Region __11___

Biennial Regional Services Strategic Plan

SFY 2017 - 2018

February 2, 2016

Biennial Regional Services Strategic Plan
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SFY 2017-2018

Region __11__

Regional Coordinator: Megan Lammert

Approved by:

Dan Brumfield
Regional Manager: _____ **DATE:** 12/16/15

Mary Holiday
Regional Finance Manager: _____ **DATE:** _____

Regional Service Council: **DATE:** 12/16/15

Karen Blessinger-Local Office Director	Karen Blessinger
Beth Dickerson-Local Office Director	Elizabeth Dickerson
Amanda Resler- Local Office Director	Amanda Resler
Christi Tucker-Beebe Local Office Director	
~~**Jessica Paxson**~~-**Prosecutor's office**, Hamilton County Andrea Miksha-	
Annette Craycraft-CASA	Annette C. Craycraft
Mike Gray-Designated representative for Judge Pancol	
Bob Bragg- Designated representative for Judge Felix	Bob Bragg
Dan Neal- Madison County DCS Supervisor	
KC Hiatt-Tipton County DCS FCM	K.C. Hiatt
Lori Shaw Region 11 Foster Care Specialist	Lori Shaw
Pam Owens Region 11 Foster Parent	Pamela E Owens

Mary Beth Bonaventura **DATE:** 2/1/16

Regional Service Council Members:

INSERT LIST OF MEMBERS AND ORGANIZATIONS THEY REPRESENT

Dan Brumfield DCS Region 11 Regional Manager

Mary Holiday DCS Region 11 Finance Manager

Sharon Ferreira Hamilton County DCS Clerical Assistant

Christi Tucker-BeBee DCS Local Office director

Karen Blessinger DCS Local Office Director

Beth Dickerson DCS Local Office Director

Amanda Resler Local Office Director

Jessica Paxson Prosecutor office

Annette Craycraft CASA

Mike Gray Designated Representative for Judge Pancol

Bob Bragg Designated Representative for Judge Felix

Dan Neal DCS Madison County Supervisor

KC Hiatt DCS Family Case Manager

Lori Shaw DCS Region 11 Foster Care specialist

Pam Owens DCS Region 11 Foster Parent

I. Biennial Regional Services Strategic Plan 2017-2018 Overview

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

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

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

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

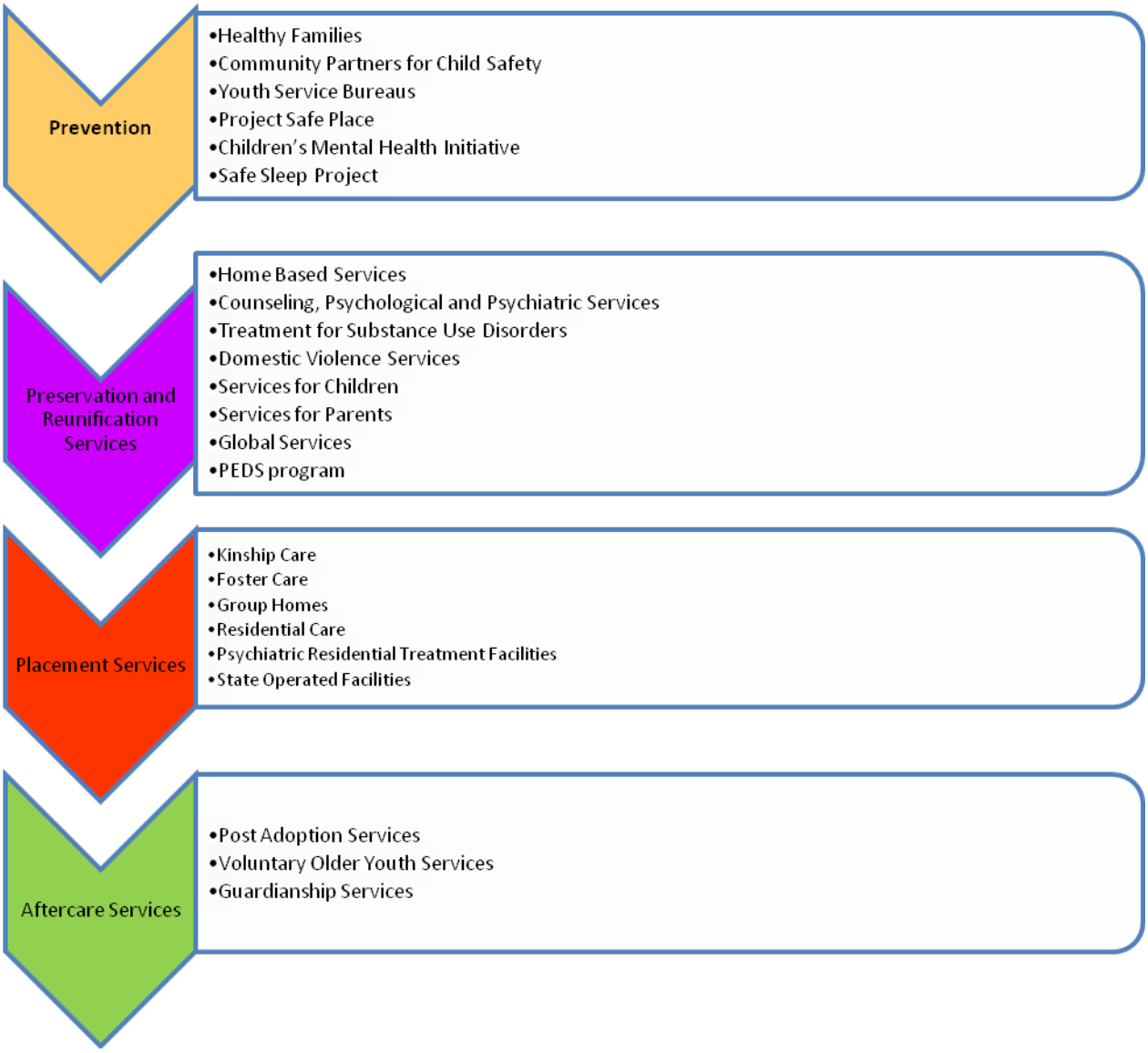
The Department of Child Services began the process of analyzing service availability, delivery and perceived effectiveness in the summer of 2015. The planning process to develop the Plan involved a series of activities led by a guided workgroup composed of representatives from the Regional Service Council and others in the community. The activities included a needs assessment survey, public testimony, and review of relevant data. While DCS has several other means with which to determine effectiveness of DCS provided services, such as Federal Child and Family Services Review measures, practice indicator reports, Quality Service Reviews (QSRs) and Quality Assurance Reviews (QARs), this process took that information and looked at it through a contracted service lens. The workgroup considered this information in conjunction with the needs assessment, previous service utilization and public testimony to determine the appropriate utilization of available services and to identify gaps in service. As a result, the workgroup developed a regional action plan to address service needs and gaps that are specific to the region. In addition, to address known statewide system issues, the Regional Action Plan includes specific action steps to address the following areas:

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

Biennial Regional Services Strategic Plans were approved by the Regional Service Council and subsequently submitted to the Director of the Department of Child Services on February 2, 2016 for final approval.

IV. Service Array

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



Prevention Services

Kids First Trust Fund

A member of the National Alliance of Children's Trusts, Indiana raises funds through license plate sales, filing fee surcharges, and contributions. This fund was created by Indiana statute, is overseen by a Board, and staffed by DCS. Kids First funds primary prevention efforts through the Prevent Child Abuse Indiana (PCAI), Healthy Families Indiana and the Community Partners for Child Safety

program.

