Region 13

Biennial Regional Services Strategic Plan
Child Protection Plan and Service Array Plan

Section 4 – Service Array

SFY 2015-2016

February 2, 2014
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I. Introduction/Summary:

Every two years, the Department of Child Services works collaboratively with the Regional Services Council, providers, and other community members to review the services available in the region and prepare the Biennial Regional Services Strategic Plan (the Plan). The preparation for this plan began in summer of 2013. The planning process to develop the Plan involved a series of activities led by a guided workgroup composed of representatives from the community. The activities included:

1. a review of relevant data including Practice Indicator Reports, Quality Service Reviews, and prevention and ongoing service utilization data.
2. a service needs assessment survey completed by Family Case Managers, Probation Officers, providers, and other community members.
3. public testimony
4. financial information

While all of this data is typically reviewed regularly by DCS, it is during the Biennial Regional Services Strategic Planning process that the information is viewed through a contracted service lens. The workgroup considered all of the information and determined the appropriate utilization of available services and identified gaps in service. As a result, the workgroup developed a regional action plan to address service needs and gaps. In addition, the workgroup completed budget projections by service for the next fiscal year as well as the next biennial budget.

II. DCS Strategic Plan, Safely Home – Families First

DCS Strategic Plan

The Biennial Regional Services Strategic plans are developed in line with the DCS Strategic plan. DCS recognizes that in order to ensure Indiana is achieving the best outcomes for children and families, the Department can never stop evaluating its current practice. To that end, and in line with Governor Pence’s roadmap agenda goal of improving the health, safety and well-being of Hoosier children, DCS developed a strategic plan to continue Indiana’s practice reform over the next year. The Department’s strategic plan includes three priorities:

1. New child support system
2. Trauma informed care
3. Staff recruitment and retention.

DCS Strategic Plan - New child support system

Every child has the right to the financial support of both parents, whether or not the parents are married or live together in the home with the child. The Indiana DCS Child Support Bureau (CSB) in conjunction with its county partners enforces this right. Title IV-D of the Federal Social Security Act requires every state to operate a child support program to perform parental locate functions, paternity establishment, support order establishment and enforcement, payment processing, and child support disbursement. In Indiana, the Title IV-D Child Support Program is administrated by the Department of Child Services Child Support Bureau, and is carried out locally by the county prosecutor's office, the office of the county clerk, and the courts.
In order to administer the IV-D program, states are required to have a federally certified Statewide automated computer system. Indiana’s system is called ISETS. ISETS is responsible for maintaining 351,000 Title IV-D cases and approximately 150,000 non-IV-D (private) cases. It processes almost $1 billion in child support payments annually. Unlike other human services programs where the automated system may be an important, but peripheral aspect of a worker’s daily routine, automated child support systems are a worker’s daily routine. If the system does not work or does not work well, it negatively impacts the state’s ability to ensure child support monies are reaching children.

ISETS is a legacy system built on dying technology and is long overdue for replacement. Although the system was developed in the mid-1990’s, the original technology was developed in the late 1980’s. Its rate of decline appears to be increasing because portions of its technology are no longer supported, making it difficult and extremely expensive to make system changes. This results in growing costs in both technology changes and staffing, an inability to provide changes to improve child support worker’s productivity, and difficulty in meeting federal/state mandated functionality changes and audit requirements.

To address these issues, the DCS Child Support Bureau (CSB) has embarked on a multi-year project, in conjunction with its county partners, to build and launch a new child support system. The new system will be called the Indiana Verification and Enforcement of Support (INvest). INvest will have a number of benefits, including increased collections for families, increased opportunity for collaboration, and decreased maintenance costs.

While INvest will take many years to complete, the Department’s strategic plan for this project includes the following goals for SFYs 2014-2015:

- Finalize all system requirements,
- Complete and ensure approval of the Federal Feasibility Study,
- Gain final approval of the RFS, and
- Complete the competitive procurement.

Once implemented, this system will help get child support monies to more kids, better enabling Indiana to ensure the financial well-being of Hoosier children.

