Members

Rep. Cindy Noe, Co-Chairperson
Rep. Kevin Mahan
Rep. Gail Riecken
Rep. Vanessa Summers
Sen. Travis Holdman, Co-Chairperson
Sen. Carlin Yoder
Sen. Timothy Lanane
Sen. John Broden
Anita Harden
Judge Christopher Burnham
Gloria Hood
Viola J. Taliaferro
Jean Willey Scallon
Jeff Darling
Charles Pratt
Judge Loretta Rush
David Judkins
Dave Powell
Larry Landis
Kevin Moore

DEPARTMENT OF CHILD SERVICES INTERIM STUDY COMMITTEE

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Authority: P.L. 48-2012

MEETING MINUTES[1]

Meeting Date: October 11, 2012
Meeting Time: 1:00 P.M.
Meeting Place: State House, 200 W. Washington St., House Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 4

Members Present: Rep. Cindy Noe, Co-Chairperson; Rep. Kevin Mahan; Rep. Gail Riecken; Rep. Vanessa Summers; Sen. Travis Holdman, Co-Chairperson; Sen. Carlin Yoder; Sen. Timothy Lanane; Sen. John Broden; Anita Harden; Judge Christopher Burnham; Gloria Hood; Viola J. Taliaferro; Jean Willey Scallon; Charles Pratt; Judge Loretta Rush; David Judkins; Suzanne O'Malley for Dave Powell; Larry Landis.

Members Absent: Jeff Darling; Kevin Moore.

Rep. Noe called the meeting to order at 1:10 p.m. and asked the members to introduce themselves. Rep. Noe stated that the focus of this and future meetings will be on best practices and solutions to problems identified with respect to the Department of Child Services (DCS). She stated that ongoing concerns may be

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[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

submitted according to the instructions on the agenda, but should not be included in any testimony during the meeting.

Rep. Noe informed those present that the October 25, 2012, meeting is cancelled and will be replaced by two meetings held in November. An all day meeting will occur on November 8, 2012, at which the members will discuss the issues and plan recommendations, and an additional meeting on November 27, 2012, at which the final report and proposed legislation will be considered.

There was general discussion among the members, including:

(1) CHINS 6 and involuntary confinement issues were not included in this Committee's interim assignments, but were assigned to the Commission on Mental Health and Addiction (CMHA). Members of both committees were invited to both committee's meetings. Rep. Noe, who chairs the CMHA, will take information obtained from this Committee concerning these issues to the CMHA for consideration in making the CMHA's final recommendations.
(2) If CHINS 6 cases are screened out, it becomes a call center issue, which is assigned to this Committee.
(3) Not all CHINS 6 cases involve mental illness so children involved in those cases should not all be characterized as having a mental illness.
(4) DCS is personally notifying the managers of all DCS local offices that community professionals may directly report allegations of child abuse or neglect to the local offices.
(5) Expiring DCS/provider contracts will be entered into for two year terms with optional two year extensions. Each of those contracts has an early termination clause which would apply if a new administration needed to terminate a contract before the end of a term.
(6) Rep. Riecken's list[2] of issues for discussion at the November 8, 2012, meeting.
(7) Judge Taliafero's recommendations[3] for discussion at the November 8, 2012, meeting.

Report from the Attorney General

Greg Zoeller, Indiana Attorney General, provided a copy[4] of his remarks. He discussed the provision of legal services by the Attorney General's office with a focus on the best interest of children. Mr. Zoeller reported that the Attorney General's office would be assuming the DCS appellate practice, which is consistent with the practice of many other states' attorneys general. Mr. Zoeller described the functions of the Attorney General's office, which functions at the direction of the General Assembly as a statutorily created office.

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[2]Attachment 1.

[3]Attachment 2.

[4]Attachment 3.

Best Practices

David Sanders, Casey Family Programs, provided a handout[5] of a slide presentation containing information about:

(1) DCS policies and functions in relation to state and federal law and policies;
(2) outcomes data;
(3) possible strategies to improve outcomes; and
(4) the centralized call center in comparison to other states.

Dr. Sanders noted that there has been objective improvement in outcomes in Indiana over the past several years, and emphasized that Indiana policymakers and administrators must ask themselves:

(1) whether they are satisfied with current outcomes;
(2) with what outcomes they are dissatisfied; and
(3) how to improve the outcomes with which they are dissatisfied.

Dr. Sanders noted that federal child welfare policy prefers relative care over other types of care and that 29 states currently have centralized call centers.

In response to questions from Ms. Scallon, Sen. Holdman, Sen. Lanane, Judge Pratt, Ms. Hood, Rep. Riecken, Judge Burnham, Rep. Summers, Rep. Mahan, and Rep. Noe, Dr. Sanders stated that:

(1) "Short term" care is generally defined as nine months or less.
(2) A broad spectrum of services is needed, rather than simple follow up, after a child is returned to home.
(3) Indiana has lost many home based providers because the providers were not paid adequately, which will be a problem if Indiana now realizes those providers are necessary to providing appropriate care.
(4) Other states have implemented a "hybrid" call center in which the general public reports to a centralized hotline and community professionals report to local child welfare offices. Dr. Sanders agreed to send information concerning those states' call center experiences.
(5) He will provide information concerning five states represented in his presentation that have a centralized call center and use a "hybrid" reporting system.
(6) States began using centralized call centers in 2002.
(7) Consistent definitions of terminology used in research (such as "substantiated") are necessary to accurately compare state data.
(8) Reporting alleged child abuse or neglect to more than one agency is not uncommon in other states.
(9) Casey Family Programs and Annie Casey Foundation are separate organizations with the same founder.

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[5]Attachment 4.

(10) Surveys have been performed nationally to measure time frames for Medicaid reimbursement to providers.
(11) He will provide information from national surveys of child welfare employee compensation levels.

In response to questions from the members, Mr. Judkins informed the other members that:

(1) the current screenout rate for the centralized call center is 22%, which is decreased from a percentage in the upper 30s approximately seven months ago;
(2) the decrease may be attributed to a new screenout tool; and
(3) the screenout rate in 2005 is unknown because the old system expunged information after a certain period.

Susan Dreyfus, Alliance for Children and Families, provided a copy[6] of her testimony. She emphasized the importance of clear state policy concerning the goal of the child welfare system before making decisions about changing the system. She stated that child protection and intervention is the government's only child welfare job, with private individuals and organizations having earlier roles in child welfare. She explained that government intervention for child abuse or neglect generally occurs very late in a child's life of abuse or neglect. Ms. Dreyfus stated that DCS should not be the sole agency to care for mental health issues of children because DCS does not possess that particular expertise.

Paul Vincent, Child Welfare Policy and Practice Group, discussed his experience establishing a child welfare program based on best practices in a specific practice model, such as the one Indiana has adopted. He described the use of practice models across the country and the success achieved when individualized family needs are addressed. He explained that such individualized plans made with family input cause the family to be more committed to making the changes that the child welfare plan is intended to accomplish, which results in more sustained change. Mr. Vincent noted that this individualized approach sometimes requires that new provider expertise be obtained, which may be difficult in the beginning. He stated that Indiana has experienced cultural and outcome changes since the current system was implemented in 2006.

In response to a statement from Judge Pratt, Mr. Vincent agreed that family team meetings must be conducted with a multidisciplinary group, not just a parent and a case manager, present to achieve an appropriate plan including the broad services that are necessary.

Michael Patchner, Indiana University School of Social Work, discussed his chairmanship of the 2003-2004 Commission on Abused and Neglected Children and Their Families and compared Indiana's child welfare status at that time and currently. He described the Commission's recommendations and the changes that were made by the current administration with the establishment of DCS, including

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[6]Attachment 5.

its use of a practice model.

In response to a question from Ms. Harden, Mr. Patchner stated that child fatalities are not an indicator of child services quality because the data does not support drawing such a conclusion (in 2003 there were 51 fatalities in Indiana due to child abuse or neglect, 11 of which were children with a prior substantiated instance of child abuse or neglect; in 2010 there were less than half the number of fatalities that had occurred in 2003 in Indiana due to child abuse or neglect, 4 of which were children with a prior substantiated instance of child abuse or neglect). Mr. Patchner expressed his belief that prevention of child abuse, neglect, and fatality is a collective community responsibility that is accomplished by creating an environment in which people have necessities such as housing, health care, employment, food, addiction services, transportation, etc. Such an environment allows parents to provide proper care of their children and thereby decreases child abuse and neglect. He stated that the needs are beyond the scope of the parenting skills that may be taught through DCS.

Public Testimony Concerning Best Practices and Solutions to Identified DCS Issues

Rep. Noe emphasized that testimony should be limited to suggestions for solutions to identified problems at DCS.

Mary Ann Halbert, National Alliance on Mental Illness, provided a set of handouts[7] concerning crisis intervention teams for youth with mental illnesses and discussed their use with law enforcement and schools.

JauNae Hanger, Indiana Juvenile Mental Health Screening, Assessment, and Treatment Project, provided a handout[8] related to her testimony concerning possible actions to meet the mental health needs of children in Indiana.

Krista Davis, Safe Families, provided a handout[9] and described her volunteer organization through which parents may voluntarily place their children with volunteer crisis homes during a time of emergency. She noted that background checks of the volunteer families are performed as is done with foster families, and the families (who receive no compensation) provide respite care for the children. She explained that the families develop an ongoing relationship with the parents of the child and become an ongoing resource for the child's family. Ms. Davis stated that Safe Families is operating in Marion County and several other counties in Indiana and receives referrals from DCS, churches, hospitals, and others.

Gary Russell described his personal history of abuse and his search for his own

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[7]Attachment 6.

[8]Attachment 7.

[9]Attachment 8.

child welfare case file, which has not been found. He suggested that after care is needed.

Doug McIntosh, Family Advocacy Group, stated that he has been representing families in their interactions with DCS since 2004. He stated that additional laws or policies are not necessary, but that laws and policies should be followed consistently and logically.

In response to a question from Rep. Summers, Mr. McIntosh stated that a federal investigation into DCS should be conducted outside Indiana.

Nancy Hemphill provided a copy[10] of her testimony and suggested formation of an oversight committee (with public access) to review and guide changes to DCS, and standardization of DCS practices from county to county.

In response to a question from Rep. Riecken, Ms. Hemphill stated that she was unaware that she could speak with the DCS Ombudsman about her own family's situation.

Georgia Kasting, grandparent, provided written testimony[11] and discussed her grandchildren's situation with DCS and stated that children should not be removed unless there is abuse or neglect.

Sheryl Canon Hill described a family accused of child abuse, which resulted in a happy family becoming "broken". She suggested that someone should have specifically been assigned to the child, and that families accused of child abuse or neglect need counseling.

Gina Andrew, parent, provided written testimony[12] and suggested that:

(1) enforcement of court orders needs to occur;
(2) DCS and law enforcement need access to civil court orders;
(3) DCS policy should include investigating the family history in child abuse or neglect cases;
(4) "indicated" should be an alternative category to "substantiated" and "unsubstantiated" so children don't become lost in the system;
(5) DCS should be required to verify information obtained from a suspected abuser; and
(6) one person in the Ombudsman office is insufficient to cover the entire state.

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[10]Attachment 9.

[11]Attachment 10.

[12]Attachment 11.

Additional testimony was submitted in written form[13] by individuals not present at the meeting.

Followup from Previous Meetings

Rep. Noe requested that Mr. Judkins briefly comment on the followup information[14] that he provided to the members based on requests made by the members during the last Committee meeting. Rep. Noe noted that the members would have time to discuss the information at the meeting held on November 8, 2012. Mr. Judkins called the members' attention to a phone question tool and a structured decision making tool, both of which are used by centralized call center personnel.

In response to questions from Ms. O'Malley, Mr. Judkins stated that screening determinations are made at the central call center, the information from each call is then sent to the appropriate local office, and the local office contacts law enforcement, if necessary. Mr. Judkins noted that screen outs are sent daily to local offices and that central call center personnel do not contact local law enforcement.

Other Business

Rep. Riecken informed those present of a town hall meeting concerning DCS issues that was to be held in Evansville on October 15, 2012.

Rep. Noe stated that further information would be forthcoming concerning the November 8, 2012, meeting.

With no further business to discuss, Rep. Noe adjourned the meeting at 5:00 p.m.

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[13]Attachments 12 through 24.

[14] Attachments 25 through 29.

INDIANA HOUSE DEMOCRATIC CAUCUS

Summary Issues Provided in Testimony, written and oral, to Improve DCS

- **STRENGTHENING THE CHILD ABUSE HOTLINE THROUGH LOCAL CONTROL**
  - Return to a county-based hotline that includes direct involvement of local family case managers and local law enforcement.
  - Review and possibly revise the definition of child abuse and neglect and DCS policies to evaluate how they have affected the increase in children being screened out by hotline staff.
- **EMPHASIZING DCS STAFF TRAINING**
  - Require DCS, by the end of 2014, to provide cultural competency training to all staff.
  - Require training to restrain an environment of fear and intimidation in the workplace.
- **PROMOTING THE SHARING OF INFORMATION WITH THE COURT SYSTEM**
  - Require that the courts be presented information about any previous CHINS involvement when a visitation or guardianship change is requested regarding a child.
  - Require DCS do a written follow up on all closed CHINS cases 6 months after closure.
- **MORE LOCAL INVOLVEMENT WILL LEAD TO BETTER CHILD PROTECTION**
  - Strengthen DCS relationships with communities through multi-disciplinary Child Welfare Advisory committees, including participation of community activists, to review the performance of the local/regional welfare offices.
- **RESTORE TRUST IN DCS WITH AUDITS & INTERNAL PROCEDURE CHANGE**
  - Quality Service Reviews must be required and outcome measurements should be comprehensive (larger, more representative sample) on all DCS functions as they are required with individual facilities and report to the General Assembly the results.

- Establish an ongoing audit commission for the DCS to renew agency credibility.

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INDIANA GENERAL ASSEMBLY'S INTERIM STUDY COMMITTEE ON THE INDIANA DEPARTMENT OF CHLD SERVICES

RECOMMENDATIONS FROM JUDGE VIOLA TALIAFERRO – DRAFT PROPOSAL

The following are recommendations to the General Assembly's Interim Study Committee on the Indiana Department of Child Services based on information provided by judges, prosecutors, law enforcement personnel, Court Appointed Special Advocates, and the general public:

1. The Indiana Gen. assembly should create a standing committee to review the performance of the Indiana Department of Child Services.

   By law, Indiana courts can only order services for which DCS has contracted. This grants DCS tremendous power. By granting or withholding contracts, DCS determines what services are available for our children. In effect, House Bill 1001 created a de facto statewide system of child services shaped and administered solely by the DCS.

   The creation of a statewide system of juvenile services requires meaningful public input from courts, service providers, and experts on the best practices available for the treatment of juveniles and their families. This is not happening. DCS's internal functions are incredibly opaque. DCS routinely announces the implementation of new policies, budget cuts, and service cuts without meaningful public input from courts, professionals, and service providers.

   This policy of DCS secrecy has unintended negative consequences. For instance, problems with the Call Center have only recently surfaced after law enforcement officials and the general public made their dissatisfaction known. Clarity, openness, and an independent review would go a long way toward instilling confidence in the screening process.

   The creation of a standing committee to review the performance of the Indiana Department of Child Services would provide, in some measure, a public forum for the discussion of our statewide system of child services.

2. DCS should be required to enforce Indiana Code 31-34-1-6.

   Indiana Code 31-34-1-6 provides that a child is a Child in Need of Services if the child substantially endangers the child's own health or the health of another individual, and the child needs care treatment or rehabilitation that the child is not receiving and that is unlikely to be provided or accepted without the coercive intervention the court. This is sometimes referred to as the "CHINS 6" category.

DCS has unilaterally decided that it will not enforce this provision. DCS's refusal to initiate CHINS proceedings for children who are a danger to themselves or others denies services to some of our most vulnerable young people. All too often, these children are being charged as delinquents children. Frustrated prosecutors often feel they have no recourse if the children are to obtain necessary services. Relatively young children are being adjudicated as "delinquents."

The Legislature may also wish to consider alternative proposals, such as Judge Pratt's, designed to ensure that children's needs are addressed in the appropriate court.

3. Children should be allowed to stay in emergency shelter care for up to 30 days.

   Recent legislation limiting stays in local youth shelters, championed by the DCS, has created an administrative nightmare. Historically, Monroe County has chosen shelter care over secure detention whenever possible. However, the 20 day limit simply does not provide sufficient time for attorneys to be appointed, discovery to be completed, and cases to be adjudicated. Often, prior to the fact-finding hearing, the Court is asked to move children out of shelter care without adequate alternatives. At a minimum, an additional 10 days would allow for completion of the adjudicatory process in most cases.

   Also, the legislation does not differentiate between youth shelters offering counseling services and those offering few or no services. Monroe County has experienced counselors on staff. These counselors work with the children and their families. They interface with our schools and local service providers to ensure that the children are receiving appropriate services. The time children spend in the Monroe County Youth shelter is spent productively. Arbitrary time limitations on length of stay are not in the best interest of the children.

4. The Call Center:

5. Salaries for DCS attorneys should be increased to a market rate.

   Salaries for DCS attorneys are generally not sufficient for DCS to hire experienced litigators. Thus, DCS tends to hire relatively inexperienced attorneys. Once the attorneys have gained sufficient trial experience, they often leave for higher paying jobs. Two of the public defenders in Monroe County are former DCS attorneys.

CSIC

Attorney General Greg Zoeller's Remarks to the DCS Interim Study Committee
1:00 p.m., October 11, 2012

Good afternoon, Madame Co-Chair and Mr. Chairman and members of the committee, thank you for providing me the opportunity to address you today on this very sensitive and important issue of child safety and government oversight.

There has been much debate and discussion, both public and private, over the past few months on the progress Indiana's Department of Child Services is making in the lives of the children it serves.

Last month I addressed several of you in front of the Commission on Mental Health and Addiction on this very matter – protecting children – and the role that the attorney general's office could play as you consider various options to enhance and build upon Indiana's past efforts in child protection.