Youth Service Bureau

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

Project Safe Place

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

Community-Based Child Abuse Prevention

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

Healthy Families Indiana (HFI)

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

Community Partners for Child Safety (CPCS)

The purpose of this service is to develop a child abuse prevention service array that can be delivered in every region of the state. This service builds community resources that promote support to families identified through self-referral or other community agency referral to a service that will connect families to the resources needed to strengthen the family and prevent child abuse and neglect. It is intended, through the delivery of these prevention services, that the need for referral to Child Protective Services will not be necessary. Community resources include, but are not limited to:

schools, social services agencies, local DCS offices, Healthy Families Indiana, Prevent Child Abuse Indiana Chapters, Youth Services Bureaus, Child Advocacy Centers, the faith-based community, local school systems and Twelve Step Programs.

Maternal Infant Early Childhood Home Visiting (MIECHV)

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

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

Children's Mental Health Initiative

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

The Children's Mental Health Initiative is collaboration between DCS and the local Access Sites,

Community Mental Health Centers and the Division of Mental Health and Addiction. Available services include:

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

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

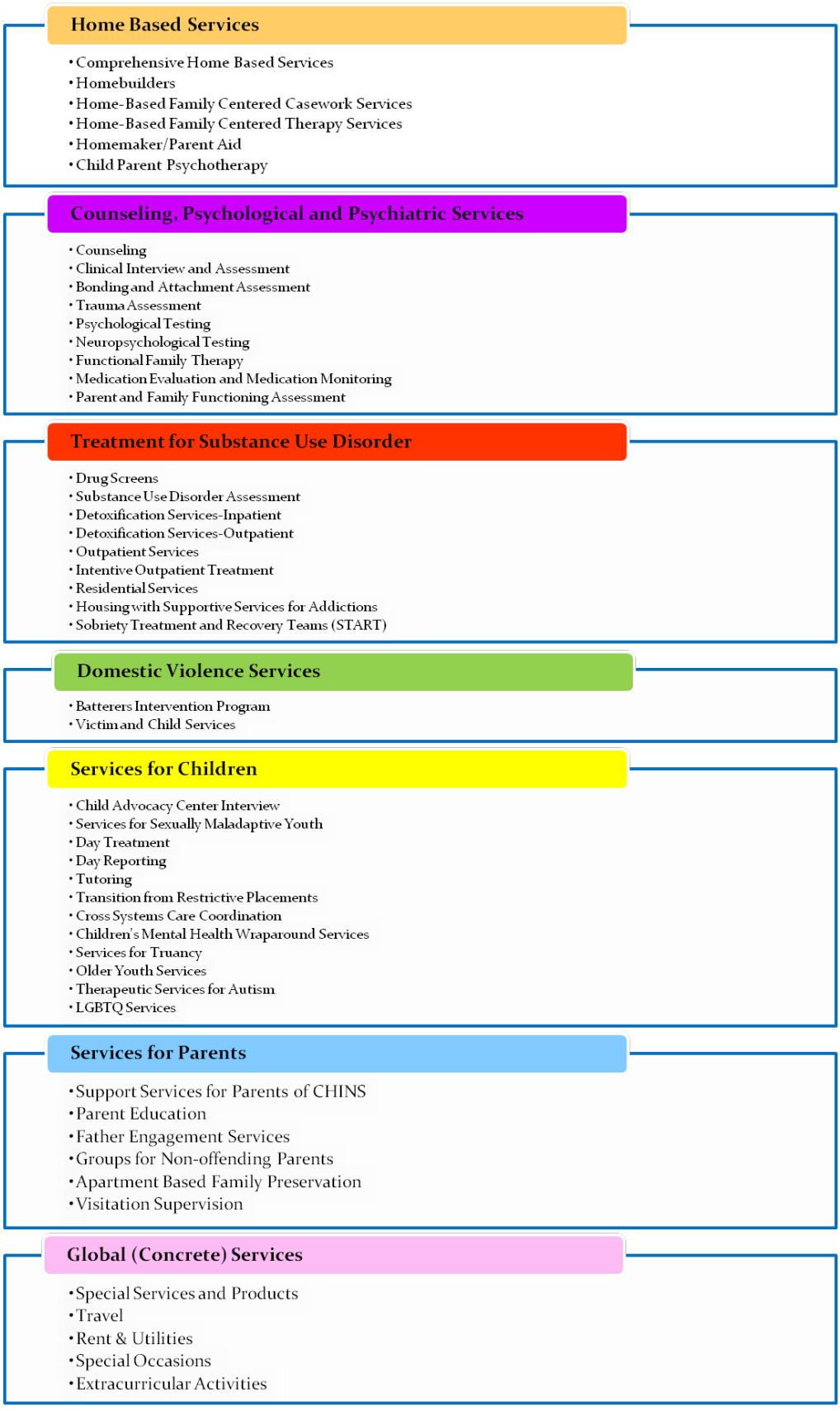
- DSM-IV-TR Diagnosis- Youth meets criteria for two (2) or more diagnoses.
- CANS 4, 5, or 6 and DMHA/DCS Project Algorithm must be a 1
- Child or adolescent age 6 through the age of 17
- Youth who are experiencing significant emotional and/or functional impairments that impact their level of functioning at home or in the community (e.g., Seriously Emotionally Disturbed classification)
- Not Medicaid Eligible/Lack funding for service array
- Other children who have been approved by DCS to receive services under the Children's Mental Health Initiative because they are a danger to themselves or others

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

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

Preservation and Reunification Services

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



These services are provided according to service standards found at: http://www.in.gov/dcs/3159.htm

Services currently available under the home based service array include:

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

Home Based Services			
Service Standard	Duration	Intensity	Conditions/Service Summary
Comprehensive Home Based Services	Up to 6 months	5-8 direct hours with or on behalf of the family	Utilizing an evidence based model to assist families with high need for multiple home based intensive services. Additionally, will provide: supervised visits, transportation, parent education, homemaker/parent aid, and case management. Some evidence based models require a therapist to provide home based clinical services and treatment. These services are provided by one agency. This is referable through service mapping or the Regional Services Coordinator Maximum case load of 5-8.