**DCS Strategic Plan- Trauma Informed Care**

The second pillar of the Department’s strategic plan is to ensure the well-being of Hoosier children by integrating a trauma-informed care approach into our child welfare practice.

Traditionally, child welfare systems have focused on ensuring the safety and permanency of youth and placed limited emphasis on acknowledging and treating the trauma that children entering the child welfare system are known to experience. Research demonstrates that trauma experienced by children at a young age can have a significant impact on their mental and physical health later in life, including altered brain development, impaired social relationships, learning difficulties and problems in school, physical and mental health conditions, increased risk for chronic health conditions and even premature death. Most children who enter the child welfare system have experienced some type of trauma, and this trauma is compounded when
children are removed from their homes.

Historically, Indiana has had a “blind spot” for trauma; the Department hasn’t done a good job identifying or treating the trauma experienced by children who enter the system. Indiana has required providers to treat the “symptoms” of trauma, but never required that they use trauma informed and evidence-based practices.

DCS is working to integrate trauma-informed care into child welfare practice by collaborating with stakeholders to share resources and improve service delivery across systems. By working with providers, schools, courts, probation, and state agencies, DCS can ensure that appropriate services are available and that all are educated on what it means to identify and treat trauma, as opposed to just reacting to its symptoms. Effectively providing for the well-being of Hoosier children involved with the child welfare system requires a multi-pronged approach that includes:

1. **Collaboration**: Improving coordination of services with other agencies.
2. **Integration**: Increasing emphasis on child well-being and integrating trauma-informed care into our child welfare practice through training and assessing for trauma.

### DCS Strategic Plan- Staff Retention and Recruitment

DCS will seek to improve the safety and well-being of Hoosier children by hiring and retaining a qualified, competent, and sustainable workforce to support the DCS mission, vision and values.

The Department employs over 3,400 individuals, more than half of whom are Family Case Managers (FCMs). FCMs work directly with children and families on a daily basis. The environment is high stress and FCMs must make difficult decisions everyday that significantly impact the lives of children and families.

FCMs are the backbone of Indiana’s child welfare system. FCM turnover has a direct effect on the children and families we serve, including significantly longer stays in foster care; delays in timely assessments; disruptions in child placements; and an increased rate of repeat maltreatment and reentry into foster care. During the first five months of SFY 2013, DCS saw a significant spike in FCM turnover. In response to this spike, and as a part of its strategic plan, DCS developed a comprehensive recruitment plan to ensure Indiana maintains a diverse, competent, committed and effective child welfare workforce.

In order to recruit qualified employees, DCS is utilizing a number of traditional and contemporary recruitment tools, including print advertisement, internet job boards, social media and job fairs. DCS also operates the BSW Scholars Program in conjunction with the Indiana University School of Social Work. DCS currently funds 50 scholarships, up from 36 in SFY 2013, for students majoring in Social Work. Upon graduating and completing the program, which includes child welfare specific coursework, students are offered a Family Case Manager position with the Department and commit to work for DCS for at least two years.
DCS and its provider agencies recognize the need to ensure a sufficient pool of social workers to support the entire continuum of services provided to vulnerable children and families. As a result, DCS is collaborating with service providers and other state agencies to promote the social work field in order to increase the pool of viable candidates with a social work background.

The Department is seeking to not only recruit new, qualified staff, but to reduce turnover so that DCS can retain its current workforce. One key strategy in this effort is to improve workplace satisfaction and commitment. DCS is partnering with Casey Family Programs to develop and launch an employee recognition program in 2013. The Department is also collaborating with the IU Kelley School of Business to identify factors leading to child welfare field staff turnover, ways to mitigate the negative effects of those factors, and develop strategies to improve staff retention.

One of the reasons that FCMs leave the agency is due to the nature and stress of the work. The State and DCS have a number of tools to help support employees in this matter. The Department is working to increase awareness and understanding of secondary traumatic stress for all employees. DCS has also created a new Critical Incident Response Program to support staff who experience traumatic job-related events, such as a child fatality. Lastly, the Department will promote employee well-being by leveraging existing state benefit programs in an effort to improve employee physical, emotional, and financial health.