One thing we covered was the ongoing discussions and development of the Attorney General's Office resuming the representation of appellate cases from DCS. As you know, the Attorney General's Office provides lawyers who represent most other state agencies. But when DCS was carved out as a separate agency in 2005, it was permitted to

utilize its own lawyers for most legal work. We continue to have a dialogue with Director Ryan to work through the details to most effectively transition the representation of appellate court cases from DCS attorneys over to Deputy Attorney Generals, while also ensuring the expertise in CHINS and other child welfare law is not lost in this process. DCS attorneys still handle trial court representation but my office always stands ready to assist, if needed.

I've specifically canvassed my attorney general colleagues in other states and discovered that many of their offices provide a full menu of legal services to their states' child services agencies. This allows for a more cohesive and uniform approach to the state's legal strategy and harmonizes a state's legal strategy throughout the years. This may have some value to you as consider and study the best practices of Indiana's Department of Child Services.

We will continue to work with you and DCS to consider Indiana's best legal approach for DCS, and if you envision some different approach or broader role, we are open to that which could include resuming all of the agency's legal work from the trial level upward.

I am not making a specific recommendation today, but I am careful to seek legislators' ideas and input before offering new proposals. I have spoken to leadership and some of

you over the past few months with some specific ideas and have sought more input on these matters.

At the Commission on Mental Health hearing, I spoke directly about CHINS cases – specifically those cases where the child is endangering his/her own health or the health of another person. As the state's chief legal officer, I am an advocate of the criminal justice system triad – Prosecutors, police officers and the judiciary. My office handles approximately 1600 criminal appeals a year that support the work of the judicial system, keeping criminals behind bars.

We are in communication with prosecutors on a daily basis providing legal support and analysis when needed as well as defending their actions before appellate and supreme court judges.

I often hear from prosecutors about the need for independent review of some CHINS 6 cases when conflict arises between a prosecutor and DCS over the path certain cases involving juveniles should take.

Additionally, we have been in communication with DCS regarding legal representation, case-processing procedures, and CHINS 6 matters in an effort to find solutions consistent with our shared commitment to protect children.

The proposals being discussed by DCS should serve to improve the communication and screening functions regarding situations where children suffering from mental health and addiction issues may be in need of mental health services. Furthermore, the Attorney General's Office is uniquely situated to work with and defend both prosecutors and DCS in the normal course of our daily responsibilities.

Our shouldering of the responsibility of DCS appellate work will allow us to provide some objective, independent guidance as the CHINS process moves forward. It will allow us to be more engaged with DCS attorneys representing the state at the local level. I wanted to take this opportunity to let you know I am willing and able to have the Attorney General's Office play any appropriate role you believe would be most helpful.

In addition, the Attorney General's Office can serve to coordinate other areas of our state's efforts to protect children. I have created within the office the "Child Protection Services Working Group". This internal group of staff is exploring ways to work with other agencies and stakeholders to enhance Indiana's work protecting children across a variety of areas.

Those areas include the Indiana's Internet Crimes Against Children (ICAC) task force -- assisting law enforcement's efforts to go after online child predators – and continued efforts in partnership with the U.S. Attorney in combating human trafficking that preys upon runaway young girls. I am also working with the Department of Correction and the Indiana Sheriff's Association on ways that could improve the effectiveness of our Sex Offender Registry. Finally, I continue to seek greater state support for School Resource Officers who provide both security in our schools while also helping to develop stronger relationships between law enforcement and our youth.

All of this requires working with you and your colleagues, other government agencies and advocates to develop specific roles for the OAG.

The past years of success in performing duties as authorized by the Legislature have developed some credibility among stakeholders and hopefully the public.

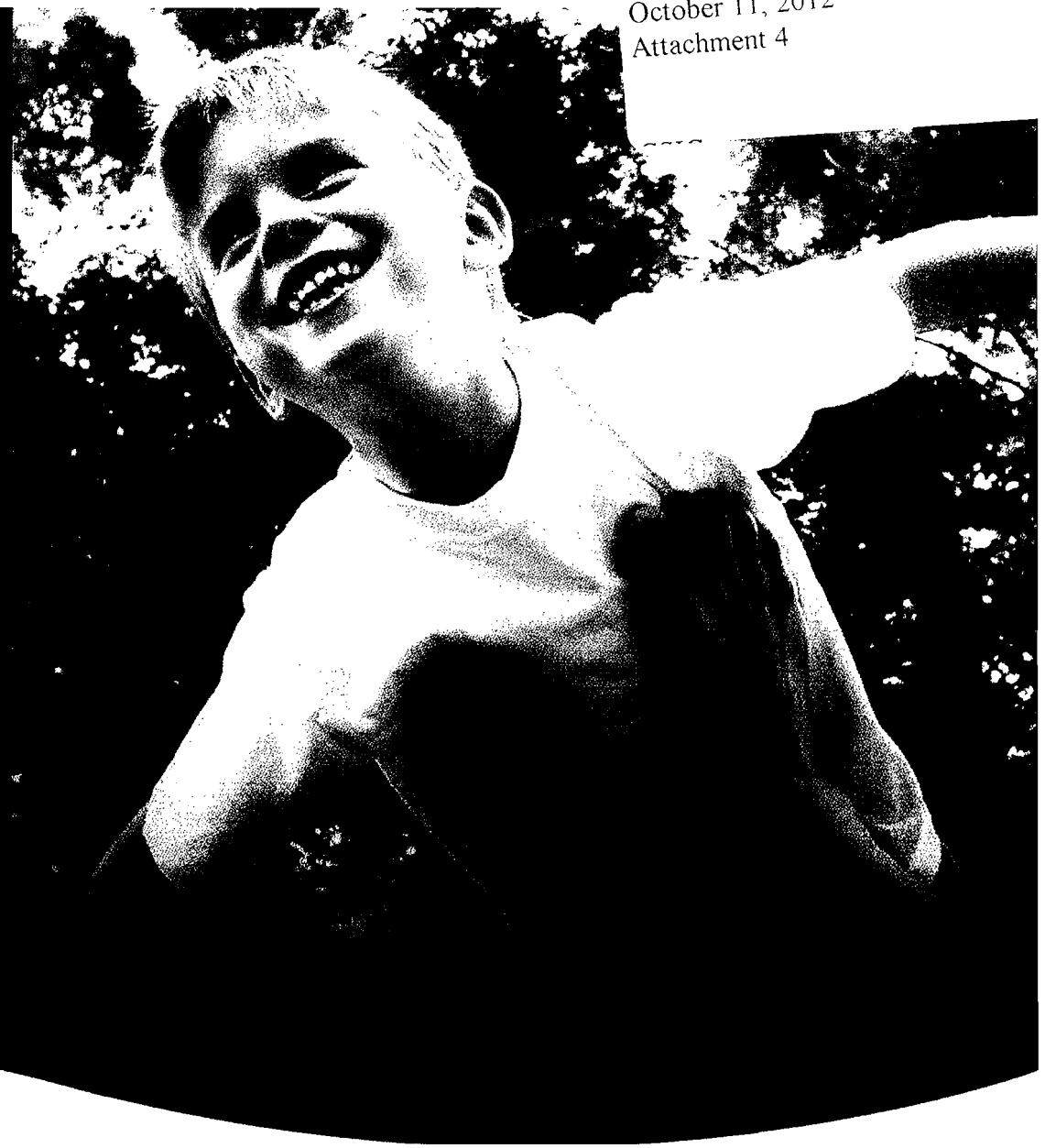
Thank you for your support and in seeking to learn more about the issue. I look forward to a continued dialogue on legal representation in child protection cases as well as on the topic presented today.

Thank you

Indiana Assembly Department of Child Services Interim Study Committee

October 11, 2012

David Sanders
Executive Vice President, Casey Family Programs



casey family programs
fostering families. fostering change.

Casey Family Programs: Investment in Support of IN DCS, 2008-2013

2008	$46,271
2009	$119,364
2010	$269,634
2011	$654,558
2012	$730,052
2013 (proposed)	$730,000
Total	**$2,549,879**

Overview of the Child Welfare System:

Assuring Child Safety, Permanence, and Well-Being

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Mission of the Public Child Protection System

- **Safety**: Children are protected from harm
- **Permanence**: Children are able to develop life-long connections to adults who love and care for them
- **Well-being**: Children are supported in attaining optimal cognitive, physical / developmental, behavioral / emotional, and social functioning.

Overview of Child Welfare

Federal and state child protection/child welfare policies focus on:

- The response to reports of child abuse and neglect by parents or other caregivers
- Services to families that need assistance in the protection and care of their children
- Arrangements for children to live with kin or with foster families when they are not safe at home
- Reunification, adoption, or other permanent family connections for children leaving foster care

Approach to Child Welfare Systems Improvements

- Use data, research and stakeholders' perspectives to examine current outcomes.
- Identify and implement effective strategies to utilize in improving desired outcomes.
- Implement strategically - work in partnership across the three branches of governments to achieve desired outcomes.

DCS Outcomes Data

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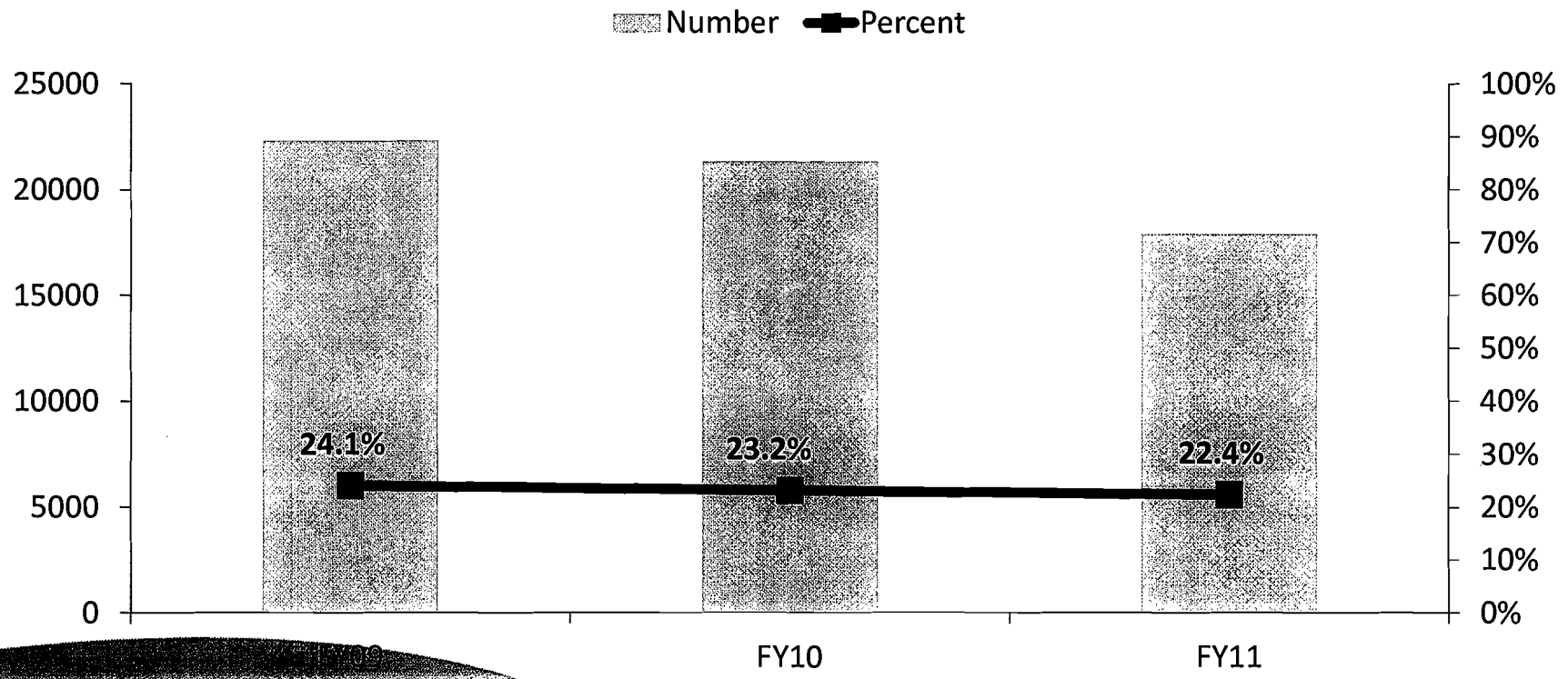
Decline in # and % of children substantiated following an investigation

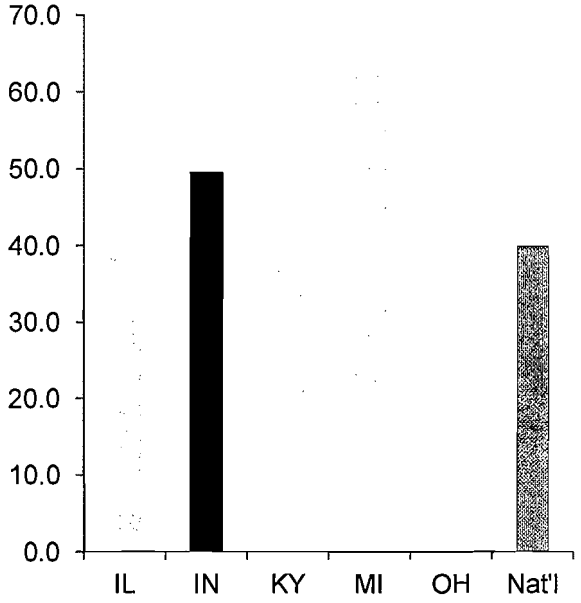
Number and Percent of Indiana Children Determined to be Victims following an Investigation



Data throughout slides from AFCARS, NCANDS, and IN's CFSR Data Profile

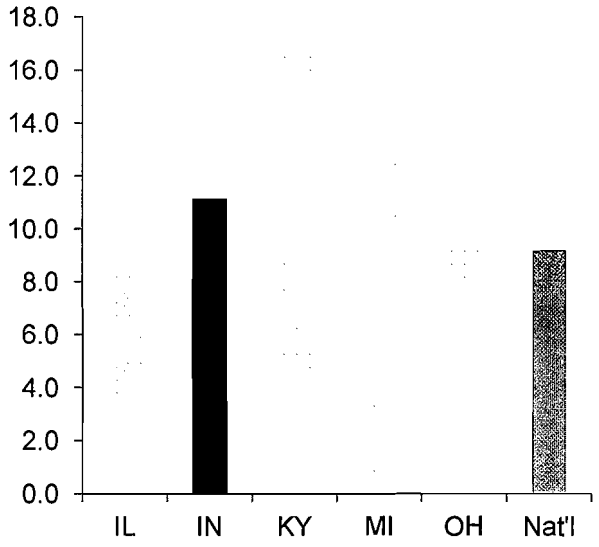
IN is about average on front end measures when compared to neighboring states

Rate of children involved in CPS investigation



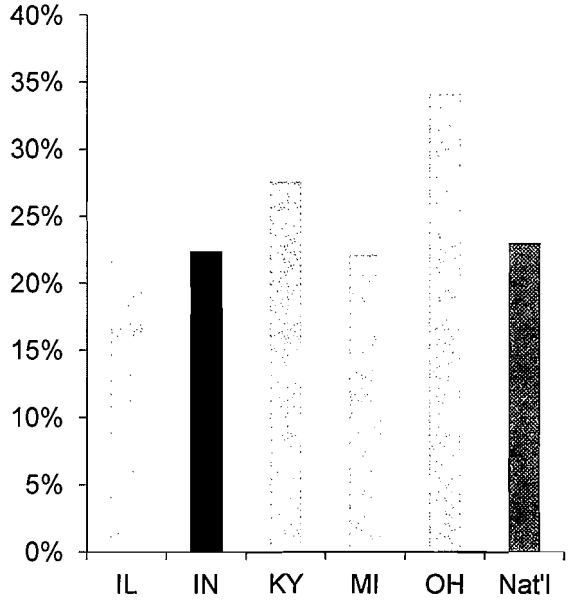
IN has a higher than average rate of children involved in investigations…

Rate of children determined to be victims



and a higher than average rate of children determined to be victims of maltreatment.