Comprehensive Home-Based Services

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

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

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
FCT – Family Centered Therapy	● Families that are resistant to services ● Families that have had multiple, unsuccessful attempts at home based services ● Traditional services that are unable to successfully meet the underlying need ● Families that have experienced family violence ● Families that have previous DCS involvement ● High risk juveniles who are not responding to typical community based services ● Juveniles who have been found to need residential placement or are returning from incarceration or residential placement	This program offers an average of 6 months of evidenced based practice that quickly engages the entire family (family as defined by the family members) through a four phase process. The therapist works intensively with the family to help them understand what their values are and helps motivate them to a sustainable value change that will improve the lives of the whole family.
MI – Motivational Interviewing	● effective in facilitating many types of behavior change ● addictions ● non-compliance and running away of teens ● discipline practices of parents.	This program offers direct, client-centered counseling approaches for therapists to help clients/families clarify and resolve their ambivalence about change. Motivational Interviewing identifies strategies for practitioners including related tasks for the clients within each stage of change to minimize and overcome resistance. This model has been shown to be effective in facilitating many types of behavior change including addictions, non-compliance, running away behaviors in teens, and inappropriate discipline practices of parents.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
TFCBT – Trauma Focused Cognitive Behavioral Therapy	● Children ages 3-18 who have experienced trauma ● Children who may be experiencing significant emotional problems ● Children with PTSD	This program offers treatment of youth ages 3-18 who have experienced trauma. The treatment includes child-parent sessions, uses psycho education, parenting skills, stress management, cognitive coping, etc. to enhance future safety. Treatment assists the family in working through trauma in order to prevent future behaviors related to trauma, and a non-offending adult caregiver must be available to participate in services.
AFCBT – Alternative Family Cognitive Behavioral Therapy	● Children diagnosed with behavior problems ● Children with Conduct Disorder ● Children with Oppositional Defiant Disorder ● Families with a history of physical force and conflict	This program offers treatment to improve relationships between children and parents/caregivers by strengthening healthy parenting practices. In addition, services enhance child coping and social skills, maintains family safety, reduces coercive practices by caregivers and other family members, reduces the use of physical force by caregivers and the child and/ or improves child safety/welfare and family functioning.
ABA – Applied Behavioral Analysis	● Children with a diagnosis on the Autism Spectrum	This program offers treatment for youth with autism diagnosis to improve functional capacity in speech and language, activities of daily living, repetitive behaviors and intensive intervention for development of social and academic skills.
CPP – Child Parent Psychotherapy	● Children ages 0-5 who have experienced trauma ● Children who have been victims of maltreatment ● Children who have witnessed DV	This program offers techniques to support and strengthen the caregiver and child relationship as an avenue for restoring and protecting the child's mental health, improve child and parent domains, and increase the caregiver's ability to interact in positive ways with the child(ren). This model is based on attachment theory but integrates other behavioral therapies.

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

Sobriety Treatment and Recovery Teams

Indiana is currently piloting a promising practice program that has shown very positive outcomes with families in Kentucky. The program combines a specially trained Family Case Manager, Family Mentor, and Treatment Coordinator to serve families where there are children under the age of 5 and the parent struggles with a substance use disorder. The Family Mentor is someone who has had history with the child welfare system and is currently in recovery. The program is being piloted in Monroe County. Currently there are three active Family Case Managers, one Family Mentor and one

Treatment Coordinator with the ability to add 2 additional mentors. It is estimated that the full team will be serving approximately 30 families at any given time. Currently DCS is expanding this program into Vigo county.

Adolescent Community Reinforcement Approach (ACRA)

The Department of Mental Health Addictions (DMHA) has trained therapists at two agencies in Indianapolis. This model will be expanded through this inter-department collaboration and ensures that the service is available to adolescents in need. This EBP uses community reinforcers in the form of social capital to support recovery of youth in an outpatient setting. A-CRA is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery.

This outpatient program targets youth 12 to 18 years old with DSM-IV cannabis, alcohol, and/or other substance use disorders. Therapists choose from among 17 A-CRA procedures that address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in pro-social activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. Role-playing/behavioural rehearsal is a critical component of the skills training used in A-CRA, particularly for the acquisition of better communication and relapse prevention skills. Homework between sessions consists of practicing skills learned during sessions and participating in pro-social leisure activities. The A-CRA is delivered in one-hour sessions with certified therapists.

Trauma Assessments, TF-CBT, CPP

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

Child Parent Psychotherapy (CPP) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) are two of the possible models that could be utilized. DCS has trained a cohort of 28 therapists to provide Child Parent Psychotherapy. This first cohort of trained therapists includes 9 teams of 3 therapists from within the CMHC network and one additional DCS clinician. These therapists completed their training in May 2014, but will receive another year of consultation through the Child Trauma Training Institute as they begin to fully implement the model. DCS began offering training to a second cohort

of clinicians to ensure service availability for children in need. DCS has trained approximately 300 clinicians throughout the state to provide TF-CBT. These agencies are both CMHC's and community-based providers and will ensure that TF-CBT is available for children and families in need.

Parent Child Interaction Therapy

DMHA has started training therapists at Community Mental Health Centers in Parent Child Interaction Therapy (PCIT), which DCS children and families will access through our collaboration and master contracts with the CMHC's. Additionally, with the DCS Comprehensive Service supporting the usage of evidenced-based models, PCIT will increase in its availability throughout the state.

PCIT is an evidence-based treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Disruptive behavior is the most common reason for referral of young children for mental health services and can vary from relatively minor infractions such as talking back to significant acts of aggression. The most commonly treated Disruptive Behaviour Disorders may be classified as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD), depending on the severity of the behaviour and the nature of the presenting problems. The disorders often co-occur with Attention-Deficit Hyperactivity Disorder (ADHD). PCIT uses a unique combination of behavioral therapy, play therapy, and parent training to teach more effective discipline techniques and improve the parent–child relationship. PCIT draws on both attachment and social learning theories to achieve authoritative parenting. The authoritative parenting style has been associated with fewer child behavior problems than alternative parenting styles.

Successful Adulthood: Older Youth Services

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

This model places the provider in the role of connecting youth with services provided in the youth's community or through a natural, unpaid connection to the youth rather than by the contracted

provider. Over time, the youth should be able to depend on their social network and individual knowledge in order to accomplish tasks related to living independently.

V. Available Services:

Region 11 has the above service array available in the region, however, there are not enough services available to the entire region. Region 11 at times has to wait for the next available service or will have refferals put on a waiting list.

Appendix A shows all contracted services in the region as well as the most frequently used services, expenditures by service, and the projected budget for SFY 2017 and 2018.

VI. Needs Assessment Survey

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

According to FCM survey results the top 5 Highest Availability/Utilized services were:
1. Homebased Casemanagment
2. Substance Use/Abuse services
3. Mental Health Services
4. Health Care Services
5. Public assistance and basic needs

According to Provider survey results the top 5 Highest Availability/Utilized services were:
1. Housing, Casemanagment
2. Homebased services
3. Concrete Items, Trauma Focused Behavioral Therapy, Motivational Interviewing, Homebased Casework, and Mental Health Services
4. Home based Therapy and Healthcare Services
5. Dental Services and Substance use/abuse Treatment

According to FCM survey results the Lowest in availability in the region were:

1. Motivational Interviewing
2. Other
3. Child Care Services
4. Housing Services
5. Child-Parent Psychotherapy

According to Provider survey results the Lowest in availability in the region were:
1. Respite
2. Homebuilders
3. Child Care Services
4. Other Services, Older Youth Services, Developmental Disabilities
5. Housing Services

VII. Public Testimony Meeting

The Public Testimony meetings were advertised on the DCS web page titled "Biennial Plan Public Notices." The web page included the purpose, dates, times and locations for each of the meetings throughout all 18 DCS Regions. Additionally, the Public Testimony meetings were advertised in each of the local offices and included the purpose, dates, times and locations for each of the meetings throughout all 18 DCS Regions. Email notifications of the public meetings were sent to all contracted providers and other community groups.

The Public Testimony meeting for the Child Protection Plan/Biennial Regional Services Strategic Plan was held on October 30, 2015 2:00pm at 938 N. 10th St. Noblesville, IN 46060. A summary of the testimony is provided in Appendix C.

Susan Anderson, a foster parent in Region 11 was the only presenter at the meeting. She read from a prepared document entitled The Destroyer, which she provided to the council, along with a sheet containing items that she wanted the council to consider after she spoke. A copy of both forms are attached to these minutes. After the public testimony concluded, the members of the council spent time discussing the testimony as well as the forms that were presented by Ms.Anderson. The group decided that a foster care component would be added to the Region 11 plan. The members also discussed upcoming meeting dates and created subgroups for the various components of the regional plan.