In a field as high stress as child welfare, DCS doesn't expect, nor desire, to have turnover at zero percent. It is imperative that the individuals who work with children and families remain committed to this very difficult work. To that end, the Department is continuously seeking ways to ensure that the right staff are hired and supported, allowing them to effectively serve Hoosier children and families.

**Safely Home – Families First**

As DCS continues to partner with families and communities to provide children with safe, caring, and supportive environments, we are constantly measuring our efforts. In so doing, it is important to ask these questions in keeping with the core values of DCS: Are we doing the very best we can do to protect children from abuse and neglect? Are we providing every child with appropriate care and a permanent home? Are we making the best possible efforts to keep children in their own homes or with relatives?

One of the values that DCS believes is that the most desirable place for a child to grow up is in their own home as long as the family is able to provide safety and security for the child. But each child deserves a permanent lifetime home where they know they belong and are loved. And that the child deserves to have that permanency established in a timely manner. Our practice model is built around our Mission, Vision and Values and is supported by the service array and capacity managed by the Support Services department and acquired through the Regional Services Councils. Finally, DCS has worked to develop a full support network of individuals and systems to support the practice model and provide the appropriate care and permanent homes for each child in our care and responsibility.
DCS is constantly working to achieve improved outcomes for children and families, and reviews existing and emerging research to continually guide and inform our practice. There is significant research that shows that the least restrictive and most family like setting is in the best interest of children. In fact, both federal and state law require that, along with child safety, the least restrictive environment is a primary consideration, when consideration of DCS involvement is required. There are some situations in which our decisions regarding the safety of the child lead us to determine that the removal of a child from the home is in their best interest. In these circumstances, we weigh the possible risks of leaving a child with his/her own family with the knowledge that there is certain damage when a child is removed from the home. It is therefore imperative that we always look at protective factors within the child’s family.

As the recent In-Service training on this topic showed, the five protective factors are:

1. A parent’s attachment or bond to the child;
2. A parent’s understanding of the child’s needs and developmental stages;
3. The family’s resilience and ability to effectively address issues;
4. The family’s social connections; and
5. The concrete supports available to the family.

Protective factors should be used to develop appropriate and realistic case plans, more effective interventions and to improve the safety, permanency and well being of the children we serve.

When a child cannot be safely maintained in the home, we are committed to finding absent parents and relatives. We look for family members who know the child and who are familiar and comfortable to the child. They have established relationships and the trauma of removal is mitigated by being with people the child knows and who desire to help the child feel included in their family. Our own Practice Indicators demonstrate that when children are placed with relatives, they are more likely to find permanency faster than when they are placed in non-relative environments.

“Safely Home—Families First” is nothing new, but in fact is a renewed and heightened effort to provide for the well-being of our children, to identify those protective factors that will help keep a child at home safely, to help family members find resources and their own informal supports, and to quickly locate relatives in the event a child is not able to remain in the home. There are many parts of this effort including the expansion of in home support services, wraparound services, intensive family preservation, intensive family reunification and others. Having those services available in a timely manner, at times when the services are needed and with the flexibility to adjust to the needs of the family have been the absolute necessity before these efforts of Safely Home—Families First can be successful.

There are many tools that are currently available to achieve this goal:

1. Sobriety Treatment and Recover Teams (START) are a partnership between DCS and CMHC’s to provide quicker access to Substance Use Treatment Services, increased intensity of those services, and a team comprised of a Family Mentor (former client in recovery), Treatment Coordinator, and the Family Case Manager that will all be specially
trained to provide the services the family needs while supporting the family’s ability to safely maintain the children in their home.

2. The CANS is a tool that can assist in identifying the strengths and challenges within a family so that more targeted treatment interventions can be pursued.

3. The Medicaid Rehab Option (MRO) has been expanded so that children and families are able to receive services within their community.

4. Wraparound, Systems of Care, Cross Systems of Care and 1915i/CMHI are options that assist in the development of informal and community supports so that successful family plans can be implemented and achieved.