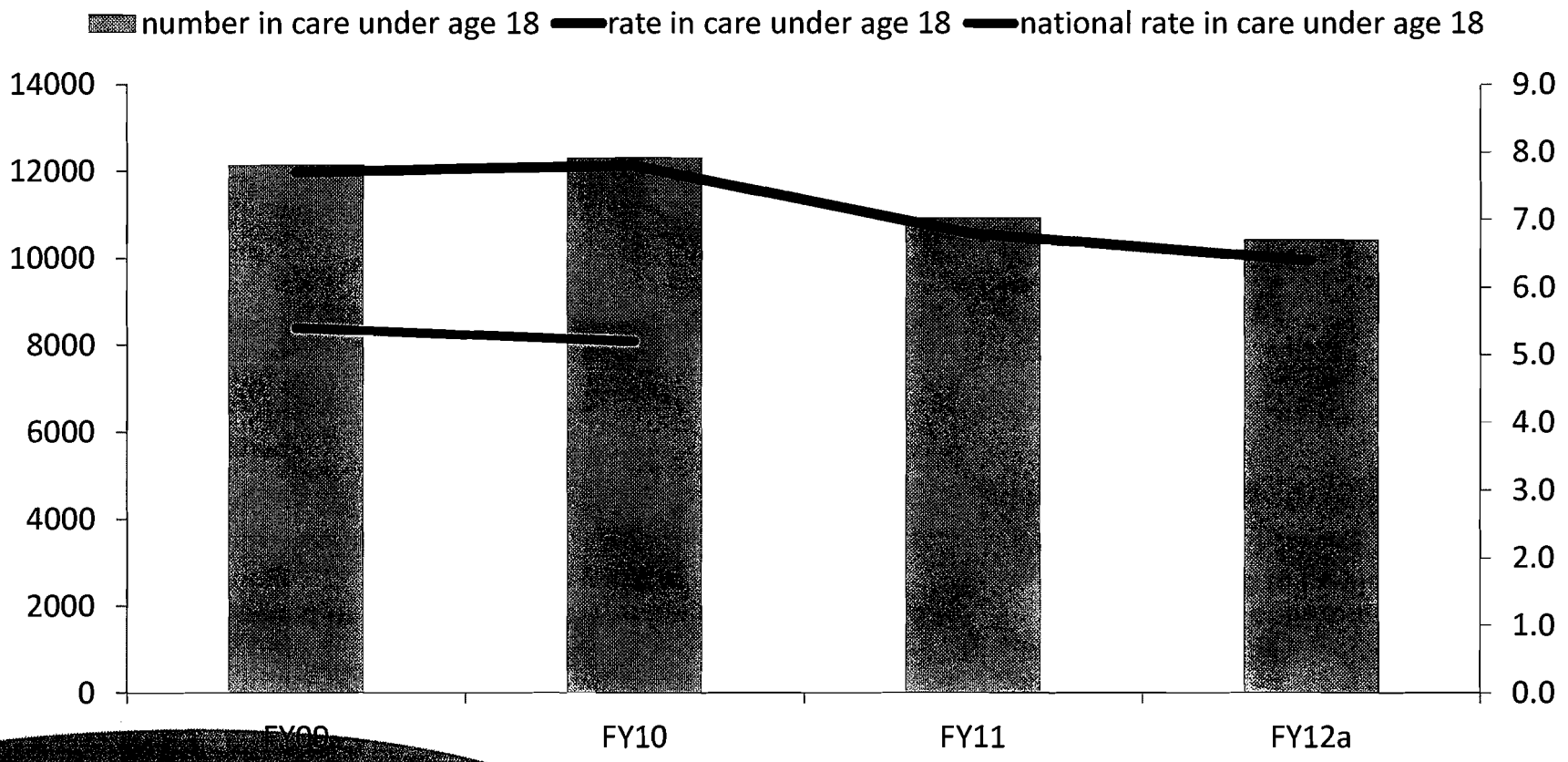
Percent of children determined to be victims



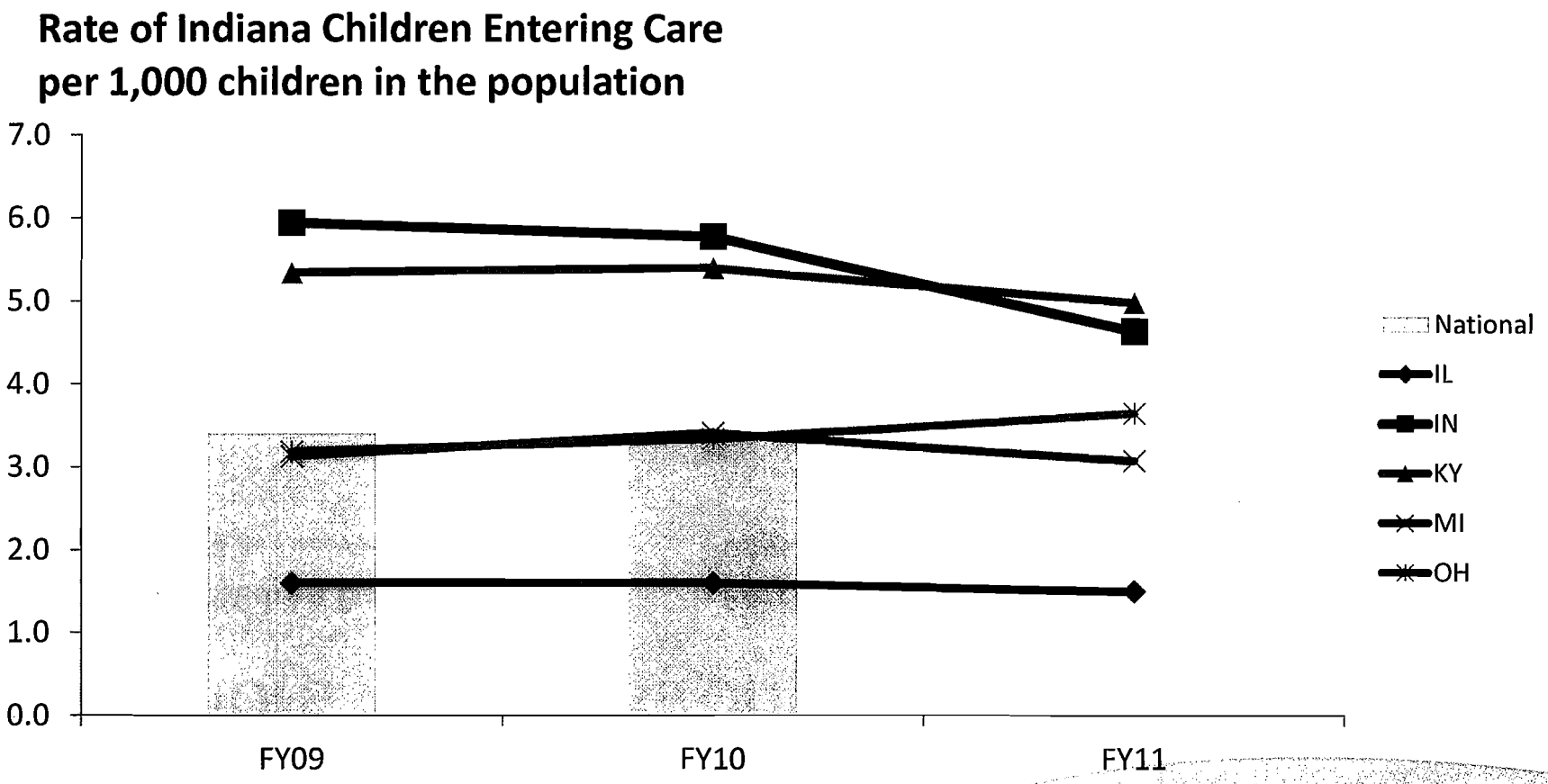
BUT, a lower than average <u>percent</u> of children investigated are determined to be victims.

Source: NCANDS, data presented as unique counts of children; data for IN is 2011, for all other states data is 2010
Note: Rates are calculated per 1,000 children under 18 in the general population.

Steady reduction in the number of Indiana children in care since FY10

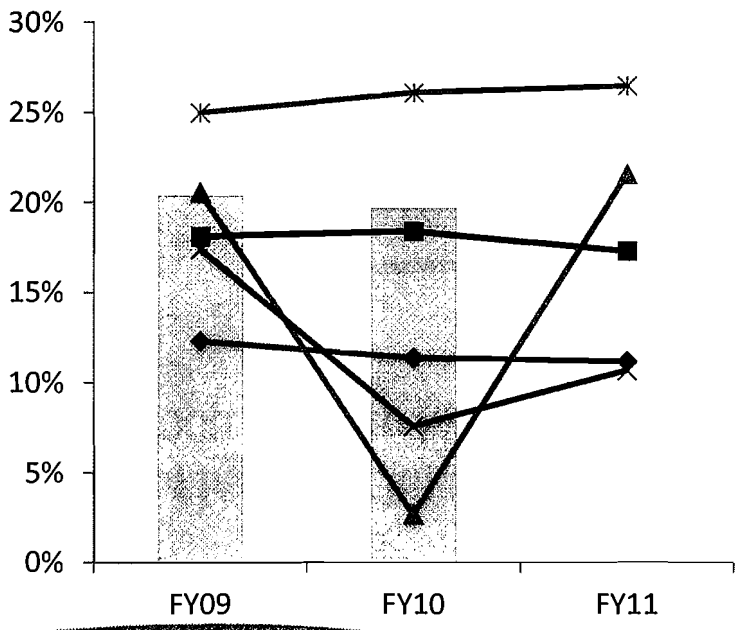


Most of the reduction attributable to decline in children entering care

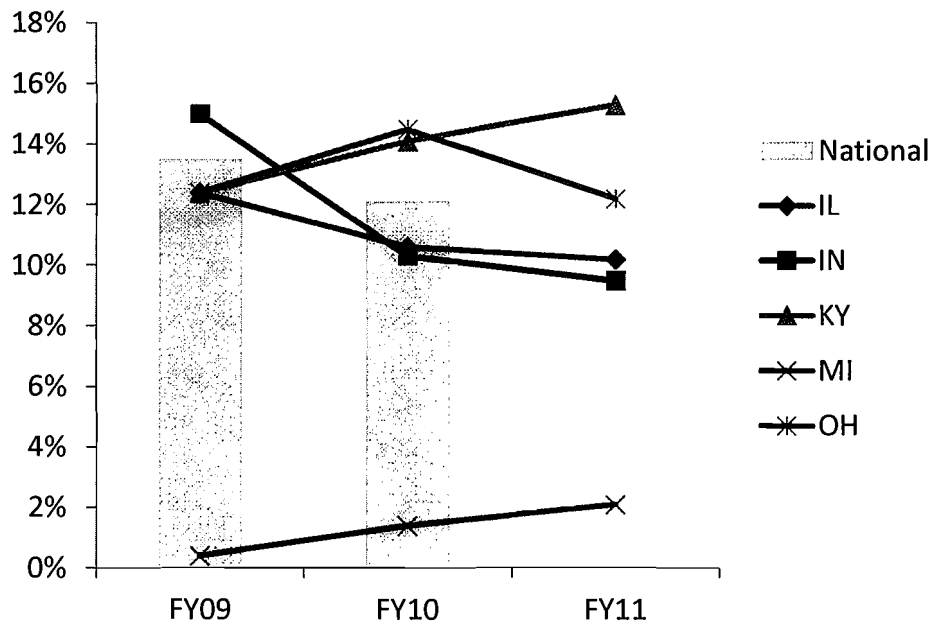


During this time of front end reduction, key indicators remain strong

Percent of Children Entering Care as a Re-Entry *(for a second or subsequent time)*

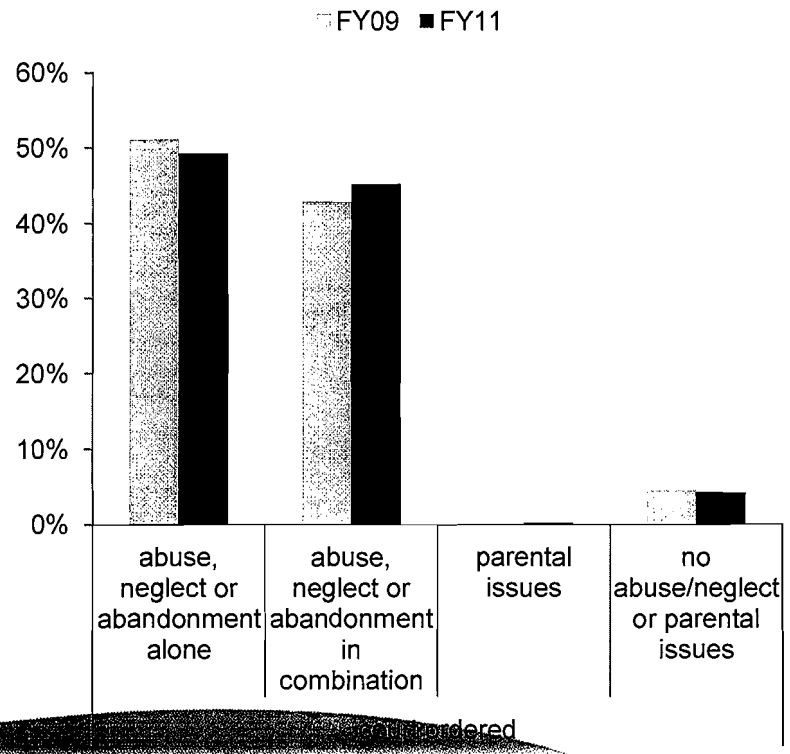


Percent of Children who Exit within 30 days of entry



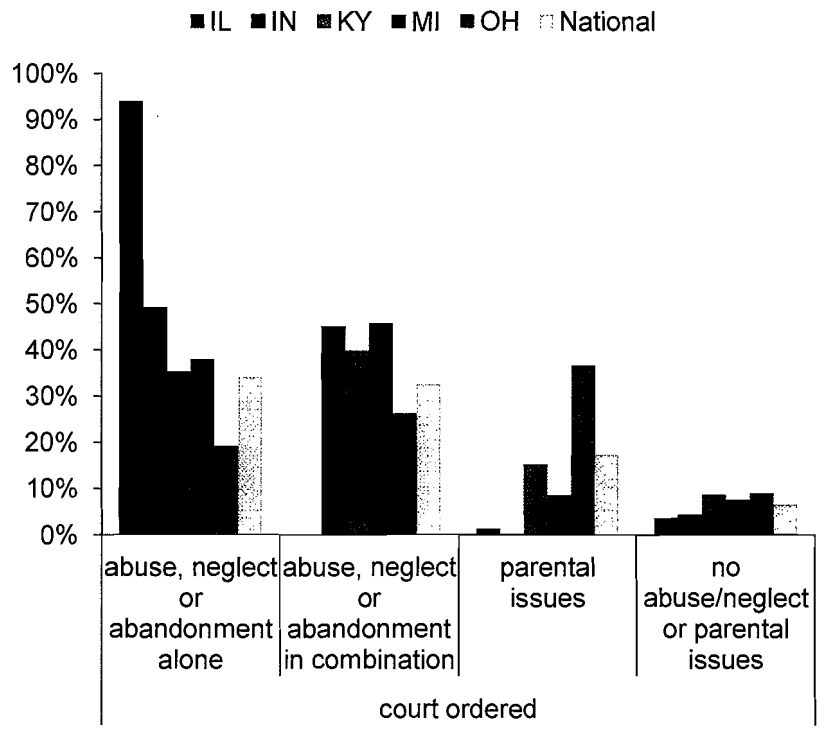
Only slight fluctuations in the reasons children enter care

Reasons Children Enter Care in Indiana



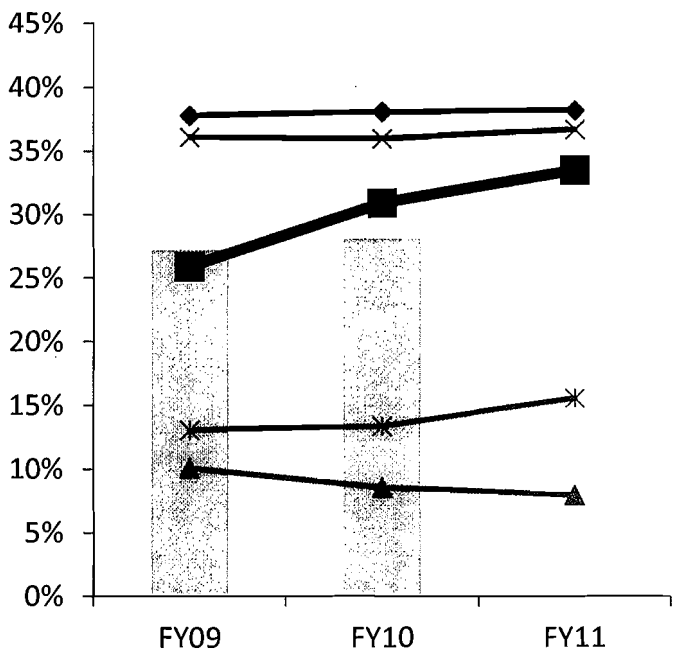
Reasons Children Enter Care

(FY11 state data; FY10 national data)

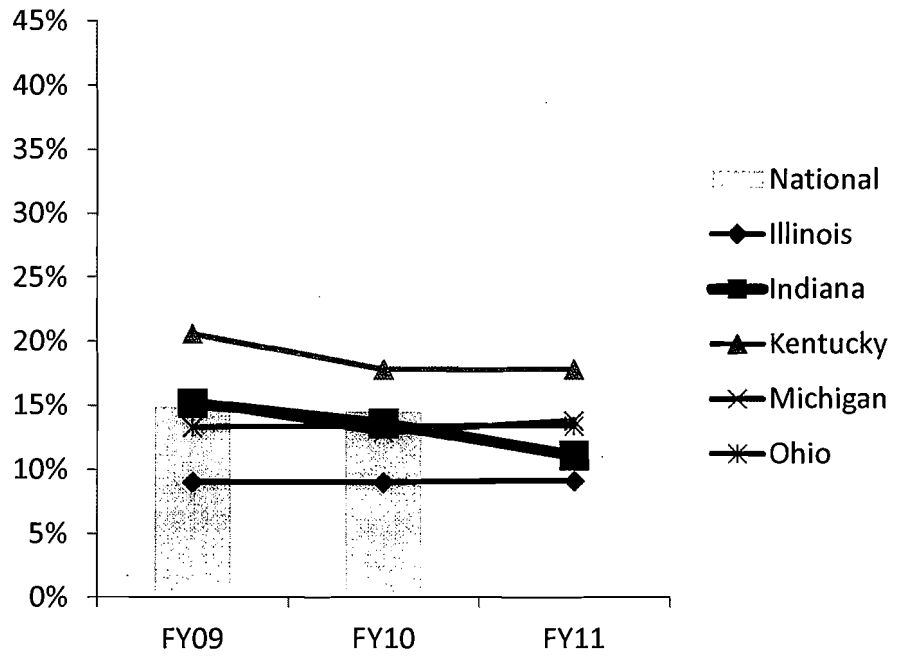


Significant increase in kinship care placements, and decline in congregate care

Percent of Children In Kinship Care

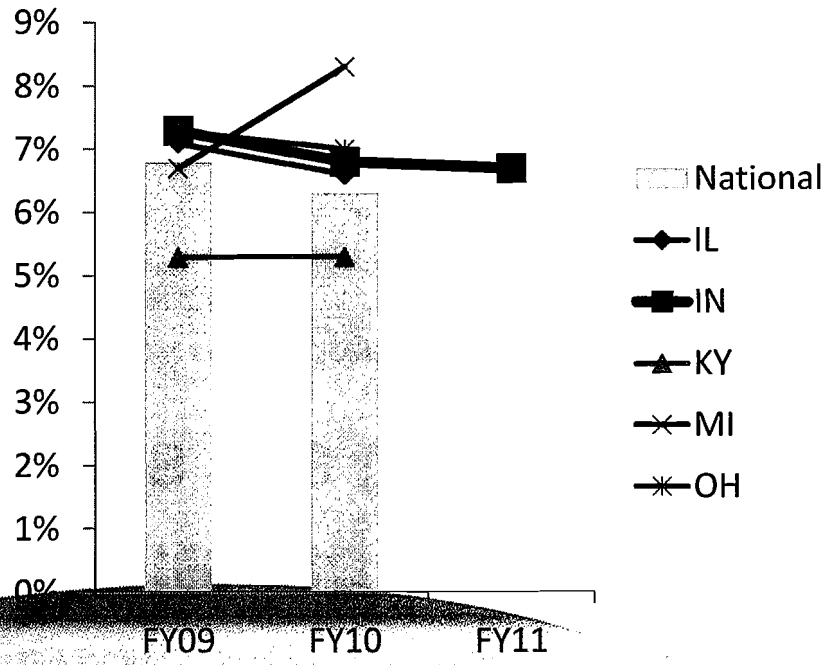


Percent of Children In Congregate Care



Key indicators of safety are stable, both for kids who stay home and those in care