VIII. Summary of the Workgroup Activities

The following meetings were held to discuss the available data on November 13, 2015.

The topics of discussion included:

1. Prevention Services

   The prevention work group discussed the multiple prevention services available but were concerned the public may not be aware of the multiple different prevention service options. The committee would like to see more of a collaboration between prevention providers servicing the community.

2. Maltreatment After Involvement

   The maltreatment after involvement was discussed around data revealing most maltreatment was after the beginning stages of the case. The work group discussed making sure the FCM understands the importance of teaming the case and involving the informal supports while including the CANS assessment and Risk/Needs assessment.

3. Permanency for children in care 24+ months

   The work group discussed the issues with children not gaining permanency in 24 plus months, which includes different issues for different children. The committee discussed putting together a committee to refer all cases on an ongoing basis to ensure the whole team is working to brainstorm permanency for children in care 24 plus months.

4. Substance Use Disorder Treatment

   The work group discussed barriers and issues surrounding substance abuse treatment, while brainstorming different strengths already being utilized and how to build on what is needed in region 11. The work group discussed using a systems of care team to meet ongoing to discuss ongoing substance abuse treatment issues and work toward making changes to better provide quality services to families.

5. Foster Care Services

This work group was created after hearing feedback from a foster parent at the public hearing. The work group discussed communication barriers between foster/resource parents and the DCS staff. The work group discussed different solutions to work towards ending those barriers and making communication better between DCS staff and foster/resource parents to ensure safety and stability for children in DCS care.

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

VIII. Regional Action Plan

Regional Action Plan

REGION # 11

Overview

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

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

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

Measurable Outcome for Prevention Services:		Increase the utilization of community based prevention services by 5% by June of 2018 (As measured by community partners and healthy families).		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Develop a Prevention Awareness team with specific stakeholders interested in community awareness of Preventative Services.	1.Identify volunteers through Regional Service Councils, System Of Care and Prevention Child Abuse.	Local Office Director, Regional Manager, Childrens Bureau	1 months	August 2016

	2. Contact the volunteers to invite to a meeting. 3.Schedule a meeting inviting volunteers.	Local Office Director, Regional Manager, Local Office Director, Children's Bureau	3 months 4 months	October 2016 November 2016
The Prevention Awareness Team will implement strategies to improve awareness of prevention services available	1. Compile a resource guide by collecting all of the information from various prevention services in the community. 2. Identify service providers in the community willing to hand out the resource guide.	Prevention awareness team Prevention Awareness Team	8 months 9 months	March 2017 April 2017

Measurable Outcome for Maltreatment after Involvement:		Decrease incidents of maltreatment 5% by 2018 through utilizing the Child and Family Team Meeting (CFTM) process in the assessment phase.		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**

Strengthen and refine the CFTM process in the assessment phase	1. Seek assistance from peer coach and mentors to assist Family Case Manager in effective teaming during the assessment phase. 2.Utilize Risk and Needs Assessments, and CANS (Child and Adolescent Needs Assessment) during CFTM in the assessment phase. 2.Needs are identified during CFTM(Child and Family Team Meetings). 3. Referrals created based on services needed.	Assessment supervisors LODs (Local Office Director) Department of child services Peer Coach Department of Child services Mentors RMs(Regional Manager) FCMs (Family Case Managers) Peer coaches	July 2016 January 2017	September 2016 Ongoing

Reviewing policy and identifying frequency and quality of CFTM during the assessment phase.	1. Utilize data available and set regional parameters for expectations of increased CFTMs. 2.Identify Qualitative measure to review increased CFTM.	Assessment supervisors LODs Peer coaches Mentors RMs	October 2016	End of December 2016
Review data regarding substantiated assessments quarterly and disseminate to FCM (Family Case Manager)	1. Select people to be in charge of collection of data. 2.Pull the data quarterly and review with FCM (Family Case Manager).	LOD (Local office director) RMs (Regional Manager) Assessment supervisors FCMs(Family Case Manager)	April 2017	End of Biennial

Measurable Outcome for Permanency for children in care 24+ months:		Of the children in care for over 24 plus months, increase the number of children achieving permanency by 5% by June 2018.		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Develop a procedure for reviewing cases over 24 plus months	1.Pull a list quarterly of children in care 24 plus months	Local office director	3 months	October 2016

	2. Identify those children to be reviewed by length of time in care.	Local Office director	3 months	October 2016
Create a team to review all children in care over 24 plus months	1.Recruit afacilitator to take on the task of developing a review team.	Regional Manager	3 months	October 2016
	2. Identify people who will be on the team.	Facilitator	4 months	September 2016
	3.Create form for the FCM and Supervisor to complete to present to the review team.	Facilitator	5 months	December 2016
	4.Identify date and location of when the teams will meet to review.	Facilitator	6 months	January 2017
The team will review and make recommendations for children to achieve permanency.	1.Discussions will be held to develop action steps to identify barriers.	Team member	Quarterly	September 2016
	2. A review will be completed to look at previous steps taken to			

	achieve permanency. 3.The team will recommend a Full Permanency Round Table review for cases identified as necessary.			

Measurable Outcome for Substance Use Disorder Treatment:		By 2018 develop a plan to increase access to and expand substance use treatment services.		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Coordinate a SOC (systems of care) team to develop an action plan and ongoing needs for the community.	1. Identify members in the community who share interest in addressing substance use treatment.	Teresa Lucchetti from Aspire, Local Office Director, and Regional Manager	3 months	October 2016
	2. Contacting those identified members to be a part of the Systems of Care team.	Teresa Lucchetti (Aspire) and Local Office Director	5 months	December 2016
	3.Schedule a meeting with a direct time and place.	Aspire and Local Office director	5 months	December 2016
	4.Develop Agenda goals for the meeting.	Aspire and Local Office Director	5 months	December 2016

The Systems of Care team will identify specific needs in the community	1. Develop sub-committees with different members of the community, stakeholders, service providers and Department of Child Services staff to work toward better treatment options in the community.	Systems of Care Team	6 months	January 2017
	2. The Sub-committees will pull a list of current treatment providers in the Region and compare to community needs.	Members of Systems of Care Team	6 months	January 2017
	3. The sub-committees will develop a plan to address the service needs.	Systems of Care Team	6 months	January 2017

Measurable Outcome for a region identified issue: Foster parent		Using QSR data by June 2018 the region will show improvement by 10% on the three indicators around planning, particularly those cases involving foster care placements.		
Action Step	**Identified Tasks**	**Responsible Party**	**Time Frame**	**Date of Completion**
Increase and improve communication between DCS staff and foster parents to	1.Create an advisory team panel.	Regional Manager	3 Months	October 2016

ensure ongoing needs are being met	2.Identify people to be a part of an advisory team panel. 3. Have a meeting time and date, with panel participants.	Regional Manager Regional Manager	3 Months 3 Months	October 2016 October 2016
DCS will ensure communication of child's needs when in foster care homes.	1. Have transitional meetings between Family Case Manager, Foster Family, and Child and Family identified Team with documentation of meeting notes. 2. Invite the FCS (Foster care specialist) to initial and critical juncture Child and Family Team Meeting's or case conferences.	Supervisor, Foster care Specialist, and Family Case manager	3 Months 3 Months	October 2016 October 2016
Increase foster parents' knowledge and awareness of services to address their own needs and the child's needs	1.Emailing foster parents to let them know about provider fair. 2.Taking a flier to foster parents during monthly visits.	Family Case Manager's and Foster care Specialist Family Case Managers	3 Months 5 months	October 2016 December 2016

Increase education on resource parent support services available for DCS staff	1.Provide list of resource services available to the counties.	Regional Service Coordinator, Foster care specialist	3 Months	October 2016

IX. Unmet Needs

The region continues to have transportation issues for clients and lacks services in supervised visitation and diagnostic and evaluation availability.

