screens can (and do) result in negative assessments.

Appendix XIX. Sample Redacted Post Site Visit Letter

Straight Path Consulting

HFI Quality Assurance, Technical Assistance and Training

Date: March 31, 2021
To: [redacted]
Cc: [redacted]
From: [redacted]
Re: [redacted] County 2021 Annual Site Visit

Dear [redacted],

Thank you for visiting with [redacted] on March 30th for the ZOOM meeting for your annual site visit. It was a pleasure having the opportunity to work with you and your team.

The 2021 Quality Assurance plan requires that the following items be reviewed on site visits:

1. Reaching the target population (1-1.A, B and C)
2. Timing of screening and assessment (1-2.C and 2-2.C)
3. Verbal acceptance (1-2.E) and behavioral acceptance rates and analysis (1-4.A, B & C)
4. Review of voluntary enrollment in services (3-1.B)
5. Review of pre-engagement outreach activities (3-2.B)
6. Family retention rates and analysis (3-4.A, B, C)
7. Home visit completion (pre-site report 4-2.B)*
8. Supervisor involvement with development and ongoing review of HFA Service Plan (6-1.B)
9. Use of the HFA Service Plan to address initial assessment and other challenging issues (6-1.C)
10. Parent-child interaction (6-3.B & C)
11. Use of evidence-informed curricula (6-4.B)
12. Monitoring linkage of target children to medical home (7-1.B)
13. Monitoring of Immunizations (7-2.B, 7-2.C)
14. Referrals and Referral follow-up (7-3.C, 7-3.D)
15. Caseload management (8-1.B)
16. Family Assignment (8-2.B)
17. Personnel Background Checks (child abuse and neglect checks, fingerprint check, law enforcement agency checks, national sex offender check, individual attestation letter) (9-3.B)
18. Orienting staff on child abuse and neglect indicators and reporting requirements (10-2.D)
19. Core Training (10-4.A-C)
20. Frequency and duration of supervision (12-1.B)
21. Rights, confidentiality and informed consent (G.A. 5.B & C)
22. GA-6.A & B Child abuse and neglect policy including criteria, definitions and practice