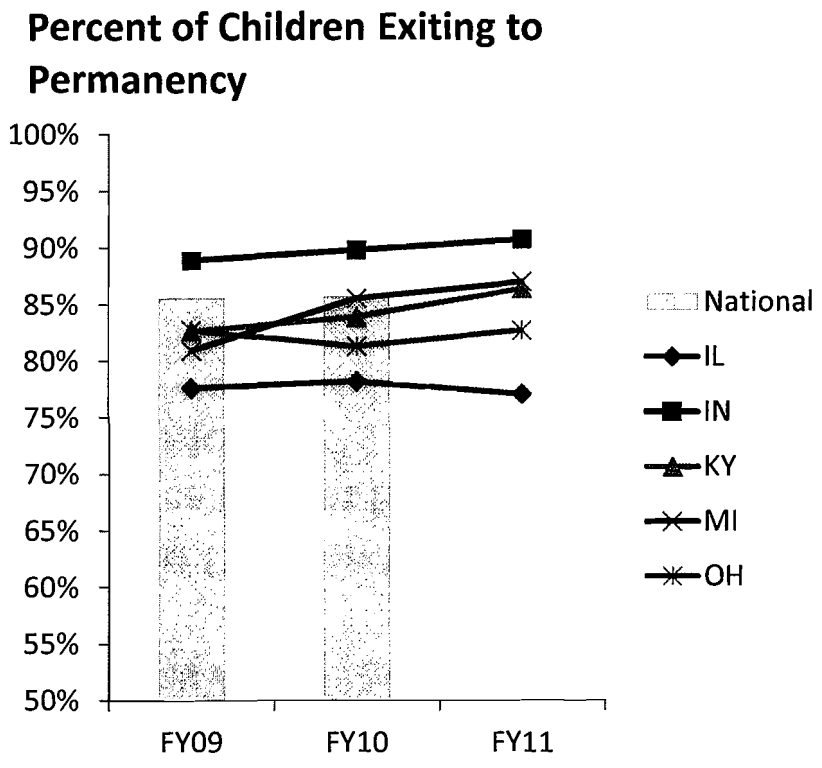
Percent of Children Who Experience Repeat Maltreatment within 6 Months

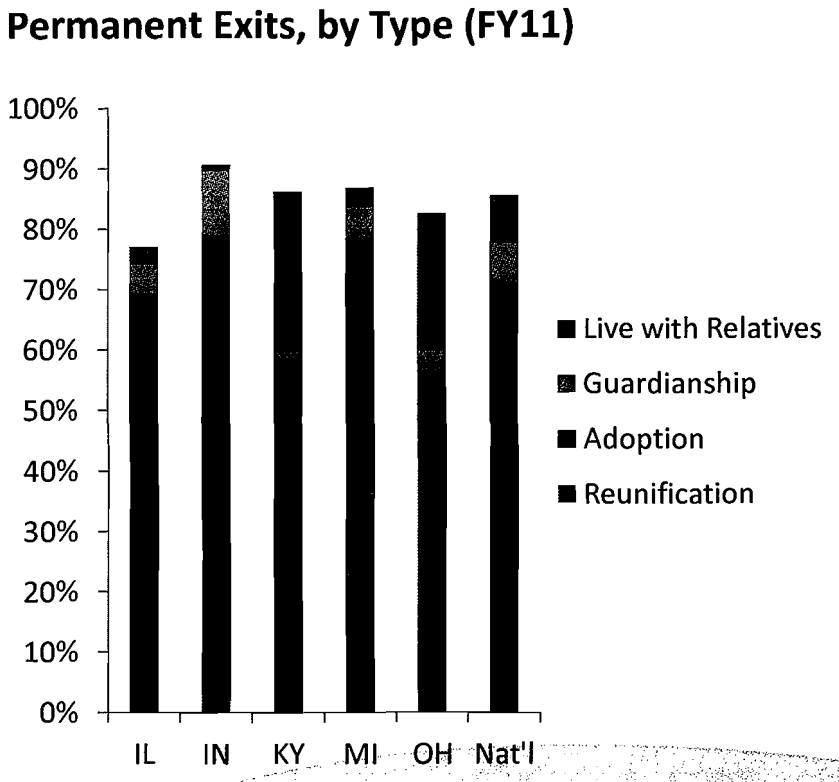


Absence of Maltreatment in Foster Care

	FY09	FY10	FY11
IL	99.4%	99.4%	
IN	**99.6%**	**99.6%**	**99.8%**
KY	99.6%	99.5%	
MI	99.3%	99.1%	
OH	99.6%	99.6%	
National	**99.5%**	**99.5%**	

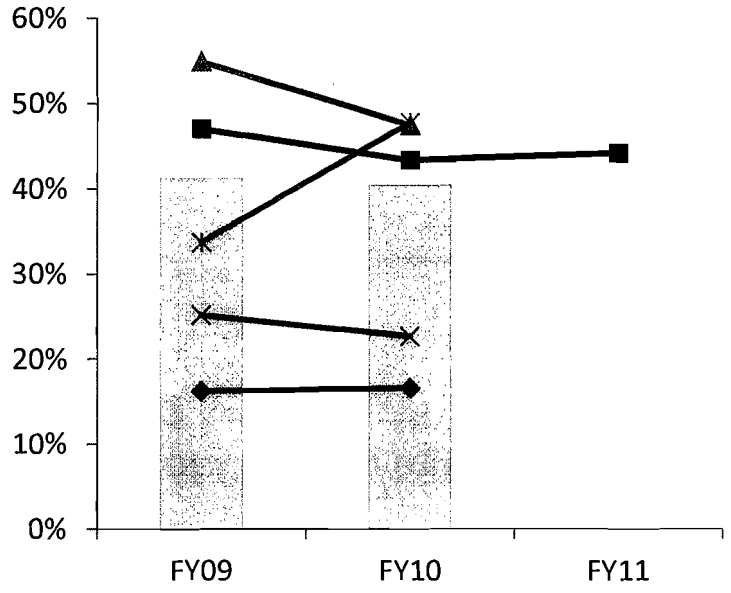
High and increasing percentage of children achieving permanency, and most permanent exits are to reunification



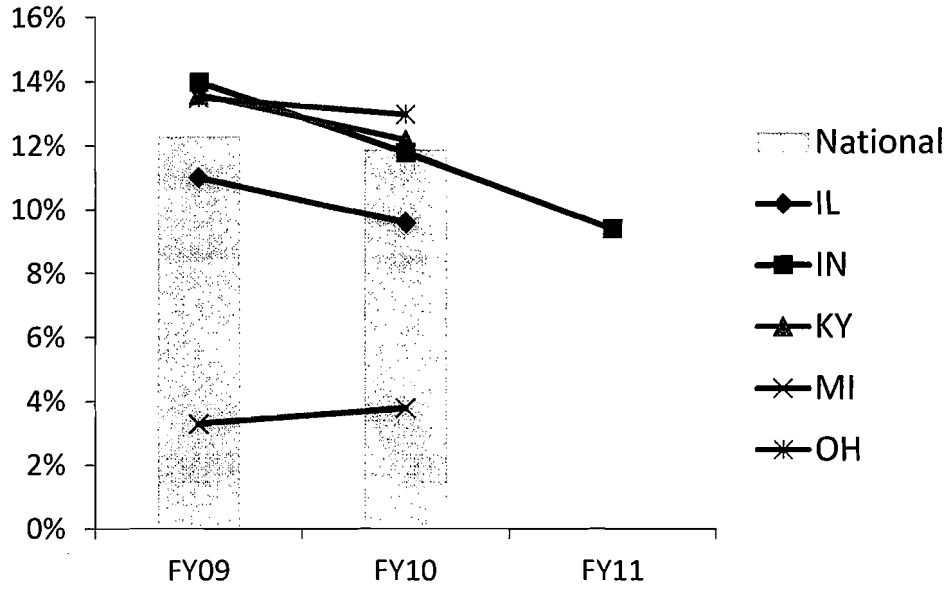


Stability of reunifications has improved, while the timeliness remains stable

Percent of Children Who Are Reunified within 12 Months of Entering Care

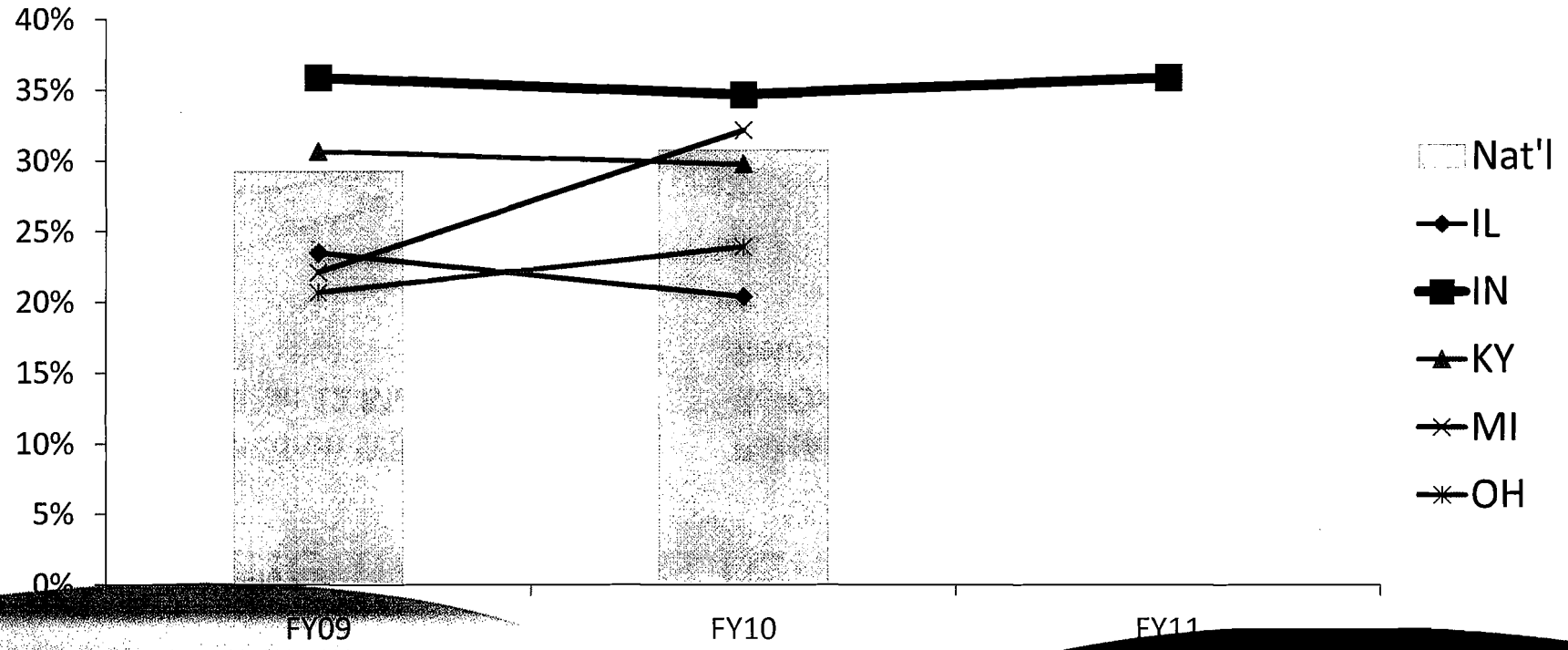


Percent of Children Who Re-Enter Care within 12 Months of Reunification



Achievement of permanency for long staying children is positive too

Percent of Children In Care for 2+ Years who Achieve Permanency within 12 Months



Brief summary of data slides:

- Decline in investigations and substantiations; IN is about average on front end measures
- Steady decline in kids in care over last several years, attributable primarily to reduction in entries
- Front-end reduction evident among re-entries and short stayers; little fluctuation in reasons children enter
- Positive trend for children in care; significant increase in kinship care and decline in congregate care

Summary of data slides, cont.:

- Safety indicators have been stable, both for kids who remain at home and those who are in care
- Trends are also positive for children leaving care, with a high and increasing percentage of permanent exits
- Since most children exit to reunification, it is important to note that the timeliness of reunification has been stable, and the stability of reunifications has improved. Permanency for long-staying youth as increased as well.

Strategies to Improve Outcomes: Congregate Residential Care, Kinship Care Centralized Hotline

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Congregate Residential Care: Research Findings

- Maintaining family ties and relationships, and coordinating after-care transitions, may be difficult when residential settings are distant from childrens' homes
- Research suggests that many children will have better outcomes in terms of social and emotional development, educational achievement, family ties and permanency if served in family settings
- Short term residential treatment may be effective in treating serious emotional disturbances
- Congregate care tends to be significantly more costly than other forms of placement (ie: foster care or kin care)

State Experiences in Reducing Congregate Care

- A number of jurisdictions including NY City, ME, LA, and VA have been able to reduce congregate placements while improving outcomes for children
- IL has successfully used Perf. Based Contracting to reduce congregate placements, cut lengths of stay, and increase successful moves to less restrictive settings
- TN has been able to reduce congregate care placements by over 50% while decreasing rates of abuse in care, decreasing overall lengths of stay in care, and increasing exits from care to permanent placements
- NY City has increased family setting placements and reduced congregate bed use by 47%, saving $41 million

Kinship Care: What the Research Shows

- Nationally, about 25% of children in care placed with kin
- Kin placements tend to be more stable than non-kin care placements, but children may remain in care longer
- Children in kin care are as safe or safer than those in FC
- Those in kin care are more likely to remain in their communities of origin and to attend the same school
- Children in kin care have fewer subsequent re-entries to care than children in non-kin foster care
- There is little research on long-term well-being outcomes, but no evidence that children in kin care are any worse off than those placed in non-kin foster care

Centralized Intake

Centralized Intake

- 29 states currently operate centralized intake systems
- 23 states operate locally based intake systems
- Indiana switched from local intake system to centralized intake in 2010.

Where are Reports Received? Indiana and Neighboring States

- **Illinois:** Statewide Central Intake hotline.
- **Indiana:** Statewide Central Intake hotline.
- **Kentucky:** Statewide Central Intake hotline.
- **Michigan:** Statewide Central Intake hotline.
- **Ohio:** Reports go to the public children service agency or law enforcement agency in the county in which the child lives or was abused.

Why 6 states moved to Central Intake:

- More consistent screening of child abuse and neglect reports
- Intake now done by dedicated specialists
- Achieve policy and program changes in timely manner
- States did not transition to CI to save money

Performance of Centralized Intake Systems: Other States' Experiences

- Initial increase in referrals first year and then decline
- Improved response time and less "abandoned call"
- Greater consistency in screen out rates across state
- Mainly cost neutral after start up costs
- Better Quality Assurance system

Data Analysis

Type of Intake System	Average Screened in Referrals	Average Screened Out Referrals	Median Screened Out Referrals	Total Referral Rate per 1,000 (2009)
Centralized System (23 states reporting)	67%	33%	41%	45.4
Local Intake System (22 state reporting)	57%	43%	49%	41.2
National Average	62%	38%	42%	43.1

Challenges to CI System

- Initial resistance of local field staff and community reporters to new system
- Less interaction between intake staff and investigative staff
- Projecting correct number of staff
- Initial issues with technology

Benefits of Centralized Intake

- Informants reported overall improved intake system
- Ability to promulgate and implement statewide policies and procedural changes in uniform way
- Improved consistency in application of law and policy
- Implementation of comprehensive and standardized intake tools

Summary

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Summary

- Child welfare system reforms undertaken by DCS are showing improved outcomes for children and families across the state
- Indiana's transition to a central intake hotline included consultation with multiple stakeholders and national experts
- The state is experiencing many of the same "teething problems" encountered by other states which have moved to centralized intake systems

Summary, continued

- During the period that Indiana has implemented multiple system reforms including its central intake system, reduced out-of-home placements, reduced use of congregate care, and increased use of kinship placements for children in care, *child safety indicators have remained stable or improved*
- In many ways, the state's improved child welfare system and the outcomes it is achieving are making it a model for other states and the nation

Presentation of Susan N. Dreyfus
October 11, 2012

Before I introduce myself, provide my background, and share what I see as the key characteristics and strategies of successful child welfare systems, I first want to begin with a story that I hope helps you see that I share with you a clear and common focus and goal.

My husband's grandmother, who would be over 100 years old now, was a longtime member of the Milwaukee Public School Board and president of the board at the height of the debate on desegregation and busing.

The public meetings were extremely difficult, incorporating much emotion, passion, anger, and fear. She would listen intently, and was known for expressing profound insights with few words.

One meeting was especially difficult, lasting quite a long while. She sat back and listened. However, when she came forward in her chair and put her elbows on the table, which signaled she had something to say, the room went quiet. At that particular time, she said something that has stayed with me as I have led child welfare systems in two states, negotiated two class action settlements, and been involved on a national level to improve outcomes for children. She looked around the room and simply asked, "But is it good for the child?"