XI. Child Protection Plan

CHILD PROTECTION PLAN

I. Region 11

A. Name and code of local offices of the Department of Child Services located within the region:

County: Hamilton	Code: 29
County: Hancock	Code: 30
County: Madison	Code: 48
County: Tipton	Code: 80
County:	Code:
County:	Code:
County:	Code:
County:	Code:
County:	Code:

II. Type of Child Protection Plan: Regional Child Protection Plan

III. Planning and Community Involvement: **(Please attach a copy of the notice(s) of the hearings on the county child protection plan.)**

A. Was the notice of the public hearing posted or published at least 48 hours in advance of the hearing (excluding weekends and holidays)?

1. Yes ☒ No ☐ (Please explain)

B. Was the procedure for notice of hearing according to IC 5-14-1.5-5 (attached) followed in detail? (Please check all that apply.)

1. ☒ Public Notice was given by the Local Office Director and Regional Manager

2. ☒ Notice was posted at the building where the hearing occurred and/or at the local offices of the Department of Child Services. (Required procedural element)

C. Give the date(s) and location(s) of the public hearings and attach a copy of the notice posted. October 30, 2015 at the Hamilton County DCS Office

D. Sign-in sheet(s) for the public hearing(s) and a copy of any written testimony presented can be found in the public testimony section of this plan.

IV. The Staffing and Organization of the Local Child Protection Service

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

1. 43 Number of Family Case Managers assessing abuse/neglect reports full time.

2. 4 Number of Family Case Managers with dual responsibilities; e.g., 50% CPS assessments and 50% ongoing services or 20% CPS and 80% ongoing services.

3. 4 Number of Family Case Manager Supervisor IVs supervising CPS work only.

4. 4 Number of Family Case Manager Supervisor IVs supervising both CPS work and ongoing services; e.g., 50% CPS and 50% ongoing services.

5. 0 Number of clerical staff with only CPS support responsibilities.

6. 13 Number of clerical staff with other responsibilities in addition to CPS support.

7. Does the Local Office Director serve as line supervisor for CPS?

Yes ☒ No ☐ * Tipton County Only

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

1. Is the 24-hour Child Abuse and Neglect Hotline **(1-800-800-5556)** listed in your local directories with the emergency numbers as required by law?

Yes ☒ No ☐

2. All calls concerning suspected child abuse and neglect are received through the Indiana Child Abuse and Neglect Hotline at 1-800-800-5556, including all times when the local DCS offices are closed.

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

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

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

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

1. Please indicate when <u>abuse</u> assessments will be initiated.

a. Within 24 hours of complaint receipt. See Chapter 4, Section 38 of the Child Welfare Manual (Initiation Times for Assessment).

Yes ☒ No ☐

b. Immediately, if the child is in imminent danger of serious bodily harm.

Yes ☒ No ☐

2. Please indicate who will assess abuse complaints received during and after working hours. (Check all that apply)

a. ☒ CPS

b. ☒ CPS and/or Law Enforcement Agency (LEA)

c. ☐ LEA only

3. Please indicate when neglect assessments will be initiated. See Chapter 4, Section 38 of the Child Welfare Manual (Initiation Times for Assessment).

a. Immediately, if the safety or well-being of the child appears to be endangered.

Yes ☒ No ☐

b. Within a reasonably prompt time (5 calendar days).

Yes ☒ No ☐

4. Please indicate who will assess neglect complaints received during and after working hours. (Check all that apply)

a. ☒ CPS only

b. ☒ CPS and/or LEA

c. ☐ LEA only

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

Please indicate if you have received and are following the "Record Retention Guidelines."

Yes ☒ No ☐

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

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

throughout the state. The Institutional Child Protection Service (ICPS) Unit will conduct an assessment of a report of Child Abuse and/or Neglect (CA/N) if the allegations state the incident of CA/N occurred while the child was in the care of one of the following:

a. Residential Facility (i.e. DCS licensed Child Caring Institutions, Group Homes and Private Secure Facilities);
b. School;
c. Hospital;
d. Juvenile Correction Facility;
e. Adult Correctional Facility that houses juvenile offenders;

f. Bureau of Developmental Disabilities (BDDS) Certified Group Home;

g. Licensed Child Care Home or Center;

h. Unlicensed Registered Child Care Ministry; or

i. Unlicensed Child Care Home or Center (see Related Information).

ICPS will NOT conduct assessments involving:

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

Please describe procedures for taking custody of an "abandoned infant," for purposes of IC 31-34-21-5.6, (Abandoned Infant Protocols should be renewed at this time and can be incorporated here to satisfy this item.)

Emergency Placement of Abandoned Infants

The DCS Local Office FCM who needs to place an abandoned infant in substitute care will initially place the child in emergency foster care when the team set out below cannot convene prior to the child's need for substitute care.

Note: This placement should be emergency shelter care only and should not be considered a long-term placement for the child.

In order to determine the final recommendation of placement for the child, the DCS Local Office FCM will convene a multi-disciplinary team comprised of the following team members:

1. CASA or GAL;
2. DCS Local Office Director or designee;
3. Regional Manager;
4. Supervisor;
5. SNAP worker (if appropriate); and
6. Licensing FCM.

The team will make a recommendation for placement, documenting the best interests of the child and the reasoning used in determining the most appropriate placement for the child. This recommendation and report on the interests served with this decision shall first be submitted to the Local Office Director (LOD), then to the juvenile court for review.

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

See Attached Protocols

H. **Describe the procedures that you follow upon receiving and referring child abuse or neglect reports to another county or state where family resides or where abuse or neglect occurs. (Refer to Indiana Child Welfare Policy Manual Chapter 3, Section 1 and Chapter 4, Section 35).**

The Hotline will refer an abuse/neglect report for assessment to the local office where the incident occurred. If it is determined that the incident occurred in another county or additional county to where the Hotline sent the assessment, the local office shall communicate and/or coordinate that information.

If a caller reveals an incident occurred out of state, the Hotline staff will provide the caller with contact information regarding the state where the allegation occurred and recommend the local office to email or fax a copy of any report taken to that agency. If the report presents concerns of a child in imminent danger, the Hotline may reach out to the appropriate state agency directly.

If the Hotline receives a call from another state referencing abuse and/or neglect that allegedly occurred in Indiana, Hotline staff will determine if the report meets legal sufficiency to assign for assessment, determine where the incident occurred, and route the report with a recommendation to the local office's county queue.

If the Hotline receives a call from another state seeking home study or placement study, that information is documented as an Information and Referral and provided to the local office. The local office shall determine whether or not they will respond to the request. The Hotline will also refer the report to the ICPC unit via email.

If the Indiana Child Abuse and Neglect Hotline receives a call from another state requesting a service request to check on children that were placed in Indiana by the calling state, the Hotline will notify the local office to complete a safety check on the placed children via a service request and will notify ICPC staff if it appears the placement was illegal.

Describe special circumstances warranting an inter-county investigation (Refer to Indiana Child Welfare Policy Manual Chapter 3, Section 11)

When a DCS local office receives allegations of CA/N that may pose a conflict of interest due to relationships between subjects of the report and local office staff, the local office may transfer the report to another county or region for assessment.