Appendix XX. HFI Multi-Site Policies

State/Multi-Site System Central Administration Standards Manual

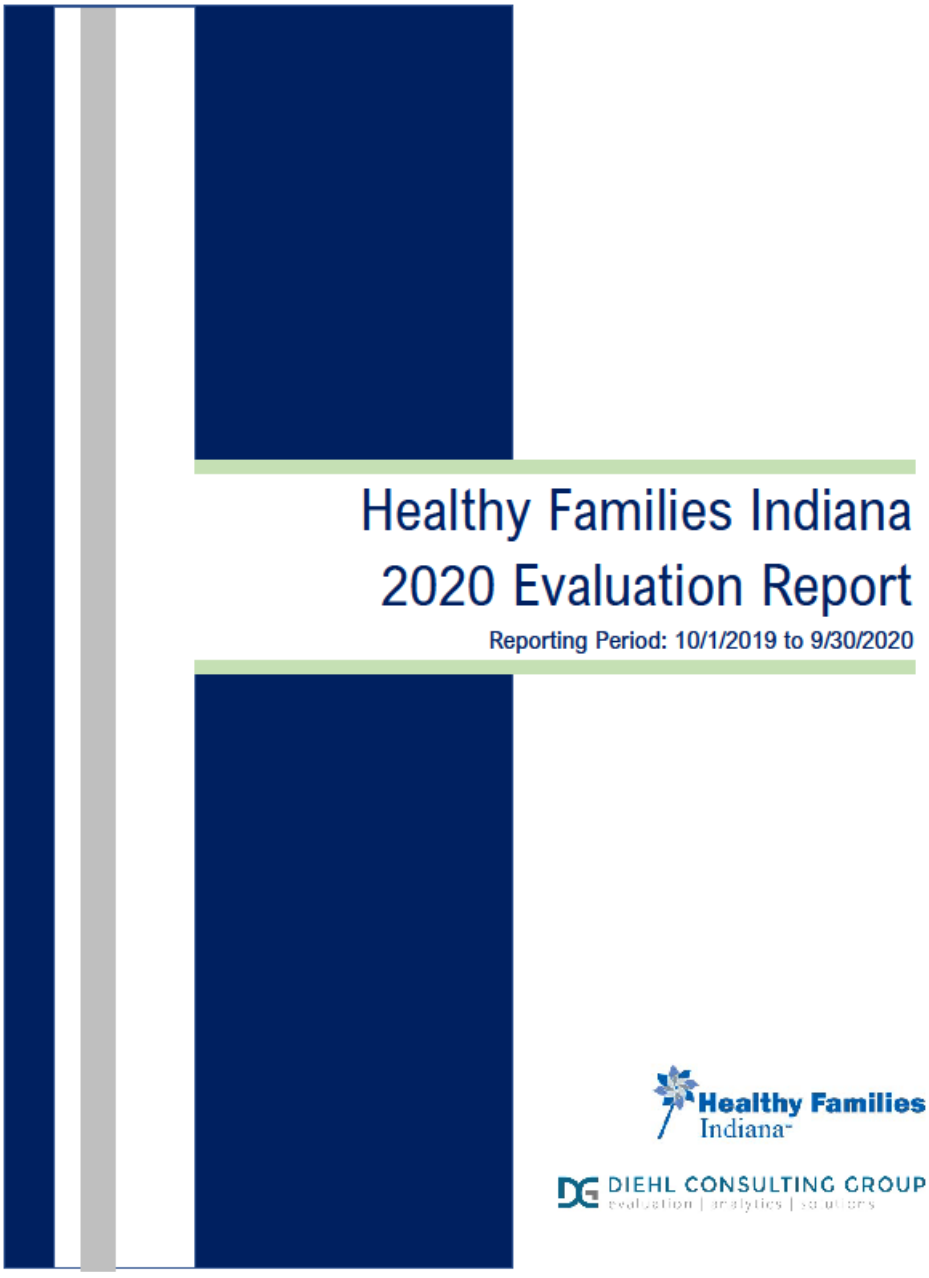
Effective February 1, 2019 through December 31, 2022

Developed by the Department of Child Services July 2018

Reviewed by the HFI Leadership and Policy Committees August 2018

Approved with recommended changes September 14, 2018

Appendix XXI. HFI Evaluation Report 2020



Appendix XXII. PAT Quality Standards

The PAT Quality Standards document is protected from insertion into this document. The pdf can be found at this link: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/57e0042737c581c512ae181d/1474298924087/PAT_2013_Quality_Standards.pdf.

Appendix XXIII PAT Affiliate Performance Report

Parents as Teachers

2018-2019 Parents as Teachers Affiliate Performance Report (APR)

Items that are new or have been reworded from last year's 2017-2018 APR are highlighted in YELLOW
**= APR items used for assessing your affiliate's implementation of the Parents as Teachers Essential Requirements through the Performance Measures Report (PMR)*