5. New service standards have been developed such as Comprehensive Home Based Services to provide additional resources and support to families so that they can successfully parent their children.

After we have considered all the research, looked to other states for their successes and read all of our own practice reports, our practice model demands that we focus on each individual child. Children desire and deserve to remain with their own families, to sleep in their own beds, and to be surrounded by their own belongings. They want to go to the same school and see their friends and learn from the teachers they know in the schools they are familiar with. In acknowledgement of this, it is important that we as an agency also want those things for them, and strive to do the best we can to ensure that children are with their own families when they can be so safely.

The foundation of excellence is in place, the service array is broad and expanding, the data is available and measured, national research and experts indicate the appropriateness of our efforts, and exceptional people are in the field, local offices and supervisory positions to assure the success of this effort. Soon we will each be able to answer the question “How are the Children” and be assured and proud of the answer.
III. Service Array Plan:

The following portion of this document includes the summary of: the available services; needs assessment/survey, public testimony; Fiscal Trends, Regional Action Plan and the unmet needs. The supportive documents are in the Appendix’s (such as: the survey, minutes to Public Testimony, listing of services by county, fiscal information, etc.)

The Department of Child Services (DCS) makes every effort to offer an efficient and comprehensive array of services to meet the needs of children and families they serve. While service needs vary greatly from region to region within the State, the present process is designed to more clearly identify areas of service availability and gaps that may require further attention from DCS. More specifically, information contained in this section attempts to answer two very basic questions: first, “What does a region have in terms of services offered to families and children?” and second, “What does a region need in terms of service?” Supportive documents are in the Appendix’s, such as:

- A glossary of regional prevention service offerings,
- A glossary of regional intervention services offerings (DCS standardized services),
- A listing of (both DCS-funded and non DCS-funded) prevention services and providers
- A listing of (DCS contracted) intervention services and providers,
- Summary of workgroup perceptions of service availability/accessibility,

Service offerings detailed in the section fall into one of two basic categories: prevention services, and intervention services. Intervention services are characterized by a formal involvement of the DCS in a case and are available:

- Through informal adjustments, which are agreements made by involved parties when a family admits to a problem and the child is at minimal risk in the home;
- To children in need of services (CHINS), which are children made wards of the court; and
- As reunification services, which are services provided to families when a child who has been removed from the family has a goal to return to the family.

It is the goal of both agencies to prevent unnecessary separation of children from their families by identifying family problems, assisting families in resolving them, and returning children who have been removed from their homes to their families. Department of Children Services offers services through informal adjustments, which are agreements made by involved parties when a family admits to a problem and the child is at minimal risk in the home; to children in need of services (CHINS), which are children made wards of the court; and as reunification services, which are services provided to families when a child who has been removed from the family has a goal to return to the family. Juvenile Probation offers services through informal and formal probation. Again, informal probation involves an agreement between parties. Formal probation involves mandates by the court with the goal of decreasing recidivism. In all cases, the best interest of the child and family are of prime importance.
Services offered may be preventative or intervening and may include but are not limited to:

- education
- counseling
- visitation
- sexual abuse treatment
- parent aides
- homemaker services
- home-based family services

Additionally, DCS offers other ancillary and support services including adoption services, foster parent training and support services, and Collaborative Care/Independent living services for children aging out of the system.

Preventative Services are utilized to prevent formal DCS involvement and may include services accessed by DCS referral, but not funded by the DCS or provided by a DCS contracted provider. Preventative services also include the DCS Family Evaluation Process, Children’s Mental Health Initiative, Community Partners for Child Safety (CPCS) program and the Healthy Families Indiana program.
IV. Prevention Services and Family Evaluations/CMHI

a) Community Partners

Community Partners for Child Safety (CPCS) provides an array of child abuse and neglect prevention services. The program is available to families not actively involved with the Department of Child Services or Healthy Families. The CPSC program offers a service continuum that builds community support for families identified through self-referral or community agency referral by connecting these families to resources needed to strengthen the family and prevent child abuse and neglect.