Good afternoon, my name is Susan Dreyfus. I am the president and CEO of both the Alliance for Children and Families and Families International. I represent a national network of multi-service, nonprofit, human serving organizations, many of whom are active in child welfare. They are involved in everything from prevention and family strengthening, early intervention, treatment, every type of out-of-home-care, reunification, and adoption.

The vision of the Alliance and Families International is a healthy society and strong communities for all children, adults, and families. Our mission is to propel the resource engine of high performing, high impact organizations who, through their excellent programs and services, strong organizational capacities, leadership, advocacy, and partnerships, achieve a larger impact. We frame this larger impact as reducing the number of people living in poverty, helping more people to live safe and healthy lives, and putting more people onto pathways for educational and employment success.

I commend the Indiana Legislature for creating this study committee since it signals your clear understanding that the children who come to the attention of the public child welfare agency are some of your most vulnerable citizens, who without an effective response are clearly on pathways to poverty, poor health, and inability to succeed in school and attach successfully to the workforce. It is an honor to be here with two highly respected colleagues, David Sanders and Paul Vincent.

I have served as chief of staff to a county executive in Waukesha County, Wisconsin, from 1991-1996. I served under Wisconsin Governor Tommy G. Thompson and his Administration as the appointed administrator of the first Division for Children and Family Services in Wisconsin. There, I had responsibility for the state's county-administered child welfare system. I also led the design and implementation of major reform efforts in the failed child welfare system in Milwaukee County that took place under a class action lawsuit for which we reached a settlement. Then I proudly served as chief operating officer of the national organization I now lead.

Most recently, I served as the secretary of the Washington State Department of Social and Health Services, where I had responsibility for child welfare, Medicaid, juvenile justice, aging and long term care, developmental disabilities, eligibility and TANF, mental health, and substance abuse. At a time of significant reductions in our budget, we led significant transformative change by focusing on impact, partnerships and seizing the integration across our systems that often sit in what I respectfully call, "cylinders of excellence". It was a true honor to serve Governor Christine Gregoire. Prior to my departure late last year, we successfully settled our longstanding class action lawsuit in child welfare and were working to improve our children's mental health care system which too was under a class action lawsuit when I arrived in 2009.

To help you analyze your state's child welfare system within your quest for continuous improvement, I would like to share with you some of the things that I have observed from my personal experience and through work in other states as key to better outcomes for children and families. I look forward to engaging in a conversation with you today.

While I understand that you are looking for specific and technical strategies, I have learned that paramount to success is a clearly articulated legislative policy on what the system is to achieve and the principles through which it is to lead and align program and practice. Too many times folks focus on the design of the program and they lose sight of not just the policy we are striving to achieve, but the fact that the only way to achieve them is through true engagement of our employees and our many and varied partners. I have learned over the years that it isn't always what we do, but how we do it that can be the key difference maker in improving outcomes for children from the individual case to the system overall.

While our first inclination is to always want to quickly focus on what we need to *do* to improve results for children, I believe we must first start with clear legislative policy on what we are to ultimately *achieve* and the principles through which we are to align and constantly improving the entire system beginning with intake.

Among states, the policy often is fractured through numerous reform efforts over many years that focus on attempting to fix only parts of the system from the outside/in. This leads to great confusion and inconsistency in performance. I believe that the recent

Information Memorandum issued by the Administration for Children and Families is the first clear policy direction from the federal government that I have seen in child welfare during my 20 years of experience. It states clearly what the system is to *achieve*, which is to promote the social, physical, and emotional well-being for children receiving child welfare services and to improve the behavioral, physical, and social, emotional outcomes for children who have experienced abuse and or neglect.

It is through this lens I suggest you conduct your review of the system and the department's vision and direction for carrying it out, as well as set the principles upon which the system is to carry out that policy. One of those principles that I believe is key is a strong statement that the system is to strive to meet the unique needs of every child every time within the context that their safety and experiences of permanency are not just ultimate outcomes, but rather are to permeate that child's experience every day they are under the state's responsibility.

What is Child Welfare?

Next is a recognition that we have for too long been holding the public sector agency singularly accountable for what we call the "child welfare system." When, in fact it is only responsible for a narrow piece of the system− the child protection and intervention function. The child welfare system is a larger shared, community-wide responsibility that includes multiple disciplines, agencies, and supports within communities. We will never achieve our goals through constant technical fixes in the child welfare agency alone until we realize the public sector response is but a piece of a larger system, and that by the time the public sector agency gets involved, it is often very late in a developing child's life.

However, I do believe that a key to successful child welfare systems is the vision and leadership of the public sector agency in inviting the community, other state agencies, philanthropy and others to actively participate and share accountability for the success of the system. Reforms from the top down may make for short term gains, but they do not bring long term and impactful change. As the legislature, you can assure that the other public sector agencies under your authority—education, mental health, substance abuse, developmental disabilities, TANF, Juvenile Justice, courts, law enforcement—are clear on their responsibilities to carrying out your child welfare policy. During the question and answer period today, I would be happy to share specific examples of this.

The Public/Private Partnership
The term "Privatization" does not fit in child welfare, when you engage the non profit sector in this work you are creating community based care and sharing responsibility with them in order to leverage resources and get better outcomes.
The systems that partner the most have the greater likelihood to be higher performers. Many systems around the country have varying levels of contracting approaches with private community-based agencies providing everything from early intervention, placements, case management, treatment, and permanency. The difference I have seen is when the contracting by the public agency isn't just a linear transactional relationship for the delivery of a discreet service, but rather a recognition of a partnership that leverages the missions and unique assets of nonprofit community-based organizations into sharing responsibility with the state in the policy that it is attempting to implement.

Their resources that need to be leveraged are their strong community ties of these organizations, their ability to innovate and bring other resources to the table need to be recognized as hidden and critical assets of the system. Where I have seen this playing out most clearly is in Florida, where through a flexible approach to financing community-based organizations are yielding not only enviable outcomes for children and families, but are creatively building the capacities of the communities in which they live through their ability to leverage and bring many partners and resources to the table.

I also don't believe the flexibility in financing can only be achieved through IVE refinancing at the federal level. We need to recognize the creative use of waivers, the creative recognition of the resources and supports that our families and communities possess, and creative budgeting and contracting approaches that give our staff and partners clear accountability for performance but flexibility as well.

If you want community based organizations to realize their promise as full and productive partners, I would encourage you to study how administrative and indirect costs are defined and believe you will find that the definition being used is greatly limiting innovation, staff development, developing new knowledge, risk management and rigorous continuous quality improvement. While I appreciate, from first hand experience, the realities of state cash flow and ability to make timely reimbursements, it is imperative to understand that delaying payments to your providers, who function on very narrow margins puts them at financial risk. If the delay in reimbursement is justified, then so be it, but we need to make sure that the process is as efficient as it can be so that delay in payments is not the norm.

My experience in Milwaukee taught me that as the system moves forward with new knowledge it is important to engage and help the community-based organizations shed,

rearrange, and create new competencies and capacities that will lead to better and more cost effective outcomes for children and families.

We will be working with the American Public Human Services Association to do our part to bring our sectors together for more strategic, creative and problem solving discussions so that children, families and communities get the most from contracts and partnerships between the sectors.

Poverty
It is time that we recognize the powerful implications of poverty in child welfare.

A study from the University of North Carolina-Chapel Hill found that a child living in a household of four with a yearly income under $15,000 was 22 times more likely to be maltreated than a child living in a household of four with a yearly income over $30,000. The vast majority of children, close t0 70% come to the attention of the system for neglect.

While I do not believe poverty causes the maltreatment of children. We have all seen children who have been raised in poverty go on to do extraordinary things. Yet I do believe the research clearly shows that the stresses of poverty have a clear correlation to maltreatment. This is shown to be especially true when you recognize that most maltreatment is neglect and the top reasons for neglect go to the inability of parents to provide for their children with lack of safe and stable housing being in the top tier.

It is based on this that I see systems implementing alternative response, and while never losing sight of child safety, they are working with families and the many community partners who too share responsibility for this system to ameliorate the conditions that are causal to neglect. Maine example.

My experience taught me that the very capacities we build within communities to respond to neglect and safely strengthen families on the front end are the same capacities we need on the deep end to successfully reunite children with their families or move them on to other permanency options. Child welfare simply cannot work if we don't accept the data that clearly shows us its connection to poverty and neglect. This is where partnerships again are key. The work being done across the country to strengthen our work with housing partners is showing great promise. (Maine example)

Medicaid
Another area for policy alignment and partnership that helps control the front end of the system is the alignment of your Medicaid policies and specifically how your Medicaid program aligns to to the clear indisputable sciences of Adverse Childhood Experiences, Trauma informed care and Early Childhood. My guess is close to 50% of all births in Indiana are funded by your Medicaid program. We know how critical the first 2000 days are in a developing child's life, but often our Medicaid programs pay for the birth, do

typical checks, minimal developmental and behavioral health screens and immunizations, but do not consider the bio/psycho/social intersections of health. They also do not consider the fact that these children and their families are likely to be your states most vulnerable and very likely to be your multi-system and high-cost utilizers of your systems across state government for years to come. Comment of WA State and 11% of all those we served across all of our programs drove 42% of our expenditures.

A child's successful transition to adulthood does not begin with a program we have come to call independent living. Rather, that transition begins at birth and everyone that comes into contact with the child can be a powerful force for equipping children with what they will need as they grow and develop. Our policies, system design and approach to partnerships must unleash this power

[Comment will be made on work in Washington State with Harvard and Casey Family and foster parents.] Work with DEL and with OSPI

The systems that perform better hardwire throughout the person, family-centered, and strengths-based principles not as a methodology, but as a transformational orientation that needs to guide our work and interventions each and everyday. With safety being paramount, many systems are realizing that with the best of intentions they are not truly living out this very important values orientation with children, their families and other caregivers.

While I have the utmost respect for unrelated foster parents and the life-saving role they can play in a child's life, as well as the caregivers in group or residential settings, I don't believe we give an equal commitment, either in our policies or our allocation of financial resources, to the birth families and extended families, and to the youth themselves. Giving families an authentic voice through evidence-based motivational interviewing, measuring engagement not just satisfaction, using mediation before taking cases into court for disposition, taking Family Finding to scale, creative and evidence-based approaches to parent education, and lacing children with their mothers or fathers in treatment are all ways I have seen systems truly walk the talk of their focus on strengthening families and developing the well-being of children. There is a reason why research has shown that most youth who age out of foster care—which, by the way, should be viewed as a system failure—go back to their families. Family is a powerful force in a child's life and in most situations, a lifelong healthy relationship to their family is in their best interests.

Out-of-Home Placement

Lastly, I would like to speak with you about out-of-home placement. In a child centered system, we need the full array of placement alternatives. We simply need to scale them commensurate with what the data shows us the system will need; no differently than we are doing as a country with the rebalancing of the long-term care system.

I first believe that we can indeed keep more children safely within their families and out of care with many of the policy, partnership, and practice approaches I have already talked about. But when a child does need to be removed and placed in out-of-home-care, our policy needs to be first placement, best placement. We need to understand that placing a child with a fit and willing relative, placing them in a least restrictive setting, often gets implemented as a least expensive alternative, which does not equate to a first placement best placement policy. When systems understand through assessment that the real presenting issue for the child is mental health, developmental disability, or other impairment that requires a therapeutic treatment approach for that child, placement in an evidence-based therapeutic higher cost setting is the best and most cost effective investment you as a state can make. We need a full continuum of care and treatment and understand that a child may need any part of that continuum based on their unique needs and circumstances. We often find that without a first placement best placement policy, children experience needless instability, trauma through multiple failed placements.

Powerful use of Data Analytics

I see this as our next frontier that if we use our data not to simply find what is not working but to understand what is working and we use the data to ask the "why" questions that can drive policy, practice, creativity and planning then we will put a powerful tool in the hands of the system.
Rhode Island Example, Florida example with predictive analytic

The entire field is moving towards an official Continuous Quality Improvement (CQI) system. Earlier this year, a Federal Information Memorandum strongly encourages states to start using a CQI system in anticipation of projected changes to how the federal government conducts reviews of states' performance on child welfare outcomes.

People and Innovation

Your greatest asset are the public and non profit agency employees who are on the front lines each and every day. I am not a social worker but have learned from the best and regularly spending time in the field. It is imperative that they are inspired by the policy you have set, appreciated, cared for, respected and truly engaged, with authentic voice, not only in their daily work with children and families but in the planning and initiation of new standards or changes in system design. States are investing through their University partnerships to equip staff with the knowledge and approaches they need for success, have invested in supervisory development so that they know how to support and develop their staff, giving them useful technology and case management systems, as you are doing with Casebook, and recognizing that a successful system needs to be innovating and adapting all of the time which requires the workforce to be empowered to do so. I am afraid that we have spent so much time telling our staff how to do the work using central planning approaches that we have not gotten the most out

of their first hand knowledge of what works and what doesn't and haven't captured the creativity and passion that comes when people are inspired by what we are trying to achieve for children, within limited resources, and feel they are active participants in realizing our shared vision and goals.

In closing, the public agency responsible for child protection is but one part of a system called child welfare. The safety, permanency, and well-being of Indiana's children are a shared and very serious responsibility which requires the public child protection agency to have the ability to bring the many other parts of the system to the table to share responsibility for the safety, permanency and well being of Indiana's children.

The constant churn of child welfare reform efforts seems to be never ending, and that is because we keep trying to fix the system from the outside in one technical fix at a time. What is needed is to step back and assure you have a clear and articulated policy and set of principles that are aligned across multiple systems and shared by the community. Then, using the power of data analytics, science, and the approach we use to create true partnerships and listen to the authentic voices of all involved, we understand that we are intervening in the lives of children and families at the worst of times.

It is complex and full of risk, but I do believe if we begin and end every discussion with that simple question, "Is it good for the child?" we will move forward and give more children an opportunity to enjoy being children and place them onto pathways to becoming healthy and productive adults.

Benefits

- Increases mental health treatment.
- Reduces arrests and the use of force.
- Decreases time spent in the criminal justice system.
- Decreases potential for injury, death or physical confrontation.
- Provides law enforcement training and education in verbal de-escalation techniques.
- Increases officer recognition of mental illness.
- Provides crisis services intended for a population requiring special needs and deserving special care and services.

"After completing CIT training, I feel more confident handling situations involving persons with mental illness. Now, I have much more success in connecting people with the help they need instead of resorting to arrests and transports to jail."

- IMPD Patrol Officer and CIT Graduate

Central Indiana Law Enforcement Communities Using CIT...

Boone County Sheriff
Carmel PD
Clairmont PD
Cumberland PD
Fishers PD
Franklin PD
Greenfield PD
Greenwood PD
Hamilton County Sheriff
Hancock County Sheriff
IUPUI PD
Indianapolis Metropolitan PD
Johnson County Sheriff
Lawrence PD
Lebanon PD
Marion County Sheriff
Noblesville PD
Speedway PD
Thorntown PD
Westfield PD
Whiteland PD
Whitestown PD
Zionsville PD

For more information about CIT, contact:

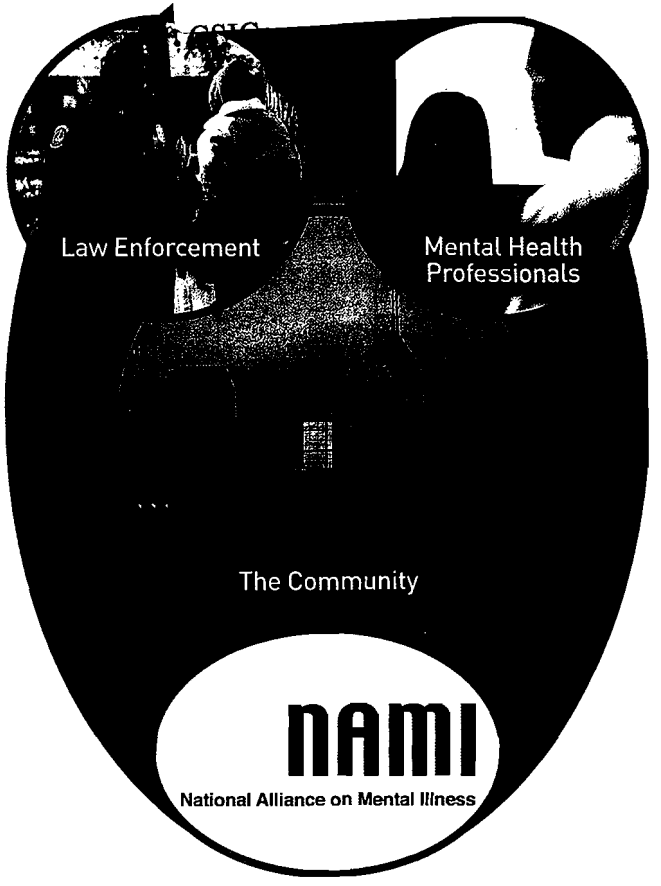
NAMI Indianapolis
P.O. Box 40866
Indianapolis, IN 46240
Phone: (317) 257-7517
www.namiindy.org

*** For a mental health crisis, call 911 and ask that a CIT officer be dispatched.**

Brochure compliments of St.Vincent Stress Center

Crisis Intervention Team

October 11, 2012
Attachment 6



Partnering for a Safer and Healthier Community

What is CIT?

The Crisis Intervention Team (CIT) program is a community partnership of law enforcement, mental health professionals, mental health consumers and family members.

Goals

- Increase safety, understanding and service to those with mental illness and their families.
- Increase access to medical treatment.
- Avoid placement in the criminal justice system for illness-related behaviors.
- Develop community partnerships.

Call to Action

Family/Friends/Community

For a mental health crisis, call 911 and ask that a CIT officer be dispatched.

Law Enforcement

For more information about CIT, contact NAMI Indianapolis at (317) 257-7517.

www.namiindy.org

How Does CIT Work?