APR Section and Item	Response
I. ORGANIZATIONAL DESIGN	
A. Infrastructure	
1. **Designed to Serve 2+ Years:** Is your affiliate designed to provide at least two years of service to families with children between prenatal and kindergarten entry?* Yes/No	
2. **Months Designed to Serve:** How many months of the year is your affiliate designed to deliver all four components of the PAT model to all enrolled families?	
B. Leadership and Administration	
1. **Advisory Committee Meetings:** In total, how many Advisory Committee meetings with a regular focus on Parents as Teachers were held during the 2018-2019 program year?*	
C. Staffing	
1. **Staff at Beginning of PY:** Please indicate the number of staff employed as parent educators at the beginning of the 2018-2019 program year (include supervisors who carried a caseload in these count): a. **Full-Time PEs Start of PY:** How many parent educators (including supervisors who carried a caseload) provided parent educator services full-time (greater than .5 FTE)[1] at the beginning of the program year? Full-time is defined as more than 20 hours per week. b. **Part-Time PEs Start of PY:** How many parent educators (including supervisors who carried a caseload) provided parent educator services part-time (.5 FTE or less)[1] at the beginning of the program year? Part-time is defined as 20 hours or less per week.	
2. **Staff Changes:** Please report on staffing changes that occurred during the 2018-2019 Program Year: a. **Newly Hired:** How many parent educators (including supervisors who carried a caseload) were newly hired during the program year? b. **Ended Employment:** How many parent educators (including supervisors who carried a caseload) reported in I.C.1. ended their employment (either voluntarily or involuntarily) in your affiliate during the program year?	
3. **Staff at End of PY:** Please indicate the number of staff employed as parent educators as of the end of the 2018-2019 program year (include supervisors who carried a caseload in this count): a. **Full-Time PEs End of PY:** How many parent educators (including supervisors who provided parent educator services) provided parent educator services full-time (greater than .5 FTE)[2] at the end of the program year?* Full-time is defined as more than 20 hours per week.	

[1] **FTE = Full Time Equivalent.** Examples of FTE and corresponding hours worked: 1.0 FTE = 40 hrs/week or 2080 hrs/year; .75 FTE = 30 hrs/week or 1560 hrs/year; .50 FTE = 20 hrs/week or 1040 hrs/year; .25 FTE = 10 hrs/week or 520 hrs/year.

Appendix XXIV HFI QA Plan.

HEALTHY FAMILIES INDIANA

Quality Assurance Plan 2022

Purpose:
To assure comprehensive and consistent high-quality Healthy Families Indiana (HFI) assessment and home visiting services.

The HFI Quality Assurance Contractor will provide a thorough review of documentation, reports, and interviews which monitors compliance to Best Practice Standards (BPS). Feedback is reported as whether adherence was found and what was expected to show adherence.

The HFI Technical Assistance Contractor will provide support that assists in being adherent to the Best Practice Standards and HFI State Policies or Procedures. It is based on the QA Team report, observation by the TA member, on request of the site, or on request of DCS. TA will be provided on-site during the annual site visit as needed.

Goals:
Quality Assurance

- To annually monitor sites for adherence with HFA accreditation standards.
- To provide meaningful and supportive feedback on the standards to sites.
- To review the QA system and make recommendations for the 2023 QA Plan.
- To implement the new Best Practice Standards, as it relates to Quality Assurance.

Technical Assistance

- To assist sites in developing quality improvement strategies during site visits or as requested in person or virtually to be adherent to HFA standards.
- To provide updated communications and technical assistance through various media such as e-mail, visits, phone calls, trainings at The Institute for Strengthening Families, webinars and HFI database (Program Manager group in EnLite).
- To utilize the newsletter as a communication tool to distribute information statewide.
- To conduct a comprehensive analysis of technical assistance (TA-3).

Objectives:
Quality Assurance
The HFI Quality Assurance and Technical Assistance Contractor(s), HFI Central Admin, and HFI QA/TA Committee will implement the annual QA Plan developed by the QA/TA Committee.

Sites will have at least one annual visit by QA Contractor. QA contractor will send a pre-site visit confirmation letter. An email outlining the annual site visit that includes the file selection will be sent six weeks prior to site visit. Sites will send pre-site documentation to QA Contractor four weeks prior to site visit.

Appendix XXV. HFI Tool Chart

Tool	Date From	Window	PN	6 Wks	3 M	4 M	6 M	9 M	10 M	12 M	15 M	18 M	21 M	24 M	27 M	30 M	33 M	36 M	48 M	60 M	Completed By
EPDS	* TDOB	2 weeks before/after	X	X			X														Primary Caregiver
HFPI	TDOB	1 month before/after			X		X			X				X				X	X		Primary Caregiver
Cheers Check-In	TDOB	1 month before/after			X			X			X		X		X		X				FSS
ASQ-3	* TDOB	1 month before/after				X		X		X		X		X		X		X	X	X	FSS/Family
ASQ:SE2	TDOB	1 month before/after					X			X		X		X		X		X	X	X	FSS/Family

Special Notes for Tools:

* Prenatal EPDS can be completed any time prior to birth of baby.