Funds under this program may be used for developing, operating, expanding, and enhancing statewide networks of community-based, prevention-focused, family resource and support programs that:

1. Prevent child abuse and neglect.
2. Decrease the risk of homelessness.
3. Provide respite care services.
4. Improve families’ access to formal and informal community resources that prevent child abuse and neglect, and prevent homelessness.
5. Provide or arrange for the provision of family resource and support services.
6. Provide family resource and support outreach service.

Services provided are primarily home-based including on-call availability, crisis intervention counseling, support and advocacy services, prevention support services, and referrals to resources and supports within the community. Services provided through the Community Partners Program are short term and goal directed.

b) Healthy Families

Healthy Families Indiana is a voluntary home visitation program designed to promote healthy families and children (0-3 years of age) by reducing child abuse and neglect and improving childhood health outcomes through a variety of services, including child development, access to health care, and parent education.

The program systematically identifies families that could benefit from education and support services either before or immediately after birth by providing screening and assessment of families in targeted areas throughout the state. Service entry points include WIC Programs, health clinics and local hospitals. Families assessed to have a need are offered the opportunity to participate in a voluntary home visiting program tailored to their individual needs.

c) Family Evaluations

The purpose of Family Evaluations is to provide service access to families when a child is determined to be a danger to him/herself or others and the family does not have the ability or
resources to access the services needed. Family Evaluations can reach many children/youth with mental health needs, developmental disabilities, and intellectual delays. Some children struggle with significant mental health issues or developmental disabilities which contribute to behaviors making their home environment unsafe. In addition, some families have difficulty accessing services generally due to inability to pay for services and have bounced from agency to agency trying to access services. In order to address this issue, DCS partnered with other agencies such as the Division of Mental Health and Addiction (DMHA), the Bureau of Developmental Disabilities (BDDS), and Community Partners for Child Safety programs around the State to ensure children with these types of needs are being served appropriately. Family Evaluations are a way to ensure these children and youth are being served in the correct system, they are being provided consistent and appropriate care regardless of financial burdens or insurance capabilities, and to ensure advocacy for the families and children being served.

DCS will serve these families by providing a Family Evaluation by specially trained Family Case Managers. DCS will conduct Family Evaluations to determine if services are needed in order to maintain the safety of the child or family members. DCS will review what might need to be offered to maintain the child safely in his/her home and if that is not possible, DCS will review if placement is an option. DCS will then connect the family to the necessary resources. Those resources include:

- Connecting families and children to Medicaid services such as Medicaid Rehabilitation Option services, Psychiatric Residential Treatment Facilities, Clinic services and the 1915i (coming soon).
- Connecting families and children to Bureau of Developmental Disabilities Services
- Providing 2 months of community based services under the Family Evaluation
- Referring the family to Community Partners for Child Safety, and/or
- Filing a CHINS 1 case with no substantiation to provide placement services or other community based services in excess of 2 months.

Family Evaluations will continue to be provided to families and children who will be best serviced in this capacity. However, once the Children’s Mental Health Initiative and 1915i roll out across the entire State, Family Evaluations will continue for children who do not meet those specific criteria and for children/youth with developmental disabilities and intellectual delays. (Please see the Children’s Mental Health Initiative summary for more details).

**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
  o Wraparound Facilitation
  o Habilitation
  o Family Support and Training
  o Respite (overnight respite must be provided by a DCS licensed provider)
• Placement Services

Eligibility for the CMHI mirrors that of Medicaid paid services under the 1915i and includes:
• Child or adolescent age 6 through the age of 17
• Youth who is experiencing significant emotional and/or functional impairments that impact their
level of functioning at home or in the community (e.g., Seriously Emotionally Disturbed
classification)
• Not eligible for Bureau of Developmental Disability Services
• Not eligible for Medicaid
• Needs based criteria include: DSM-IV-TR Diagnosis- Youth meets criteria for two (2) or more
diagnoses.
• CANS 4, 5, or 6
• Dysfunctional Behavior- Youth is demonstrating patterns of behavior that place him/her at risk of
institutional placement & unresponsive to traditional outpatient and/or community-based therapy.
• Specifically: Maladjustment to trauma, Psychosis, Debilitating anxiety, Conduct problems,
Sexual aggression, and Fire-setting
• Family Functioning and Support- Family/caregiver demonstrates significant need in one or more
of the following areas: Mental health, Supervision issues, Family stress, and Substance abuse