CIT Officers

- Receive 40 hours of specialized training regarding mental illness, de-escalation techniques, and community mental health resources.
- Assume the role of lead officer at situations that involves persons with mental illness.
- Work with the community to resolve situations in a humane, calm manner while demonstrating concern and respect for citizens' well-being.

Mental Health Professionals

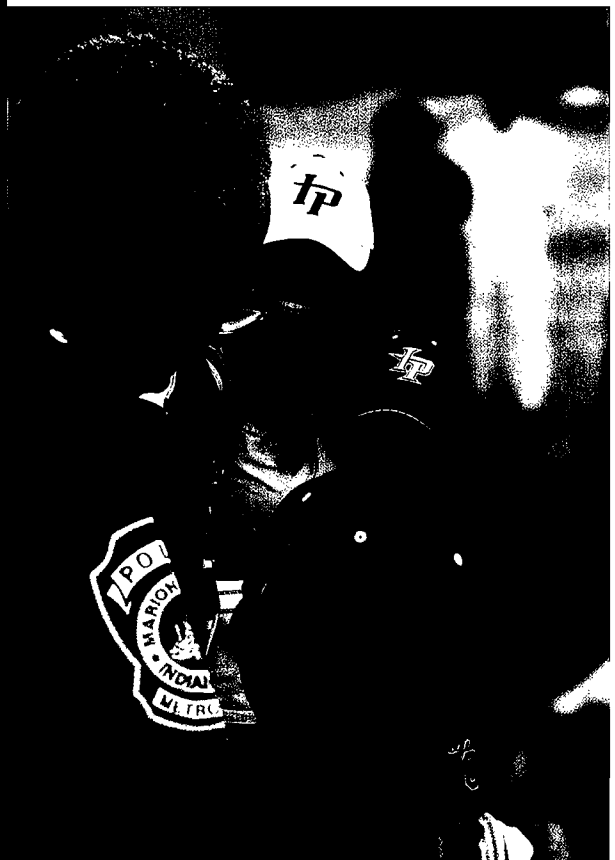
- Provide comprehensive training for CIT officers.
- Accept mental health consumers for assessment and treatment 24 hours a day, 7 days a week.
- Allow officers to quickly return to their patrol or other duties.

NAMI

- Helps to facilitate and evaluate the CIT program.
- Participates in recognition ceremonies of CIT officers.
- Offers support to consumers and family members.
- Provides outreach to other communities.

Community Partners

- Adult & Child Community Mental Health Center
- Aspire Indiana Behavioral Health System
- Cummins Behavioral Health
- Department of Veterans Affairs
- Gallahue Community Mental Health Center
- IUPUI School of Public & Environmental Affairs
- Midtown Community Mental Health Center
- Mental Health America of Greater Indianapolis
- NAMI Indianapolis (National Alliance on Mental Illness)
- St.Vincent Stress Center
- Tara Treatment Center
- Valle Vista Health System
- Witham Hospital



NAMI Indiana CRIMINAL JUSTICE
National Alliance on Mental Illness

CIT for Youth

What is CIT? CRISIS INTERVENTION TEAM

Goals:

- Dramatically decrease the number of persons who suffer from mental illness being brought into our jails/prisons (or for youth, into our juvenile detention facilities)
- Increase safety for the officer, the individual in crisis, and the community or school
- Increase access to treatment and community partnerships

Safety First: CIT is not meant to replace, but to supplement traditional police training:

- Typically officers are trained in the force continuum
- Forcefully approaching someone who is paranoid, manic, or suicidal might actually escalate the situation – the officer could make the situation worse
- Active listening, slowing things down, building trust, are valued over a quick resolution
- 40 Hour training. Mental Illness, addictions, law, personal stories, role-playing, Community Resources, observation in a crisis unit

Fort Wayne Police Department 2011:

- 1234 - calls responded to by CIT
- 329 – Party using alcohol/drugs
- 78 – Party armed
- 1205 – Immediate Detentions
- **0 - Arrests**
- **111 Involved Juveniles**

POSITIVE FEEDBACK from citizens after IMPD CIT runs:

- "Handled well. Kind and Gentle"
- "Lots of knowledge about mental illness"
- "Very Impressed"
- "The best thing that's ever happened to me…officer changed my life by talking to me"

WHY "CIT FOR YOUTH"?

- **70%** of youth in the juvenile justice system have one or more psychiatric disorders
- Only **20%** of youth with mental illness receive appropriate treatment
- **50%** of youth with a mental health condition drop out of school
- Youth are not "mini-adults". Unique diagnoses, resources, and consequences, stakeholders
- Law Enforcement – School based officers/School Resource Officers
- Families and Youth – Parent and Caregivers
- School Personnel – Principals, Teachers, Counselors, etc.
- Community Mental Health Providers
- Manual available for free download at www.nami.org/citforyouth
- www.namiindiana.org mhalbert@namiindiana.org

Crisis Intervention Team (CIT) Training for Youth
Indianapolis Metropolitan Police Department
June 25-29, 2012

Monday 6/25	Tuesday 6/26	Wednesday 6/27	Thursday 6/28	Friday 6/29
Welcome/Pre-test Sgt. Robert Hipple & Nicole Freeman 8:00-8:30	**Review/Game Show/Evaluations** CIT Trainers 8:00-8:30	**Review/Game Show/Evaluations** CIT Trainers 8:00-8:30 AM	**Legal Issue – Part I*** John Kautzman 8:00 – 8:40am	**Review** CIT Trainers 8:00-8:30
Sequential Model & applied to CIT, CIT experiences Gael Deppert & Nicole Freeman 8:40-9:50	**Trauma Effects in Children PTSD / Complex Trauma /Reactive Attachment** Kelly Rounds / Vanessa Enos 8:30-9:10	**Traumatic Brain Injury** 8:30-9:20AM	**Autism/Asperger's Syndrome & Intellectual Disabilities** Dr. Kelly Blankenship 8:50-9:40	**Consumer/Family Member** 8:30-9:00
Developmental Stages of Childhood & Adolescence Dr. Tom Hummer 10:00-12:00	**Trauma Effects in Children PTSD / Complex Trauma Overview/Reactive Attachment (cont)** 9:20-10:30	**Parental Deployment** Kathy Broniarczyk 9:30-10:20	**Autism/Asperger's Syndrome & Intellectual Disabilities (cont)** 9:50-10:40	**Role of CIU/Paperwork** Mike Hughes, Shelley Tracy Brad Bennett, Kimble Richardson 9:10-10:00
12:00-1:00 **Lunch** On your own	**Suicide / Self Injurious Behaviors and BPD** Rita Langlois, LCSW 10:40-12:00	**DCS / CHINS /Respite** Austin Hollabaugh/Katie Connel 10:30-11:20	**Community Resources** Panel 10:50-12:00	**Inpatient Options / Procedures** Community North / Methodist / Valle Vista / St V's/Options 10:10-11:00
Mental Illness in Children and Medications Mick Welling MD 1:00-3:00 PM	**Lunch** On you own Noon-1:00PM	**CIT Officer** Matt Andrade Mark Merrel 11:30- 12:00	**Lunch** On your own Noon-1:00 PM	**Post-test/Course Evaluation** 11:00-11:30
Mental Illness (cont.) 1:00-3:00pm	**Anxiety / Depression Gender differences** Kendra Belden 1:00-2:15 PM	**Lunch** On your own Noon-1:00 PM	Human Trafficking 1:00-1:30	**Pictures/Social Time** 11:30-12:00PM
Child and Family Addiction/Substance Abuse Kara Lauck 3:15- 4:30pm	**Conduct Disorder vs. Bipolar Disorder** Jim Bush 2:25-3:15 pm	**PARC Clinic / Prodromal Stage of Schizophrenia** Dr. Alan Breier 1:00-1:50	**Role Playing** 1:30-2:50 PM	**Lunch Provided!** 12:00-12:45
Child and Family Addiction/Substance Abuse (cont)	**Active Listening with Youth and Families** Kimble Richardson 3:25-4:20pm	**De-Escalation Techniques** James Davidson & Nicole Freeman 2:00-3:15	**Role Playing (cont)** 3:00-4:30	**Graduation Ceremony** Certificate Presentation 12:45 – 1:30
Consumer (Parent) 4:30-5:00	**Family Member** Mike Kempf 4:30-5:00	**Role-playing** 3:30-5:00	**CIT experiences** IMPD CIT officers 4:30-5:00	**To be scheduled:** **4 hr. shadowing of staff in Crisis Intervention Unit**

Mental Health Needs of Indiana's Children: Options to Bridge

Over the past several years, the Advisory Board for the Indiana Juvenile Mental He
Treatment Project has identified significant challenges in connecting the youth witl [illegible] y or substance use issues to appropriate treatment. A workgroup of the Advisory Board met regularly over the past year to further consider these challenges. The workgroup recognized that the challenges faced by youth who have contact with the juvenile justice system are common challenges for all youth with mental health and/or substance use issues across the state. The following summarizes important options to address the current challenges.

Create a statewide, evidence-based treatment system of care for youth identified with mental health disorders.

- **Access:** Provide youth involved with juvenile justice (detention or probation) with access to care, including universal screening all youth entering the juvenile justice system for mental health and/or substance use issues, and including comprehensive assessments and treatment when necessary. This includes requiring a universal assessment process be used consistently by all systems, across all sectors (i.e., the Child and Adolescent Needs and Strengths tool). Adequately support implementation, and require comprehensive training through state funding.

- **Evidence-based intervention in community:** Ensure early intervention, community-based, best practices. This includes funding mental health front-end diversions for youth, and integrate them into detention reform efforts (e.g., Juvenile Detentions Alternative Initiative). Ensure that all assessments address trauma and educational needs, and require trauma-informed, culturally competent practices to be implemented across public systems. Place school behavior in context and implement interventions and alternatives in schools. Ensure that community based care framework is available to all youth in juvenile justice, including youth committed to correctional facilities. This includes receiving appropriate care for their mental health needs while in confinement, and that appropriate supportive services are provided to youth as they exit from juvenile justice facilities into community based care.

- **Cross-system collaboration:** Support and allow for cross-system collaboration of all child-serving agencies, including information and data sharing, and policy and funding system alignment. Require and fund evidence-based systems of care at sufficient levels in all counties. Services should be developed around home and community based care at multiple levels of intensity that are age appropriate, and should utilize a team approach which is driven by the child and family. Ensure a sufficient number of residential care beds within the state for those who need it. Create programs that allow residential care for stabilization and treatment of children without having to adjudicate the child and without the requirement of failed placements.

Pilot a model of care through a collaborative consortium for purchasing services for all.

- Work with cross-system collaborative, including mental health, addiction, juvenile justice, academic community, child advocates, community mental health, health, education, legal, intellectual/developmental disabilities, families and caregivers, and child welfare, to plan a collaborative consortium for purchasing services for all children.

- Ensure that consortium services are accessible to youth in the juvenile justice system and youth ineligible for Medicaid.

Create a multi-agency fund or funding protocol for treating youth with serious mental illnesses.

- Reform funding and fiscal policies to support a "medically needed" Medicaid funding category so that children with serious mental health needs at all income levels can access care.

- Enable seamless care between systems without children entering the juvenile justice system. Ask DMHA, DOE, DDRS, DCS, DOC and OMPP to develop new funding protocols that blend multi-agency funding to deliver services to children at the earliest possible point. Children's mental health needs should drive programs.

Develop or preserve statutory provisions that act as safety measures

- Prevent youth from entering the juvenile justice system due to mental health crisis or serious, complex mental health needs through statutory provisions that act as safety measures, allowing courts to order appropriate mental health care for children without a delinquency adjudication.

Definitions:

System of Care – a comprehensive spectrum of services and supports which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

Evidence-Based – refers to the existence of a body of research that documents the effectiveness of the process.

Evidence-Based Practices – refers to a defined treatment process that has been shown through objective research to be effective in treating specified conditions.

Best Practices – refers to a defined treatment process that is accepted as being effective in treating specified conditions but does not have the body of objective research to support being classified as evidence-based.

Screening – a process, usually a brief set of questions, which is designed to identify individuals who are at-risk of having mental health/substance use problems or concerns and/or those who would most benefit from more in-depth assessment.

Behavioral Health Assessment – a formal process that is reliable (results are the same regardless of who conducts the assessment) and validated (measures what is intended to be measured) and that results in a thorough depiction of an individual's mental health, social-emotional functioning and/or substance abuse.

For more information please contact:

Youth Law T.E.A.M. of Indiana
Amy Karozos
Coordinator, Indiana Juvenile Mental Health Screening, Assessment and Treatment Project
akarozos@youthlawteam.org

CSIC
October 11, 2012
Attachment 8

Are you overwhelmed?

Is dealing with a crisis keeping you from being the best parent you can be?

Would a break from your kids help you achieve your goals?

Safe Families *for* Children

Helping Families in Crisis Get Back on Their Feet

Families Helping Families

When a crisis strikes, many of us rely on relatives and friends for support. But for some parents, this is not an option. Safe Families seeks to help parents in crisis get on their feet by providing short-term care for their children with volunteer families for as little as a couple of days to as long as a year.

How does Safe Families work?

Some parents call us directly while others work with existing case workers to arrange care for their children. We work quickly to match children with volunteer families, often placing them on the same day we receive a parent's call.

Safe Families provides a loving, temporary home for children whose parents are in a crisis situation.

- Placing parents maintain full custody and can request the return of their children at any time
- Volunteer families are extensively screened with background checks and home studies
- Children ages 0-18 are eligible, including parenting teens
- Stays can be as short as a couple of days and as long as a year
- We are committed to reuniting parents and children as soon as possible

Other Services

Safe Families offers a variety of assistance for those who are in need in addition to living arrangements for a child.

Support for Existing Situations

If a relative or friend is already caring for a child and is in need of support, Safe Families welcomes them into our vibrant volunteer network by making home support visits, inviting them to community groups and giving them access to physical resources in order to strengthen them as they provide a stable environment for a child.

Safe Families *for* Children

Safe Families for Children – Central Indiana
Indianapolis
7168 Graham Rd.
Indianapolis, IN 46250

www.safe-families.org

317-519-3839

I am Nancy Hemphill, from Henryville, Indiana. I would first thank you the members of the interim committee for allowing me to send my message and State Representative Steve Davisson, for bringing this study to my attention.

My subject is coming from a different perspective. I am referring to the abuses resulting in the next step, after Children's Protective Services had spoken with the alleged victim.

I wish to bring to your attention the outrageous behavior by the CPS of Clark County which is not only out of control but appears unwilling to answer to any overseeing authority. On May 12th, 2010, my husband received a call from the Clark County Department of Child Protective Services. He was informed that some accusations had been made and he needed to come in the next day. They ordered him to cancel our daughter's birthday party the following weekend until they gave us permission to have children in our home. This decision was made by their office before even meeting us, or coming to our home.

I called them back to inform them they would not cause that kind of disturbance in our home on the basis of a rumor and that I was continuing on with the party plans. They allowed us to have the party only if my husband took take a hotel room that weekend as he was now seen as a potential danger to children. And yet they hadn't met my husband or even visited our home.

When he arrived at the CPS office, my husband found that he had been accused of molesting a young friend of our daughter who had stayed at our home on occasion. Despite the hideous detail of the acts which the girl had reported, she couldn't remember when it happened or how many times. She had guessed that it could have been as often as 4 to 5 times but she just wasn't sure. The CPS worker and the detective threatened him with immediate imprisonment if he didn't cooperate; he refused and eventually left the office.

That night, I spent five hours at the Clark Memorial Urgent Care praying that the doctors would be able to lower his blood pressure. It

had risen to the danger zone, risking a major stroke. Thankfully, his blood pressure was lowered but, I spent the rest of the night watching him for any further problems.

The next morning, my daughter and I were called in to speak with the same CPS worker and detective. We were immediately separated despite the fact that my daughter did not want to leave me to stay alone in a strange room. I was given a choice; remove my crying child from the room; or come back the next day and do exactly same thing all over again. I couldn't imagine putting my child through that kind of treatment twice. Her crying could be heard through the wall but I truly felt that I had no good options. I doubt I will ever forgive myself for my decision; however I chose the lesser of two evils and stayed.

The detective asked me what my initial thoughts of the investigation. I said "Oh no, she's done it again." They sat up with interest and said, "You mean he has done it again!"

I answered, "No, my husband has never touched a child. But since the alleged victim had quit my scout troop, several mothers have come to me with stories about her accusing others. I knew immediately what the girl had done and what we were in for."

Were they going to look in to the fact if the girl had been previously molested? What if this kind of abuse could be the root cause of her accusing my husband without even an idea as to when the alleged crime had occurred? They replied that I had a bad attitude and wasn't cooperative.

The CPS worker and the detective had no idea when the alleged crime or crimes had been committed. They decided to use the process of elimination to zero in on a date range; instead of personally looking into the case. They told me that they the alleged crime must have happened the summer before. They were visibly shocked to find that none of our daughter's friends come over in the summer as she is gone

visiting relatives in Louisiana. They actually had to take a minute to recover their composure

They then demanded to know when the supposed victim came to our home during the school year. In my calendar it showed that the young girl had stayed at our home in March. I pointed out that this was only two months prior to when the accusations were filed and yet the girl couldn't remember this? They told me that I was not an expert in child psychology and my point was irrelevant to the case.

I offered photos of the trip to the Louisville Zoo where I had taken the girl and my daughter that March. In those photos, she was laughing and having a wonderful time and later begged her mother repeatedly to stay another night in our home. They decided that this point was also irrelevant to the case.

I asked them when they assumed the other 4-5 dates of the alleged crimes were. Again, they felt my point was irrelevant and I needed to

tone down my attitude. No other investigation was done as to finding out any other times or dates for the alleged crimes.

I asked why they were refusing evidence. They informed me that they decided what was relevant. The photos couldn't prove that my husband didn't commit the alleged crime. I could email the photos to them, but, they had already decided not to use them, sight unseen.

I offered the names and contact numbers of the parents of other girls who had stayed at our home and who felt perfectly safe. I was told that they weren't necessary. I mentioned that it would show a pattern of conduct that would prove my husband's innocence. They decided they weren't interested.