I. **Describe the manner in which the confidentiality of records is preserved (Refer to Indiana Child Welfare Policy Manual Chapter 2, Section 6)**

The Indiana Department of Child Services (DCS) will hold confidential all information gained during reports of Child Abuse and/or Neglect (CA/N), CA/N assessments, and ongoing case management.

DCS abides by Indiana law and shares confidential information with only those persons entitled by law to receive it.

DCS shall comply with any request to conduct CA/N history checks received from another state's child welfare agency, as long as the records have not been expunged, when:

1. The check is being conducted for the purpose of placing a child in a foster or adoptive home;
2. The check is being conducted in conjunction with a C/AN assessment; and
3. The requesting state agency has care, custody and control of the child and the request is to check Child Protection Services (CPS) history of an individual who has a prior relationship with the child.

DCS will advise individuals who make calls reporting CA/N, parents, guardian, or custodian and perpetrators of their rights regarding access to confidential CA/N information.

DCS will make available for public review and inspection all statewide assessments, reports of findings, and program improvement plans developed as a result of a full or partial Child and Family Services Review (CFSR) after approval of the Chief Legal Counsel.

DCS will provide unidentifiable CA/N information of a general nature to persons engaged in research. The DCS Central Office shall provide such information upon written request.

DCS Central Office will submit all public records requests for substantiated fatality or near fatality records to the juvenile court in the county where the child died or the near fatality occurred for redaction and release to the requestor.

All records sent from DCS shall be labeled or stamped "CONFIDENTIAL" at the top of each record. Any envelope containing records shall also be labeled "CONFIDENTIAL".

DCS will protect the confidentiality of all information gained from non-offending parents in families experiencing domestic violence. Prior to releasing any information (i.e. during court proceedings where disclosure of certain information is mandatory), the non-

offending parent will be notified so they may plan for their safety and the safety of the child(ren).

J. **Describe the follow-up provided relative to specific Assessments (See Chapter 4, Section 21 of the Indiana Child Welfare Policy Manual):**

The Indiana Department of Child Services (DCS) will provide a summary of the information contained in the Assessment Report to the administrator of the following facilities if such a facility reported the Child Abuse and/or Neglect (CA/N) allegations:

1. Hospitals;
2. Community mental health centers;
3. Managed care providers;
4. Referring physicians, dentists;
5. Licensed psychologists;
6. Schools;
7. Child caring institution licensed under IC 31-27;
8. Group home licensed under IC 31-27 or IC 12-28-4;
9. Secure private facility; and
10. Child placing agency as defined in IC 31-9-2-17.5.

DCS will provide this summary 30 days after receipt of the Preliminary Report of Alleged Child Abuse or Neglect (SF 114/CW0310) (CA/N intake report).

K. **Describe GAL/CASA appointments in each county**.

Describe how guardian ad litem or court appointed special advocates are appointed in your county? Hamilton - By the judge, Hancock - Every case is assigned a CASA at the initial hearing. However, if we do not have a trained volunteer available, then those cases will go on a wait list. GAL's are appointed by the court on the recommendation for DCS or other party to the case, Madison- The court will appoint for CASA to be assigned on cases. There is currently a waiting list due to availability of advocates within Madison County. Therefore, advocates are assigned as available, there is a watch list where the CASA staff monitors the case and attends

hearings, and a "wait list" for children. , Tipton - The court appoints the CASA program on every case, but not every case has a specific volunteer assigned.

What percentages of CHINS cases are able to have advocates assigned? Hamilton - 100% , Hancock - 80% , Madison - 29% , Tipton - 12.5 %

L. **Describe the procedure for Administrative Review for Child Abuse or Neglect Substantiation in DCS (See IC 31-33-26, 465 IAC 3 and the Indiana Child Welfare Policy Manual, Chapter 2, Section 2).**

For any report substantiated by DCS after October 15, 2006, DCS will send or hand deliver written notification of the DCS decision to substantiate child abuse or neglect allegations to every person identified as a perpetrator. The notice will include the opportunity to request administrative review of the decision.

DCS Administrative Review is a process by which an individual identified as a perpetrator, who has had allegations of child abuse and/or neglect substantiated on or after October 15, 2006, has the opportunity to have a review of the assessment done by an Indiana Department of Child Services (DCS) employee not previously involved in the case. The alleged perpetrator can present information for the Administrative Review with his or her request to unsubstantiate the allegations.

A request for Administrative Review must be submitted by the individual identified as a perpetrator and **received** by the DCS local office that conducted the assessment or the DCS Institutional Child Protection Services (ICPS) within **fifteen (15) calendar days** from the date that the Notice of Child Abuse and/or Neglect Assessment Outcome and Right to Administrative Review (State Form 54317) was hand delivered to the alleged perpetrator. If the Notice is mailed, an additional three (3) days is added to the deadline.

Note: If the request for an Administrative Review deadline is on a day that the DCS local office is closed, the deadline is extended to the next business day.

DCS requires that the Administrative Review be conducted by one of the following:

1. The DCS Local Office Director in the county responsible for the assessment;
2. The DCS Local Office Deputy Director in the county responsible for the assessment;
3. The DCS Local Office Division Manager in the county responsible for the assessment; or
4. The Regional Manager in the region responsible for the assessment.

If the DCS Local Office Director, Deputy Director, Division Manager or Regional Manager was the person who approved the initial Assessment of Child Abuse or Neglect (SF113/CW0311) determination, or was otherwise involved in the assessment, preparation of the report, or has a conflict of interest, he or she will not conduct the Administrative Review. The Administrative Review will be conducted by a different DCS Local Office Director, Deputy Director, Division Manager or Regional Manager.

The individual identified by DCS to conduct the Administrative Review may at his or her discretion and subject to the time limits stated herein, refer the request to the community Child Protection Team (CPT) review and make a recommendation.

DCS will require that the Administrative Review decision is made by the appropriate DCS Local Office Director, Regional Manager, Local Office Deputy Director or Division Manager. Community CPT's are prohibited from making the decision.

The objectives of an Administrative Review are to:

1. Provide an internal review of the assessment by DCS at the request of the perpetrator; to determine whether or not the assessment provides a preponderance of evidence to support the conclusion to substantiate the allegation(s);
2. Provide an opportunity for the alleged perpetrator to submit documentation (not testimony) regarding the allegation(s) substantiated to challenge the substantiation;
3. Comply with due process requirements that mandate DCS to offer a person identified as a perpetrator the opportunity to challenge allegations classified as

substantiated. An Administrative Review is one step in the DCS administrative process.

If a Court's finding(s) support the substantiation, DCS **will not conduct** an Administrative Review, the person will remain on the Child Protection Index (CPI) and any request for Administrative Review will be denied. Findings of this type can be found in a Child in Need of Services (CHINS) or criminal/juvenile delinquency case orders.

1. A court in a Child in Need of Services (CHINS) case may determine that the report of child abuse and/or neglect is properly substantiated, child abuse and/or neglect occurred or a person was a perpetrator of child abuse and/or neglect. The determinations made by the court are binding.
2. A criminal (or juvenile delinquency) case may result in a conviction of the person identified as an alleged perpetrator in the report (or a true finding in a juvenile delinquency case). If the facts that provided a necessary element for the conviction also provided the basis for the substantiation, the conviction supports the substantiation and is binding.