Anyone can make a referral to the CMHI on behalf of the child/family. The family will then be
able to enter into the multiagency services approach through the Access site in their local
community. Pre/post screenings are completed prior to the assessment to determine eligibility
requirements. If a family is not eligible for services through the CMHI, the access site will refer
that family to other appropriate services. (JD/JS) case will not be eligible for the CMHI. If the
CHINS or JD/JS case is opened, the child should be served through available services under the
CHINS or JD/JS case (not the Children’s Mental Health Initiative). An assessment for the
Children’s Mental Health Initiative may be completed while there is an open case to determine
where that child and family would be best served. If the child/youth is eligible for the CMHI,
then the case would need to close prior to service provision.
The CMHI started as a pilot project 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.
V. Available Services

Region 13 is composed of five counties including Brown, Greene, Lawrence, Monroe, and Owen, in south central Indiana. Brown, Greene, Lawrence, and Owen Counties are mostly rural areas with smaller populations. Monroe County is a midsized county with less rural areas. Greene County is the largest county geographically. Bloomington is home to a Big Ten University, Indiana University. Since Monroe County is geographically the centrally located county, and has the highest population, services are more readily available with a wider selection. Due to the University, Monroe County is more diverse than the other counties with a wider range of cultural opportunities. Brown County is home to Nashville which is a large tourist area, especially for artists. Lawrence County is home to Bedford, Oolitic, and Mitchell, which is where much of Indiana’s limestone is produced.

Region 13 convened a work group on November 25, 2013 to work on the biennial plan. The meeting convened at the Monroe County DCS Office in Bloomington, Indiana. The work group was tasked with looking at existing prevention and intervention services, identifying areas of need, and developing a plan to address existing service needs for DCS and probation. To accomplish this task, the work group reviewed data from the Statewide QSR and regional indicators, QSR stress factors, prevention data and the Service Needs Assessment Survey.

During the course of the work group it was discovered through a combination of group discussions, survey results, and DCS documentation that there was a significant need to address issues surrounding substance use treatment at all levels. All of the counties identified individual substance abuse as a major problem in the community. In addition, a significant amount of DCS and probation cases include substance abuse issues. A discussion ensued on if DCS timeframes were appropriate in covering the whole scope of treatment to account for relapse and after care services. The region has limited substance abuse providers which lead to the services being difficult to access, particularly intensive outpatient services. There is a need for juvenile services to have certified personnel completing treatment for that population and for the clients to be held accountable during their recovery process. There is concern the clients do not have access to adequate interventions when there is a relapse in recovery. Family Case Managers need to have open communication with the providers to ensure the treatment goals are appropriate with the desired outcomes of the case. Therefore DCS discussed holding meetings with providers to identify the challenges of being certified to conduct substance abuse treatment. There is a need for Family Case Managers to know the specific information providers need on a referral to ensure the provider can guide treatment appropriately. Increasing education and expectations with DCS and providers is important in improving the quality of services for clients.

Services for mental health were another area determined to be a high need. Although services are currently in place to address this issue, the survey illustrated that services were deemed low in effectiveness. There is a need for mental health providers to address the needs of the specific client and not generic treatment goals. Psychological assessments need to be utilized to better understand the client, have individual service recommendations, and tailor the treatment goals to specific individuals. More service providers are needed in this area, particularly in Brown County where there are not enough resources to meet the needs of the population.
There is a need for providers in the area of diagnostic and evaluation services. There are providers in the area but there is not enough interest by them to contract with DCS for services. There is a need to identify the barriers for providers to contract with DCS. Providers who can provide diagnostic and evaluations need to be recruited to ensure families are being serviced appropriately and have quality evaluations.
VI. Needs Assessment Survey – Public Testimony