I asked if they were going to visit our home to see how impossible the accusation was. They felt that this would be unnecessary. Were they going to check our computer for pornography? They declined. I reminded them that monsters who prey on children will often molest their own children first. Weren't they concerned about my own child

who was taken from me and was crying in the next room? They decided that she was not the focus of their investigation. And she wasn't, their focus was based on a rumor and was colored by what they considered to be my poor attitude.

I reminded them that they had no proof that my husband was guilty and I demanded to know why they were so cavalier with evidence. I was told that I had a poor attitude and that they were the professionals. They believed that a child wouldn't lie and the victim's word was good enough for them.

When my daughter was returned to me, she clung to me and wouldn't answer their questions for quite a while. I was told that I was manipulating her. They didn't consider that my little girl was traumatized, only that I was the problem. I realize that CPS carries a tremendous burden, protecting the children who have been terribly hurt. But my daughter is also a child, and was terribly hurt and frightened during this nearly two hour ordeal. But, as she wasn't the

main focus of the investigation and consequently her fears were not addressed.

The job of CPS must be quite difficult, however, there had been no visit to our home, and none of my co –leaders in girl scouts or any of my daughter's other friends had been contacted. I only wanted a full and complete investigation. But as far as the Clark County CPS was concerned, the word of the alleged victim was investigation was enough.

I know that there is only an overworked governmental agency that stands between those innocent children and the perpetrators who stalk them. It must be an amazingly difficult job, one I wouldn't want to take. But, by not looking into all the facts is not serving anyone best interests.

How can we protect our children when those in charge of these investigations see no need to even visit the home where the alleged crime happened? In Clark County, we don't have an agency that

should be trying to protect children from actual or potential harm. We have a band of crusaders who conduct their witch-hunts without fear of reprisal or condemnation. They act as if they alone are the final word and the public in general is guilty until the Department of Child Protective Services decides otherwise.

We were asked to come with some solutions to our problems, not just to complain. I agree, to sit and list the wrongs of others without helping to find answers is a waste of both my time and yours.

I find there is a definite need for an oversight committee who can not only review the handling of the investigations but also improve the techniques of those investigators. The public should have access to this committee as a means of understanding the overall operations of CPS.

I don't understand how each county can conduct their business any way they please. A statewide oversight committee could set down a guide for investigations which should be followed and not used as a suggestion.

Confidentiality is needed when helping children. But, if insurance companies, doctor's offices, and schools, can know what their employees are doing and how the work is handled, why can't CPS?

I only ask that there be checks and balances so that all who are involved in the case are protected. This is not a lot to ask.

I hope that my comments will go a long way toward bringing a resolution to this problem.

Thank you for your time.

Thank you Chairman Noe, Co-Chair Holdman, and Committee members. This interim study on the Department of Child Services is needed to help protect innocent children. Families are in crisis and children are still being destroyed and are dying.

My two grandchildren were taken by MCDCS. There has never been any accusation of abuse or neglect. When my granddaughter was released back to her mother, the DCS case manager ordered my granddaughter to a public school. She was never allowed to return to her private Christian school. Both children, while attending the private Christian school, were in accelerated classes and on the honor roll.

My grandson was in the gifted and talented program at school, in honor classes, and won a spelling bee. He enjoyed all sports he was in, loved his family, friends, and classmates, and enjoyed activities in our church before he was taken by MCDCS. Now that has all *drastically* changed.

The first case managers from DCS were [redacted] and [redacted]. They told my little grandson it was my plan to put him in that placement. He was also over medicated so severely, his mouth was over to one side. His mother told us he had difficulty talking. He was never on psychotropic drugs until DCS got involved. He had never needed that type of medication. The placement was over crowded. His mother was told the placement didn't have a bed for him, so they made a little makeshift bed in a closet. I can't begin to imagine how my little seven and a half year old grandson must have felt. No one ever comforted him.

He was body slammed, physically, emotionally, and sexually abused by the very system that was supposed to protect him.

DCS gave him, and has given many other children, psychotropic drugs and sleeping pills. Psychotropic drugs are *not* FDA approved for pediatric use. Research has proven these drugs damage brain cells in children. His pediatrician has never been contacted.

My grandson was hospitalized in May of 2006 because he was severely over medicated. It had weakened the muscles in his neck, his speech slurred, and he could *not* hold his little head up (this is called EPS). DCS told his mother he was faking it. [redacted] at the hospital, told his mother these were side effects from the medication DCS prescribed. [redacted] stopped all of his medication and said this could have permanently damaged his little neck or could have even been fatal. After a week or so in that hospital, DCS put him in another hospital where he was placed on different psychotropic drugs. My grandson had never been hospitalized or ever on psychotropic drugs until DCS got involved.

In July 2006, when his mother visited, she found bruises on his chest and both arms. She was told, by [redacted] DCS, to file a 310 report, but *no* action was ever taken as a result of filing this report.

My grandson lived in my home for a good portion of his life. In November 2006, he was told he had to write a letter saying he only lived with me to use my money to buy his toys and electronics, that he never loved me, and that he never wanted to live in my home again. When DCS moved him to Mishawaka in March 2007, he told his mother and [redacted], LCSW, many times, he did *not* want to write this untrue letter. [redacted] ordered him to write this letter. Then [redacted] said, "It will be okay because no one will ever read this letter." Both his mother and I were sent a copy of the untrue letter. DCS entered this untrue letter into the juvenile court reports and records.

My grandson had surgery on both feet and both legs. [redacted] his orthopedic surgeon, prescribed braces that go inside his supportive shoes. DCS has *never* allowed him to wear his braces or supportive shoes, even after letters being faxed from Dr. Jackson's office. DCS never honored that request.

On June 25, 2008, at age twelve, my grandson was placed in a group home. This home is for older males who have jobs and are learning to live independently. During this time, he has been exposed to sex and pornographic materials. At the first meeting at this group home, his mother asked [redacted] the director, where the children were of the same age as her son's. [redacted] said the home had never had anyone as young as him before and said they would make it work because he had already signed a contract with DCS. They claimed to not know my grandson's age. He should never have been placed in that home. DCS told his mother he would never be going home, and that he too would be taught to live independently at twelve and a half years old.

DCS has told my daughter repeatedly that I have talked to too many politicians, and I'm not to disclose what my grandson is enduring. DCS talked of putting a restraining order on me because I have talked about my grandson, Furthermore, DCS also told my daughter they will take her daughter again if I keep talking about my grandson.

My grandson has been traumatized by what he had to endure for four years. He was never allowed to have his own birthdays or Christmas with his family for four years. His mother was the only visitor allowed. Also, DCS told my grandson *not* to talk or think about me again. DCS told his mother she was *not* allowed to talk about me with her son, and she was *not* to give him anymore gifts from me. My grandson lived in my home when he was younger. He talked about all the fun things we did together – swimming, sports, travel, church, Sunday school, and his friends. DCS didn't want to hear about that. MCDCS has stolen his innocence, and his

childhood is destroyed. He has been in twenty-nine different schools. At one placement, they had even taken his backpack from him so that he was never able to turn in his homework. He has been very traumatized by the predicament he was made to live in. *No one* can ever give him back the wonderful childhood he should have had.

What an astronomical, wasteful spending of our Hoosier tax dollars! The twenty-nine different placements he has lived in range from $3,100 to $3,500 weekly, plus the additional cost of the outside services providers DCS hires with our tax dollars. Although this is a state problem, federal tax dollars are being used to partially fund these atrocities without any apparent federal oversight. There are many boys in Marion County that have gone through this. Bogus stories have been told so that the state can receive federal dollars. I can understand why our prisons are overcrowded by the way some children are mistreated by DCS.

My grandson never had a voice in court. His guardian ad litem, [redacted] always said in court, "Judge I conclude with DCS". She was always on DCS's side. I had tried to hire an attorney for my grandson, but my attorney was told no because he had a guardian ad litem.

DCS must be held accountable to the highest standards to protect our innocent children. My grandson will never have the life he should have had. We did not get the same grandson back that was taken by MCDCS. He came back as an adult man. He is addicted to sex, pornography, and chat lines. He lies to his family and becomes violent at times. He will not play sports anymore, and he will not go to church. He refuses to spend time with friends he knew from before he was taken. His friends waited all these years to see him again.

I want to thank State Representative Dave Frizzell for his tireless dedication and endless work in helping my family. He became frustrated because my grandson was forced to remain in the sexually and physically abusive environment, and he wanted to desperately help. Rep. Frizzell, had meetings with Mr. Payne and his attorney Mr. Ryan. Seems like no one could help my grandson out of the horrible situation. He did write a letter to the Children's Bureau about their computers with pornography and chat lines.

Thank you Rep. Frizzell. We appreciate you. You are a godly, Christian man who truly cares about children and your constituents.

Thank you Chairwoman Noe, Co-Chair Holdman, and committee members for your time in this very important matter. Children are our future and a very special gift from the Lord, not a business deal. Please save our innocent children.

I do not merely want to give you a 'list' of the problems but am offering so the problems my family has experienced with D

Gina Andrew
8123914592 – 1GMHope@gmail.com

DCS & the police both claim this is the judge's responsibility; but the judge said it must not be too bad if DCS & the police aren't doing anything. A DCS caseworker wrote in her report that a court order was violated (the father was ordered not to use corporal punishment) but said I needed to go to the judge.

Our experience is that all agencies who receive funding to protect children refuse to do so & thus binding my hands from being able to protect them either. Police, judge, & guardian ad litem refuse to get involved saying DCS found abuse unsubstantiated so they all refuse to view any evidence & innocent children continue to suffer the consequences. These children have learned that they cannot trust DCS (their dad had been telling them this all along) because they have told DCS about a dozen different times that their dad hits them, caseworkers take pictures of bruises only for nothing to be done to protect them, & then they get into trouble with their dad for talking. The children continue to return home with their privates red & swollen & sometimes bruised & bruises on their backsides, but I will not put them through any more exams because nothing is done & the children get into trouble. We also continue to have to fight for my son to get his asthma meds-last week the new pulminologist suggested I call DCS but I know that is a waste of time.

Authorities DO NOT work together or even communicate with each other [redacted] has given different stories to each agency proving his dishonesty. ~~Because~~ but he continues getting away with everything because there is NO ENFORCEMENT of any of the laws or court orders he's violating. So he continues abusing the children.

-The first thing I am convinced needs to be done is to ENFORCE COURT ORDERS. As it is now, neither the police nor DCS are able to enforce or view civil court orders. Right now the only way to have a civil court order enforced is to hire an attorney to take the person violating the order back to court (which takes months). I had court orders stating medication was to be given to my children & corporal punishment was not to be used (among other issues). My son's lung function decreased by half due to his medication being withheld but DCS refused to return my phone calls & the judge gave us a hearing but cancelled & refused to reschedule. My son began having asthma symptoms at 2mon. His father doesn't believe in medication & or the medical establishment & has consistently refused to give medications as prescribed & sometimes not at all. His medications being withheld last year caused this little boy's lung function to go down to 56%. But DCS still refused to do anything claiming it was the judge's problem (because we had a 3 court orders stating he was to get his medication), but the judge won't do anything claiming DCS would act if it were serious. My son's pulminologist for his first 5yrs quit due to father's abusive behavior against her & her staff.
His doctors have been telling me that I need to find a way to get his medications to him because his liungs are already scarred & this could also be causing perminant heart damage. But DCS makes sure my hands are tied in this as well.
- DCS has refused to listen to or review any history. DCS needs to look into history. I've been told numerous times that they do not care what has happened before (despite video, pictures, & medical records offered). A family's history matters for many different reasons. One caseworker told me that they don't waste time looking at other people's pictures because it's so easy to Photoshop them. I told her I don't have Photoshop & that my FBI dad said it is easy to determine whether or not a picture has been altered, but she still refused to look at them.
-'Indicated' NEEDS to be returned to DCS' list of possibilities. There are times when there is not enough evidence to prosecute (if the abuser has a good attorney or connections) but abuse is obviously happening. Indicated would 'flag' the case so the reports wouldn't be destroyed & someone can make sure these children don't fall through the cracks.
- DCS must verify what they're being told by the suspected abuser: It is mind boggling that DCS ~~immediately~~ has automatically believed this suspected abuser without verifying anything he tells them. I have found out some of the lies he has told DCS & tried to reach them to let them know I have proof he's lying to them, but DCS refuses to return any of my calls let alone view the evidence. The abuser then boasts on FaceBook.

In 2006 I had to get a protective order to remove my children's father from our home-he refused medical treatment to the children & would pull their diapers off before they could walk to beat them-they had no idea why they were being hit. Their father took me to a 'Christian counselor' who said I must submit as he had the right to do anything he pleased & it would be my fault if he didn't come to God due to my disobedience.

My experience with DCS began in 2007 when my children's doctor called them because of bruises & the children said their dad hit them. This doctor documented abuse almost weekly for over a year but then altered medical records removing all mention of abuse & claimed the children were brought in for runny noses. But they weren't able to alter the hospital's records for the same day showing the doctor stated child abuse & neglect. Earlier this year I was told by a detective that DCS painted me to be a crazy mother who just takes her children to the doctor all the time. The only reason I took them to the doctor was because the prosecutor told me to take them to the doctor to have bruises documented when the children return from visits with bruises & say their dad hit them.

DCS hotline was called by my father because my girls told him their dad put cream inside their privates making one of them bleed. He gave details of my children's plight & they told him they were ready to get involved. But when I called (as instructed), I was told they could do nothing & they still refused to view any evidence. My dad called back & the same lady did a complete turn around telling him there was nothing they could do.

Our mayor has personal experience with my children's father & knows how he & his brothers live as a cult-against the medical establishment & any form of authority. He suggested I go up DCS' chain of command: which I did. Director [redacted] refused to meet with me but spoke on the phone to a former state representative acting on my behalf [redacted] stated that he was familiar with the political climate in our county. He was impathetic but said it was a complete different playing field when custody is an issue as they tend to dismiss abuse accusations [redacted] suggested we go to the juvenile court; but I called them only to be told DCS has to file the complaint with them first.

DCS continuously refuses to speak to any of my witnesses. A child advocate came with me to several exchanges of the children & to emergency room visits when my girls returned from the visit with their dad complaining their privates hurt. She has also known the children's father for 30yrs & knows the family dynamic very well

DCS refuses to turn over 75% of their reports to me but gives them to the abuser. I've submitted written requests for all of the DCS reports (each time one is made) but they refuse to give them to me.

The children's counselor quit saying she cannot help the children as long as they're forced to continue under his dominion. She had filed a cease & desist against the children's father but he still did not stop his dominate tactics. She told me that the DCS director [redacted] told her she would remove the children from both parents if she documented the emotional stress the father was putting on the children. She was also told by DCS that she could not file reports when the children reported abuse (by father) but DCS stated 'the mother has to do it'.

— The children's doctor begged me to not get her involved. The children's father had called her office with intimidating demands that shook up her receptionist so badly that she locked the office doors & wouldn't even allow patients to enter.

— I've heard from all authorities involved that they have seen worse-but that doesn't make what my children are enduring acceptable. I have numerous pictures, videos, & medical records showing abuse is happening yet I cannot get anyone to act.

Our school principle knows of several other children enduring abuse but their experience has been the same as mine. I know several other women who are enduring abuse but won't get out because they have watched my family's situation & have learned its better to endure abuse to protect your children. I used to counsel women to get out of abusive situations but cannot give this counsel any longer; it only gives the abuser free reign to do whatever he pleases to the children.

I also would encourage those in authority who are willing to stand against the tide to do their jobs. I know how difficult it is to stand in the face of adversity. But I would admonish those in authority who receive a paycheck to protect children to do so because every little child is the Apple of God's Eye & deserves protection. I have received threats & pray all of those unwilling to stand against fears of retribution to change vocations because I believe God has placed those in authority that do not bear the sword in vain-eventually all will be exposed. My most earnest prayer is that the needless suffering of our children be stopped now.

* THERE NEEDS TO BE A SAFETY NET FOR WHEN CHILDREN'S PROTECTIVE AGENCIES FAIL. HAVING AN OMBUDSMAN IS A GREAT IDEA, BUT SHE NEEDS ADEQUATE FUNDING TO SUCCESSFULLY DO HER JOB.

* I WOULD ASK THAT PRESSURE WOULD NOT BE APPLIED TO MERELY KEEP STATISTICS DOWN BUT RATHER TO TRULY PROTECT OUR CHILDREN.

ST. JOSEPH PROBATE COU

Peter J. Nemeth, Judge
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1000 S. Michigan St.
South Bend, IN 46601-3426
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October 5, 2012

Senator John Broden
Indiana State Senate
200 W. Washington Street
Indianapolis, IN 46204-2785

RE: DCS Interim Study Committee

Dear John,

I am writing this letter to advise you of certain items which I think should be seriously considered in trying to improve the Indiana Department of Child Services.

My recommendations are as follows:

1. Eliminate the central call center in Indianapolis.

2. Allow prosecutors to once again file CHINS actions.

3. Take the power to license service providers away from DCS. Under the current set up the DCS is judge, jury and prosecutor, and too much power is centralized in one office. It is my view that this power has been misused in that service providers have been forced to reduce rates and as a result services for children have been cut dramatically in the State of Indiana. It would appear to me that the free market is the best place to control costs.

4. Restore the ability of Juvenile Judges to place children in out of state placements. As you may be aware, this Court had used several out of state placements which cost less and produced better results than any such placements in the State of Indiana. It also provides a free market check on cost because it gives the Juvenile Judge a wider latitude in determining the best service for the best price.

Very truly yours,

Peter J. Nemeth, Judge
St. Joseph Probate Court

PJN/sab

CSIC
October 11, 2012
Attachment 13

Michelle L. Woodward
Prosecuting Attorney

Timothy M. Sledd
Chief Deputy Prosecuting Attorney

Office of the Prosecuting Attorney
81st JUDICIAL CIRCUIT
LAWRENCE COUNTY, INDIANA

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Bedford, Indiana 47421
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October 11, 2012

Attention Members of DCS Interim Study Committee:

I was asked to provide comment on the issue of the "Hotline Pilot Program" implemented in Lawrence County. The comments and suggestions contained herein are not exclusively mine; rather when asked to comment on these issues, I sought input from law enforcement officers, members of our Child Protection Team, and Senator Brent Steele.