EPDS screens are the only tool required for subsequent births.

Referral and wellness plan required if EPDS is 13 or higher (10 or higher for males).

Call a supervisor to make a plan if they answer 3 on question 10 of EPDS.

* ASQ-3 due dates age adjust if TC is 3 weeks or more premature through 18-mo ASQ-3.

The ASQ-3 should not be completed on the same visit as ASQ:SE2.

A referral is required if a delay is indicated on the ASQ-3 or SE2.

If a child is receiving dev services, you are NOT required to give the ASQ-3 or SE2.

** It is always better to do a tool late than not at all. **

FPGs and other plans:

Service Plans:	Created by FSS and supervisor within 30 days of enrollment. Updated throughout service delivery with progress and new concerns.
Family Goal Plans:	First FGP needs created with family within 90 days of first home visit. After the first FGP, family needs to have an active FGP at all times.
Transition Plans	Created based on input from family, FSS, and supervisor 3-6 months from a known termination

Appendix XXVI. Proximal Outcome Data Points

Program	Proximal Outcomes	Metrics Used	Data Location
FFT	Youth's behavior improves. Parent skills improve managing youth behaviors.	-number of sessions/family contacts each month -specific individualized treatment goals - progress toward goal achievement - provider recommendations.	All metrics are included in monthly reports directly entered by service providers into the DCS KidTraks system. DCS owns this data and can access family-specific data at any time.
TF-CBT	Child skills improve managing trauma responses. Parent skills improve managing trauma responses.	-number of sessions/family contacts each month -specific individualized treatment goals - progress toward goal achievement - provider recommendations.	All metrics are included in monthly reports directly entered by service providers into the DCS KidTraks system. DCS owns this data and can access family-specific data at any time.
PAT	Risks to the child are eliminated or the parent has the skills to manage the risk.	-number of sessions/family contacts each month -specific individualized treatment goals - progress toward goal achievement - provider recommendations.	All metrics are included in monthly reports directly entered by service providers into the DCS KidTraks system. DCS owns this data and can access family-specific data at any time.

MI	Parent substance use is no longer a relevant safety concern.	-number of sessions/family contacts each month -specific individualized treatment goals - progress toward goal achievement - provider recommendations.	All metrics are included in monthly reports directly entered by service providers into the DCS KidTraks system. DCS owns this data and can access family-specific data at any time.
HFI	Risks to the child are eliminated or the parent has the skills to manage the risk.	-number of sessions/family contacts each month -specific individualized treatment goals - progress toward goal achievement - provider recommendations -assessment and screening results -tools results -referrals made -notes and documentation	All family data is collected within the Enlite data system for the program from referral to discharge. Providers of HFI directly enter all assessments, screens, and tools completed with the family into the system. All home visits, activities completed with each family, referrals made for the family, etc. are documented within the system. DCS owns this data and can access family-specific data at any time.

Appendix XXVII. Use of Enlite for HFA/HFI Reporting

HFA/HFI records all family data within Enlite Data system for the program from referral to discharge. This includes all assessments/screens/tools completed with the family, all home visits, all activities completed with the family, and all referrals made for the family. HFI providers are required to use and enter all documentation for the program into the Enlite data system (which DCS owns). All prevention staff and a few DCS IT staff have access to the data system and can at any time review the documentation for a specific home visit, the family service plan in place for the family, referrals that were made for the family, etc.

DCS Prevention administers the HFI program in Indiana so there are several mechanisms in place for ongoing program monitoring including development of an annual QA plan and annual QA site visits, monthly meeting of the HFI Central Administration as well as other HFI committees (DCS Prevention staff attend all committees), monthly data matching with the Child Protection Index, quarterly monitoring of several statewide reports, ongoing program evaluation, monthly sampling of claims, etc. This results in ongoing programmatic data monitoring and quality assurance for HFI.