Each region in the state conducted a needs assessment survey of DCS Family Case Manager’s (FCM) and individuals who have knowledge and experience with child welfare services. The intent of the survey was to evaluate local service needs. Results of the survey were to be used to assist in determining the regional child welfare service needs and the appropriate service delivery mechanisms. The Department of Child Services (DCS) Local Office Directors (LOD) compiled lists of “key” respondents (refer to Section E for key informant categories). An electronic version of the survey was distributed to persons on the contact lists. The DCS FCM survey consisted of 39 questions that included both DCS funded services, as well as other community–based services not currently funded through DCS. It also included questions pertaining to the FCM position such as case load, case types, ages of children, etc. The survey for “key” community individuals consisted of 12 questions that included both DCS funded services, as well as other community-based services not currently funded through DCS. In both survey’s, respondents were asked to rate each service in terms of need, availability when needed, utilization when available, and effectiveness when utilized of the service to children and families in a particular county.

Most of the counties had many services rated 3.0 to 4.0 in terms of availability but rated 2.0 to 3.0 in service quality, which indicate an availability to the service but minimal to average quality and effectiveness.

The following services were seen as highly needed and minimally or not available:

Substance Abuse Services

Although substance abuse services were rated at “usually available” the effectiveness of the service was seen as slightly too moderately effective. Substance abuse services were seen as highly needed. There were concerns of the clinicians having the appropriate credentials to service clients, having providers to serve the juvenile population, having effective interventions with clients when they relapse and adequate aftercare services. DCS needs to evaluate if their time frames are appropriate for families struggling with addiction to account for the relapse and recovery stages.

Public Assistance

Public assistance was rated as a high need and sometimes available. The effectiveness of current services in place was seen as moderately effective. Having public assistance more readily available to families will increase their ability to self sustain and access services to better strengthen the family unit.
Mental Health Services

Putting in more individualized treatment programs, specifically for the client to ensure the clients treatment matches the client’s needs were seen as a high need. The family needs to be assessed as a whole and not just youth specific assessments. Treatment programs were viewed as a high need, sometimes available and moderately effective.

Health Services

Healthcare was seen as a high need and only available sometimes. The effectiveness was rated as moderate. Areas of concern were linking families to public healthcare, family planning services, Medicab services and medical services.

Home Based Case Management

Home based case management was ranked as a high need and although it is usually available, it is only moderately effective. The community and DCS agreed this service is needed in the community to better support, educate and strengthen the family unit. A service that produces long lasting change in a family unit and utilizes an evidence based model is what is desired. When compared to the prior process of analyzing service availability, delivery and perceived effectiveness documented in 2011, Substance Use Treatment programs appear to have more availability, but still rate as a high need and slightly effective. Mental health needs were seen as a high need and moderately effective. More client specific treatment is needed.

When compared to the prior process of analyzing service availability, delivery and perceived effectiveness documented in 2011, Substance Use Treatment Programs appear to have more availability but still rate as a high need and slightly effective. Employment/Training, child care and housing remain low availability and highly needed.
VII. Public Testimony

Public Testimony for the Child Protection Service Plan/Biennial Regional Services Strategic Plan was scheduled for November 12, 2013 at 10:00 AM. While it was advertised in each local office, at the Region 13 October 11th Regional Service Council Meeting, on the DCS website and an email to all DCS contracted providers, there was no attendees that offered any form of public testimony.
## FAMILY & CHILDREN FUND

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<th>Fiscal Region 13 Biennial SFY 2014 Budget</th>
<th>SFY 2014 Q1 Actual Spending</th>
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<td><strong>TOTAL FAMILY &amp; CHILDREN’S FUND</strong></td>
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## TOTAL CHILD WELFARE

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<th>SFY 2013 Actual Spending</th>
<th>Fiscal Region 13 Biennial SFY 2014 Budget</th>
<th>SFY 2014 Q1 Actual Spending</th>
<th>SFY 2015 Budget Forecast</th>
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<tr>
<td>Care of Wards in Foster Homes</td>
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<td><strong>TOTAL CHILD WELFARE</strong></td>
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<td><strong>$5,404,875</strong></td>
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<td><strong>$5,404,875</strong></td>
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## TOTAL PROBATION