If a CHINS Court orders a finding that the alleged child abuse or neglect identified in the report did not occur; or the person named as a perpetrator in a report of suspected child abuse or neglect was not a perpetrator of the alleged child abuse or neglect, DCS **will not conduct** an Administrative Review. The finding of the court is binding and the report will be unsubstantiated consistent with the court's finding. The DCS local office will notify the alleged perpetrator of the assessment conclusion, whether or not an Administrative Review occurs based on the court's finding. Upon notification, the individual identified as a perpetrator will have the opportunity to request reconsideration of a denial in writing within 15 days of the denial (including an additional three days if the denial is sent by mail) and provide any basis he/she may have to support the basis for alleging an error in the decision to deny administrative review.

The individual identified by DCS to conduct the Administrative Review may deny the Administrative Review, uphold the classification of the allegation(s) as substantiated, reverse the allegations classified as substantiated or return the report for further assessment so that additional information can be obtained. An Informal Adjustment does not justify a denial of an Administrative Review. The individual identified by DCS to conduct the Administrative Review may not stay the administrative review process.

Note: For those Administrative Reviews that were stayed before the effective date of

this policy, the administrative review process must be concluded in accordance with the stay letter provided to the perpetrator. If no deadline was provided by DCS, see Notice of to Reactivate Administrative Review or Appeal Request (Chapter 2 Notification Tool- Section M).

DCS will complete the Administrative Review and will notify the DCS local office of the decision so that appropriate action can be taken consistent with the decision. The individual identified by DCS to conduct the Administrative Review will also notify the individual identified as a perpetrator in writing of the outcome within **fifteen (15) calendar days** from the DCS local office receipt of the individual's request for administrative review.

The DCS LOD or designee will maintain in the assessment case file a record of:

1. The date of the Administrative Review;
2. The person who conducted the Administrative Review;
3. The Administrative Review decision; and
4. The copy of the review decision letter. See Practice Guidance.

This procedure does not apply to child abuse and/or neglect (CA/N) substantiated assessments involving child care workers, licensed resource parents or DCS employees. DCS will notify a DCS employee substantiated for child abuse or neglect that an automatic administrative review will be conducted after substantiation has been approved. The review will be conducted by a team of DCS staff members as designated by DCS Policy. DCS will notify a child care worker or a licensed foster parent, in writing, of the date, time and place of a face to face meeting with the DCS staff member who conducts the administrative review before the DCS determination to substantiate is approved. These administrative reviews are conducted automatically, without any request for review from the individual identified as a perpetrator. While these individuals are invited to attend their administrative review, the administrative review will occur regardless of the attendance of the individual identified as a perpetrator. DCS will require that the administrative review occur prior to supervisory approval of the assessment finding. A written review decision will be mailed or hand delivered to the individual identified as a perpetrator. Following the review, the DCS staff member will notify the person of the review decision. The written review decision will include procedures that the person must follow to request an

administrative appeal hearing before an Administrative Law Judge. (Refer to the Indiana Child Welfare Manual, Chapter 2, Sections 3 and 4.)

Are you automatically holding an Administrative Review on all Child Care Workers, foster parents substantiated for child abuse and/or neglect prior to substantiation?

Yes ☒ No ☐

Does your region schedule administrative reviews for child care workers and foster parents in accordance with DCS Policy?

Yes ☒ No ☐

The Indiana Department of Child Services (DCS) recognizes the right of the alleged perpetrator to request an Administrative Appeal Hearing if substantiated allegations of Child Abuse and/or Neglect (CA/N) are upheld in the DCS Administrative Review or when an administrative review is denied. The process outlined herein will apply to all assessments that substantiate CA/N against a named individual identified as a perpetrator on or after October 15, 2006. (Refer to the Indiana Child Welfare Manual, Chapter 2, Section 5.)

If the substantiated assessment is against a minor perpetrator, the request for an Administrative Appeal Hearing must be made by the child's parent, guardian, custodian, attorney, Guardian ad Litem (GAL), or Court Appointed Special Advocate (CASA).

DCS requires that all requests for Administrative Appeal Hearing by an individual identified as a perpetrator utilize the Request for an Administrative Appeal Hearing for Child Abuse or Neglect Substantiation (54776) and that the request be received by DCS Hearings and Appeals within **thirty (30) calendar days** (if request hand delivered) or **thirty-three (33) calendar days** (if request mailed) from the date identified on the Notice of Right to Administrative Appeal of Child Abuse/Neglect Determination (State Form 55148).

Note: If the request for an Administrative Appeal is received on a day that the DCS Hearings and Appeals is closed, the next business day is considered the receipt date. If the request deadline is on a day that DCS Hearings and Appeals is closed, the deadline is extended to the next business day.

If the substantiated assessment is against a DCS employee or a child care worker as defined in DCS policies Chapter 2, Section 3 Child Care Worker Assessment Review (CCWAR) Process and Chapter 2, Section 4 Assessment and Review of DCS Staff Alleged Perpetrators, the Administrative Appeal Hearing will be scheduled to be heard within twenty (20) calendar days of the date the request is received by Hearings and Appeals, unless the perpetrator (appellant) waives the time limit in writing as outlined in 465 IAC 3-3-9.

At the hearing, the DCS local office representative will:

1. Review assessment documentation prior to the hearing; and

2. Bring supporting documentation to be entered as evidence and witnesses to the hearing. Exhibits should be appropriately redacted to eliminate all Social Security numbers, identification of the report source, and any other information necessary for redaction.

V. **Community Child Protection Team (CPT)**

A. Have confidentiality forms been signed by all team members?

County	Yes	No
Hamilton	☒	☐
Hancock	☒	☐
Madison	☒	☐
Tipton	☒	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

B. How often are CPT meetings scheduled at the present time? Include the date of the last meeting.

County	Weekly	Monthly	Telephone	As necessary, but at least	Date of last meeting
Hamilton	☐	☒	☐	☐	11/24/15
Hancock	☐	☒	☐	☐	11/24/15
Madison	☐	☒	☐	☐	11/19/15
Tipton	☐	☒	☐	☐	11/23/15
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

C. How many meetings were held in:

County	SFY 2014	SFY 2015
Hamilton	9	12
Hancock	10	10
Madison	12	12
Tipton	9	10

D. Are emergency CPT meetings held?

Yes ☐ No ☒

If yes, how many:

a. in SFY 2014? _____

b. in SFY 2015? _____

E. What was the average attendance for the CPT meetings?

1. in SFY 2014? Hamilton - 8, Hancock - 15, Madison - 11, Tipton - 10

2. in SFY 2015? Hamilton - 8, Hancock - 15, Madison - 13, Tipton - 12

F. What was the number of reports reviewed by the CPT:

1. in SFY 2014? Hamilton - 14,Hancock - 18, Madison - 36, Tipton - 76

2. in SFY 2015? Hamilton - 16, Hancock - 20, Madison- 50* this excludes screen outs - A CPT member reviews all screen outs in Madison County, Tipton - 72

G. What was the number of complaints reviewed by the CPT:

1. in SFY 2014? Hamilton - 0, Hancock- 0, Madison - 0, Tipton - 0

2. in SFY 2015? Hamilton - 0, Hancock -0, Madison - 0, Tipton - 0

H. Please list **names, addresses,** and **telephone numbers of CPT members** (Refer to I.C. 31-33-3) and **note the name of the coordinator by adding ** next to their name:**

1. Director of local DCS or director's designee

Hamilton	Lyndsay Krauter**	938 N. 10th Street, Noblesville IN 46060	317-773-2183
Hancock	Amanda Skinner**	13 N. State Street, Greenfield, IN 46140	317-467-6360
Madison	Tashia Arteaga**	222 E. 10th Street, Anderson, IN 46016	765-649-0142
Tipton	Beth Dickerson**	701 E. Jefferson Street, Tipton IN 46072	765-675-7441