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<th>SFY 2014 Q1 Actual Spending</th>
<th>SFY 2015 Budget Forecast</th>
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<tr>
<td>Care of Wards in Foster Homes</td>
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## OTHER FUNDING

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<td>Community Partners Services (10803)</td>
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<td><strong>Grand Total</strong></td>
<td><strong>8,797,569.80</strong></td>
<td><strong>2,205,807.71</strong></td>
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## Region 13

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<th>SFY 2012 7/1/11 to 6/30/12</th>
<th>SFY 2013: 7/1/12 to 6/30/13</th>
<th>SFY 2014-Q1 7/1/13 to 9/30/13</th>
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<td>Number of Families Served</td>
<td>Number of Families Served</td>
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<tr>
<td>Community Partners*</td>
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<td>438</td>
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<tr>
<td>Healthy Families Indiana**</td>
<td>542</td>
<td>456</td>
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<tr>
<td>Youth Services Bureau***</td>
<td>34</td>
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</table>

*Service includes those that consented to service or met needs prior to enrollment (Information & Referral)

**Service includes those with an Assessment and/or Home Visit.

***Service includes enrollment in a program in time frame.

Units of service for YSB is per client/per day, per client/per week, per client/per session, or per client/per month.

Funding, utilization and number served for Community Partners for Child Safety, Healthy Families Indiana, Youth Services Bureau, and CHAFFEE Independent Living Services are listed below. While these services benefit DCS children at a local level, the funds are distributed at a state level. As such, the figures above represent statewide not regional data.
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, Section E)
- Service effectiveness (through the needs assessment survey, Section E)
- Public perception of regional child welfare services (through public hearings, Section F)
- Practice Indicators (13-month summaries, Section G)
- Regional workgroup determination of service available/accessibility (service array tables with codes, Section H)
- 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.

<table>
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<tr>
<th>Measurable Outcome:</th>
<th>Diagnostic and Evaluation Increasing Accessibility and Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action Step</strong></td>
<td><strong>Identified Tasks</strong></td>
</tr>
<tr>
<td>1. Hold Meeting</td>
<td>Determine Barriers to contracting, Evaluate DCS Service Standard, Guidance for Quality Assessments, Increasing Accessibility and Immediacy to Services</td>
</tr>
<tr>
<td>2. Identify Education Opportunity for Referral Sources Concerning Different Testing</td>
<td>Service Coordinator, Clinical Consultant</td>
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<tr>
<td>Measurable Outcome: Substance Use Treatment Availability and Assessments</td>
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</tr>
<tr>
<td><strong>Action Step</strong></td>
<td><strong>Identified Tasks</strong></td>
</tr>
<tr>
<td>1. Hold Meeting with Providers</td>
<td>Determine Barriers to contracting, Barriers to Certification, Evaluate DCS Service Standard, Guidance for Quality Assessments, Increasing Accessibility and Immediacy to Services</td>
</tr>
<tr>
<td>2. Hold Meeting with Attorneys, FCM’s, Probation Officer’s</td>
<td>Discuss what is needed in the assessment and recommendations</td>
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<tr>
<td>3. Identify Education regarding Referral for FCM’s and Probation Officer’s</td>
<td>Increase knowledge of the Service Standard and Service Expectations</td>
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<tr>
<td>4. Define Effective and how to measure client outcomes</td>
<td>Gather feedback from meetings and develop outcome measures</td>
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</tbody>
</table>
X. Unmet Needs:

The 2013 Needs Assessment Survey identified several needs that will not be addressed or met with this biennial plan. Many of these obstacles have been known to the region and continue to be addressed as barriers through the Regional Service Council as they are able. Several unmet needs are a result of financial limitations of the community and the Department of Child Services and could not be effectively accommodated through the strategies created in the biennial plan. These needs included Public Assistance, Healthcare, Basic Needs, Life Skills and Education.