2-3 Two (2) designees of juvenile court judge

Hamilton	Bob Bragg	1 N 8th St #29, Noblesville, IN 46060	317-776-5856
Hamilton	Tricia Akers	2728 E. 171st Street, Westfield, IN 46074	317-679-8303
Hancock	Wayne Addison	9E Main St, Greenfield, IN 46140	317-477-1135
Hancock	Vacant		
Madison	Ashley Hopper	120 E. 8th Street, Anderson, IN 46018	765-648-6005
Madison	Liddia Sanglton	3420 Mounds Road, Anderson, IN 46017	765-646-9213
Tipton	Tracy Regnier	101 E. Jefferson St., Tipton IN 46072	765-675-3565
Tipton	Barb Burton	101 E. Jefferson St., Tipton IN 46072	765-675-4353

4. County prosecutor or prosecutor's designee

Hamilton	Brandi Pass	Hamilton Sq, Ste 134 Noblesville, IN 46060	317-776-8595
Hancock	Brent Eaton	27 American Legion Pl., Greenfield, IN 46140	317-477-1139
Madison	Steve Koester	16 E. 9th St., Anderson, IN 46016	765-641-9585
Tipton	Sara Pearce	101 E. Jefferson St., Tipton IN 46072	765-675-2968

5. County sheriff or sheriff's designee

Hamilton	Kija Ireland	18100 Cumberland Rd, Noblesville IN 46060	317-407-3001
Hancock	Mike Shepherd	123 E. Main St., Greenfield, IN 46140	317-477-1139
Madison	Darwin Dwiggins	720 Central Ave., Anderson, IN 46016	765-646-9281
Tipton	Tony Frawley	121 W. Madison St., Tipton IN 46072	765-675-7004

6. The chief law enforcement officer of the largest LEA in the county or

Designee

Hamilton	Vacant		
Hancock	Randy Ratliff	116 S. State St., Greenfield, IN	317-477-4410
Madison	Steve Denny	1040 Main St., Anderson, IN 46016	765-648-6759
Tipton	Jeff Stout	225 E. Jefferson St., Tipton, IN 46072	765-675-7004

7. **Either** president of county executive or president's designee **or** executive of consolidated city or executive's designee

Hamilton	Barry McNulty	18030 Foundation Dr.,Ste A, Noblesville, IN 46060	317-776-8500
Hancock	Vacant		
Madison	Vacant		
Tipton	Lisa Connors	P.O. Box 1302, Anderson, IN 46015	765-643-0218

8. Director of CASA or GAL program or director's designee

(*See note after #13.)

Hamilton	Greg Hege	124 N. 10th St., Noblesville, IN 46060	317-459-6170
Hancock	Annette Craycraft	800 Main St., Ste 301 Anderson, IN 46016	765-649-7215
Madison	Annette Craycraft	800 Main St., Ste 301 Anderson, IN 46016	765-649-7215
Tipton	Tia Heaver	221 N. Main St., Tipton, IN 46072	765-675-7083

The following members are to be appointed by the county director:

9. **Either** public school superintendent or superintendent's designee **or** director

of local special education cooperative or director's designee

Hamilton	Mike Beresford	13485 Cumberland Rd, Noblesville, IN 46060	317-594-3542
Hancock	Dawn Hanson	110 W. North St., Greenfield, IN 46140	317-462-4434
Madison	Amanda McCammon	1600 Hillcrest Ave., Anderson, IN 46016	765-641-2135
Tipton	Kathy Heaston	1009 S. Main St., Tipton, IN 46072	765-675-7397

10-11. Two (2) persons, each of whom is a physician or nurse experienced in pediatric or family practice

Hamilton	Dr. Megan Landwerlen	7233 Fishers Landing Dr, Fishers, IN 46038	317-578-4193
Hamilton	Teresa Lucchetti	17840 Cumberland Rd, Noblesville, IN 46060	317-587-0567
Hancock	Mary Hernandez	938 N. 10th St., Noblesville, IN 46060	317-416-8831
Hancock	Vacant		
Madison	Dr Ray	2101 Jackson St, Anderson IN 46016	765-642-8025
Madison	Janet McIntyre	2015 Jackson St., Anderson IN 46016	765-649-2511
Tipton	JoEllen Scott	1000 S. Main St., Tipton, IN 46072	765-675-8500
Tipton	Mitzi Brannum	1000 S. Main St., Tipton, IN 46072	765-675-8500

12-13. One or (2) citizens of the community

Hamilton	Britany Winebar	1100 S. 9th St., Noblesville, IN 46060	317-773-6942
Hamilton			
Hancock	Cheryl Seelig	98 E. North St., Greenfield, IN 46140	317-477-0034
Hancock	Terri Parke	15530 Herriman Blvd, Noblesville, IN 46060	317-773-6342
Madison	Kandi Floyd	P.O. Box 1302, Anderson, IN 46016	765-643-0218
Madison			
Tipton	Sherry Murray	2228 W. 100 N., Tipton, IN 46072	765-675-3408
Tipton	Amanda Mendenhall	321 W. Jefferson St., Tipton, IN 46072	765-675-9362

***Note:** If your county does not yet have a CASA or GAL program, add another citizen of the community to make your number of team members total 13 as specified by I.C. 31-33-3-1 Director of local CPS or director's designee. (Refer to Child Welfare Manual, Chapter 1, Section 1.)

VI. Regional Child Protection Service Data Sheet

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

1.	List items purchased for the Child Protection Team and costs	**2014**	**2015**
2.	Child Advocacy Center/Other Interviewing Costs		

B. Please provide the annual salary for the following positions and total the salaries for each of the classifications listed below: (Please include all staff with dual responsibilities and estimate and indicate percentage of salary for CPS time only. For example, if a Family Case Manager works 40% CPS and 60% ongoing child welfare services, use 40% of the salary, the

I certify and attest that the local Child Protection Service Plan of Region 11 is in compliance with IC 31-33-4-1; and copies of the plan have been distributed in conformity with same.

Average Salaries to be used in calculations

	SFY 2014		SFY 2015	
Job Classification	***Average Salary***	***Fringe***	***Average Salary***	***Fringe***
Family Case Manager	$ 38,031.61	Salary X (1.2375)+ $12,446	$ 38,184.72	Salary X (1.2375)+ $12,446
Family Case Manager Supervisor	$ 49,418.15	Salary X (1.2375)+ $12,446	$ 46,784.28	Salary X (1.2375)+ $12,446
Clerical Support	$ 24,620.93	Salary X (1.2375)+ $12,446	$ 24,061.15	Salary X (1.2375)+ $12,446
Local Office Director	$ 62,052.12	Salary X (1.2375)+ $12,446	$ 62,922.62	Salary X (1.2375)+ $12,446

		2014	**2015**
1	Family Case Managers IIs	33	39.5
2	FCM Supervisors (or Local Director)	6.33	6.66
3	Clerical Support Staff	5.33	6.83
	Total Cost of Salaries	$ 2,663,621.11	$ 3,121,573.07
C.	**Grand Total of VI (Total Cost of Services In A, plus Total Cost of Salaries in B**	$ 2,663,621.11	$ 3,121,573.07

CERTIFICATION

CPS portion. Also, if the Local Director acts as line supervisor for CPS, include the proper percentage of salary on the line for Family Case Manager Supervisors. (**Attach a separate sheet showing your computations.**)

	Daniel Brumfield	
Signature of Regional Manager	Regional Manager's Name	Date