Apparently, a "Pilot Program" was launched in Lawrence County allowing law enforcement to bypass calling the hotline and call an on-call local DCS caseworker in an emergency-type situation involving abuse. In talking with law enforcement, it appears they are appreciative of the opportunity to contact the local DCS office directly and feel that the times they have had to do that, it has worked out well. I understand Senator Steele is suggesting a bill that would expand that option to prosecutors, judges, doctors and school officials.

The Lawrence County Child Protection Team (CPT) has been reviewing hotline screen-outs via email, for about the last two months. I do not know if this is part of the Lawrence County "Pilot Program", because frankly there has not been good communication regarding the "Pilot Program," and what it entails. Further, I have been told that other counties have been reviewing their "screen-outs" for some time, so this does not sound like a new concept. In late September, our local newspaper reported that the "statewide hotline isn't even in use in Lawrence County now because of problems and delays. Lawrence County has a state-approved pilot program that does not rely on the hotline." Which of course, is not true. Regardless, our CPT receives a batch of screen-out reports via email from the DCS Director. The CPT is typically given a short window, of about two working days, to review the screen-outs. If upon review, someone on CPT believes the report should be "screened-in" and investigated, they reply to all setting out the reasons. If a majority agree, it is my understanding the DCS Director takes that request to someone like a regional director and a decision is made by DCS whether to investigate. There is little to no follow-up to the CPT regarding what action was taken.

I have several concerns regarding this process that I would like to bring to your attention:

1) **There is a significant time period between when a report is initially made and when the CPT responds requesting an investigation.** An example: an initial report came in on September 10, 2012. It was screened-out. The screen-out was sent to the CPT on September 20, 2012 (10 days later). The CPT had until September 24, 2012 to reply and request an investigation. The majority of our CPT replied that we did not believe the report should have been screened-out and requested an investigation. So at that point, fourteen (14) days have passed and a child's situation that should have been looked into has been put off and for fourteen (14) days that child could have been in danger.

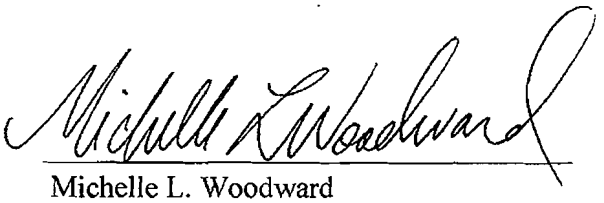
2) Typically, your CPT is made of busy professionals who are volunteering their time to serve on the CPT. Further, I am sure there are CPT throughout the state that do not have good participation from their members. There have been times, when I have been in a trial and have been unable to reply to the screen-out email. Or someone on CPT could be on vacation and unable to respond. **If a majority does not reply then that child and their situation that should have been investigated does not get investigated because a majority were unable to reply to the email. That child falls through the cracks.** That is unacceptable and it should not be the responsibility of those volunteers on the CPT to ensure that does not happen – **that is not our job!**

3) **It does not appear that the screenings by the hotline comport to community tolerance and standards.** Since our CPT has been reviewing screen-outs, nearly every week there has been one (1) or two (2) cases that the majority believe should not have been screened-out and should be investigated. We are a relatively small county, so the number of screen-out reports to review is manageable. I assume in a larger county, reviewing those screen-out reports would be extremely difficult to stay on top of. If every week, there are cases that our CPT believes should have been investigated and not screened-out, one should ask why is it that this team of professionals thinks this should be investigated but DCS does not. Is there something wrong with DCS protocols? An example of a screen-out that got a majority request to be investigated was a doctor's office calling in that they believed the parents were using a child's medication and not providing it to the child. How does that get screened-out? Another example of problem was a situation that got called into the hotline by either a school or law enforcement and was screened–out and the same situation got called into the hotline by the child's treatment provider and was screened-in. I, of course, do not know the specific information provided in each call but find it disturbing that two calls could come into the hotline regarding essentially the same situation and get opposite results. Are there "magic words" that have to be said in order for a case

to be screened-in? **Is anyone keeping track of the cases that were initially screened-out and then screened back in and comparing those situations to DCS protocols to determine if there are changes that need to be made to the protocols?**

I appreciate you taking the time to read this letter. I hope this information provides useful to you in considering changes that need to be made in order to better DCS and ultimately better serve Indiana children.

Sincerely,



Michelle L. Woodward

CSIC

October 10, 1012

Written Testimony for the Indiana Legislative Interim Study Committee on the Department of Child Services; submitted to K. Norwalk via Legislative Services; with regards to Agenda for October 11, 2012 hearing.

Prepared by: Christina Morrison, Executive Director of the Indiana Foster Care and Adoption Association, Inc.; and on behalf of the Board of Directors.

Dear Senator Holdman and Representative Noe, and Committee members;

Thank you for receiving this letter and your attention.

Indiana Foster Care and Adoption Association (IFCAA) is an organization that supports, educates and advocates for foster, adoptive and kinship families. IFCAA was incorporated in 1974 and has enhanced the foster care system in this state through its past partnership with Family Social Services and recent partnership with the Department of Child Service as a bridge and liaison to parents and children navigating a government system. I have had the privilege of serving as Executive Director for 20 years.

IFCAA recruited foster and adoptive homes for the state of Indiana from 2003 through 2010 that benefited not just state government but private agencies, as well as families and the children themselves. IFCAA led the state's very first advertising campaign to recruit foster families and assisted the state with their plan to create permanency for children and improve communication to the network of people involved with caring for children. IFCAA staff and leaders worked with DCS staff in a spirit of team effort to improve the child welfare system, through statewide community recruitment events to coordinated training events that brought the wisdom of seasoned parents and the knowledge of the DCS staff together to educate caregivers. But in 2010 all of that changed.

As DCS began to implement the austerity measures called for by the Governor, recruitment efforts for children were scaled back. The Indiana Heart Gallery website was shut down, the Indiana Foster and Adoptive Call Center was shut down and the DCS adoption website to recruit families for waiting children was outsourced to a national website, making communication for families more difficult. The publication of the Indiana Adoption Picture Book, which features children waiting to be invited to join a family, was scaled back from a monthly issue to every other month. In light of our current environment of the political advertising campaigns, it seems everyone knows that advertising and public relations is the key to successful recruitment. The stated recruitment vehicles for children were and are considered best practice, and indeed the Department of Child Services was lauded for the recruitment successes aided by IFCAA. However, in order to save money, the department shaved programs and cut in half the means to achieve permanency for children. *The research shows that achieving permanency for children saves more money to our communities than it costs to recruit for them.*

Other cost-cutting changes that directly affected foster parents and children in foster care began to be implemented. DCS ended all contracts with the statewide network of training providers that had educated and provided a vast amount of child welfare knowledge, specifically foster care

knowledge, to the thousands of care givers in Indiana that parent special needs children. The training of foster parents was transferred to DCS case managers. Deep knowledge and years of experience was replaced with staff that had to be taught to train basic skills and a DCS workforce that turns over constantly, with a strong reliance on internet training. Thousands of foster parents lost the support and advice of competency-based trainers and they lost access to a vast pool of knowledge. In that process, as relationships were being severed across the state by DCS, the department continued to change course without the input and teamwork from stakeholders and community liaisons. DCS changed the required training hours for people to become foster parents from 23 hours down to 10 hours. The required number of continuing education hours increased a little, but the current required education is still less than it used to be, and cost is the only consideration. *It is not safe to put children into a foster home that is not adequately trained.*

More than two thirds of the children that come into the foster care system go to school and/or require daycare. One of the requirements to become a foster parent is that you must have income independent of the daily foster care per diem to care for children. Many, if not most, foster parents work outside the home. The recent decrease in the foster care per diem daily rate has caused many foster parents to pay out of their own pocket for the daycare costs of foster children. The daily per diem rate for a child needing daycare adds up to about $159 a week in reimbursement to the foster parent. If daycare for that child is $125 a week, then the foster parent subsidizes the cost of caring for Indiana's foster children, because the cost of the child's food, needed clothing, toys, shoes, etc., tally up to more than the $34 a week difference. The stated DCS policy allows foster parents to request funds for special items needed for a child, but the purchase has to be pre-approved and requests are often denied. Like other providers, foster parents must invoice the state and wait 30 days to be reimbursed for out-of-pocket expenses. Their invoices have been denied without sufficient explanation or notice, and then foster parents deal with DCS staff that is unsure of billing procedures when searching for those explanations. *While some people may continue to foster for the department, their commitment may be as short-lived as their ability to subsidize the child welfare system allows or they stay in long enough to finalize an adoption and quit fostering.*

Cost cutting measures have affected adoptions too. While perhaps the adoption trend has shown some decline, that is only a small part of the adoption picture. Several years ago, when the child welfare system became funded by the state budget, rather than the counties' budget there was another financial cut to children with special needs who were waiting to be adopted. The federal adoption subsidy does not reimburse the state for some children needing adoption. So instead of providing a state subsidy like the county departments used to do, the state signed agreements with all of the new adoptive parents and stated they would financially assist the qualified parents as soon as funds were available. *The unwillingness of the administration to fulfill a financial promise to almost one thousand adoptive families in funding state adoption subsidies while returning money to the general fund is not good public relations. It doesn't rank among best practice and it hurts children.*

As part of the austerity measures, DCS negotiates federally-subsidized adoption subsidy with pre-adoptive parents. DCS begins negotiations by offering nothing to assist the parent with the same special needs that required services in foster care. In the world of child welfare, not only is adoption subsidy considered best practice, the research indicates it is critical to achieving permanency and saving the state money in the long run. Aside from offering nothing to a family to help achieve permanency for a child with special needs, the process itself has been reported to be intimidating and mean-spirited. *One pre-adoptive parent reported that the DCS attorney told them that the husband should get a second job instead of allowing for the federally subsidized assistance.*

Imagine what it is like to bond to a child with Cerebral Palsy through a year of fostering. In trying to make the decision to adopt, the parent's financial picture is a big part of the equation. When the DCS attorney offers no subsidy to assist the ability to parent the child in the future and tells the parent they have to demonstrate why federal adoption subsidy is needed, the parent must submit dozens and dozens of receipts. After that is all done, the parent of the child with Cerebral Palsy is offered $6 a day and told to "take it or leave it." When the pre-adoptive parent says they cannot possibly afford all the extra costs of care at $6.00 a day, then the pre-adoptive parent is threatened that DCS will remove the child and put the child in an "adoptive home." *This is a true story and there are many, many more like it.*

What all of this adds up to may be a leaner budget, but the impact is an eventual downturn in adoptions and the inability to provide competently trained and willing foster parents to care for children. Given all the past testimony to this committee, it is apparent that the public and the care providers are willing to go the extra mile for children and dig a little deeper out of their own pocket to help children. Unfortunately, their willingness has been breached by the administration's actions of cutting services and resources. As the DCS austerity measures became broader and deeper, relationships between providers and DCS became more strained. The environment of child welfare in this state changed from a team-effort strategy to aid children and families with community partnerships to a silo strategy where input from providers, stakeholders and the public has been shut down and cut off. *A provider's contract with DCS to provide services now is not a testament to partnership; rather it is a tool to provide just cause for deniability at the state level.*

Members of IFCAA have observed, and some have experienced, that at the most basic level of the foster care system – where children taken out of their homes are placed into foster homes – the decisions being made are aligned with cost first and people second. Foster parents are struggling more now to care for children, not just financially, but also keeping up with the constant turnover in front-line DCS staff and lack of staffing, the changes to policies and how they are implemented, and the loss of services to themselves and the children they care for. *There is a knowledgeable and skilled staff that works for DCS, but they cannot replace the body of wisdom that exists within the community and its field of professionals in the services of a child welfare system.*

IFCAA's experience of over 39 years of training, educating and supporting foster parents has demonstrated that foster parents equal professionals when given the proper tools and information. It is disappointing that the DCS study committee has not given foster parents time on the agenda to voice their concerns as they are essential to the child welfare system, especially at a time when more and more children are being placed in foster homes instead of residential care. *If there is an agreement among the public, and those spending the public's money, that safety of our community's children is a priority, then the resources cut from the current foster care system must be restored.*

This Committee has stated that it desires testimony that offers recommendations and solutions. It is in that spirit that IFCAA submits the following recommendations on behalf of the thousands of foster/adoptive parents that care for over seven thousand children a year in this state:

- IFCAA recommends that foster care per diem rates are supplemented with assistance for daycare costs and make available the monies that are in reimbursement policy to reimburse foster parents with clothing and incidentals; and provide foster parents better assistance in the invoicing process.

- IFCAA recommends restoring federally subsidized adoption subsidy to adoptive parents at the standard rate, rather than making the negotiation process

one that is demeaning to people. IFCAA also recommends that the state adoption subsidy be funded and adoptive parents are given the same assistance as federally subsidized assistance.

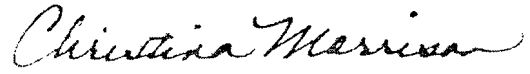
- IFCAA recommends that the policies which were put in place prior to 2005 that provided foster parents a voice and a means of communication for case plans, case conferences, court hearings, mediation and allegations be restored, because they were erased from the policy manual. Additionally, IFCAA recommends that the intent of the federal Adoption and Safe Families law be restored in DCS policy requiring the participation of foster parents in the creation and implementation of case plans.

- IFCAA recommends that the number of training hours required by new foster homes be restored to 23 hours and that DCS ends the policy of restricting foster parents to be trained solely by DCS staff for licensure qualification. Additionally, IFCAA recommends that foster parents be trained immediately in the care of trauma, before children that require therapeutic care are placed in their homes.

- IFCAA supports IARCCA and others that have offered the solution-based suggestions of re-claiming and re-designing the Regional Service Councils, as well as restoring partnerships and improving collaboration between DCS and the private sector.

Thank you for consideration of these recommendations.

Respectfully submitted,



Christina Morrison, Executive Director

10/04/12

CSIC

All interim DCS study committee members,

As all e-mail addresses were not available for all members, I trust this e-mail will be relayed to all committee members.

In all the many years I have been to Indianapolis fighting for children in the child welfare system, I felt this year had the best potential for making drastic changes.

We have one political party in charge, the onus is ALL on them to really change the DCS and focus on the children in the system first.
Now, at least there is no collective bargaining union members job, who comes before the life of a child.

I'm feeling quite perplexed at the announcement from Sen. Holdman, that he and Rep. Noe have surmised from the 3 DCS hearings, they will introduce a bill on tweaking the hotline.

With all the judges and lawyers available knowledge on the committee, is there no sense of violating the civil rights of children with the hotline?
Would we say a woman or a person of color has to call an 800# to report abuse? Why are we giving the most precious and vulnerable among us the least protection?

As I stated in my suggested solutions above, discontinue the 800# immediately, it's a violation of the Civil Rights Act of 1964, Does anyone believe children who don't vote, aren't classified as persons? Narcissistic adults trample on children at risk because they don't have a voice, yet Gitmo prisoners have their rights represented by U.S.taxpayer attorneys.

Safety personnel like law enforcement and firefighters work 24 hour shifts. I urgently suggest DCS social workers,
ride with an assigned law enforcement officer in every city and county each shift.

The DCS reports this hearing, said DCS workers go into dangerous situations, riding along with the law, they will be better protected.

The way child abuse calls or addressed now, the child is not given first responder emergency attention. If a house is on fire, seconds count, the child abuse call should be treated with immediate responsive emergency, as a reported fire is treated. The 911 dispatcher doesn't ask how high are the flames for a reported house fire.

So many issues need to be addressed to strive for making the pendulum swing to the other side, maybe Indiana could be revolutionary in the U.S. in saving the lives of children, instead of being number one in killing them after they are born. It's heartbreaking neither political party was unnerved by this egregious distinction in Indiana.

Republicans, don't tinker with mealy mouth legislation, you have the power to help save children in a very failing agency. By the DCS admission, only 6% goes for prevention in their agency. Why is this alone not a red flag?

My 10 suggested solutions above were not without merit, the I.U. study was very good and could be updated and put in graph form without much effort.
Rep. Charles Brown told me years ago at a DCS study he was going to see all legislators got a copy, speak up if you received a copy.

All long term legislators are aware of the on going child welfare agency problems, drop the politics and

work together for the children, now is the time.

In all the years I've been watching legislation for the benefit of children in DCS, there has been next to nothing that errs on the side of children.
This year I'm hoping ALL the legislators will refine the DCS into a stellar agency that protects children first and foremost.
The DCS needs a complete ovehaul, no business could survive with such careless policies and practices.
The DCS has to be scrutinized with the utmost precision, a child's life is at stake, it could be one of your loved ones, as James Payne can attest to!

This legislative DCS study committee work is far from finished, It was a two headed monster, one head was decapitated, one head and an enormous body with
a very menacing aggressive nature is alive and functioning. The curtain on Oz is ragged, finish the job, pull the curtain back and expose the creature that has terrorized
the lives of families and been negligent in the preventable deaths of innocent healthy children.

So many issues in one agency to fix, You wouldn't let your money stay in a bank with such incompetent management.
I have approached Old National Bank about working on real time data for tracking children in the DCS.
They are Indiana based and very community minded. ONB just won a prestigious ethics award, they could help in many ways.
We have the means to correct an archaic, dysfunctional child state agency.

There are 3 to 4 % of children lost in the DCS system, maybe more at any given time, That teflon word confidentiality is old scare tactics, redact names.

After all the testimonies to this committee, I hope you have had insight enough to understand you need to do more than to change a few words here and there,
that won't save a child.

The anger and sadness I feel every year, is that politics has been a cause in part, of preventable deaths of children.

Ignorance and Indifference or the only two reasons for the continuation of our "Humpty Dumpty" DCS.

All of you together can make the difference in saving the life of an innocent child.

Let us all put meaning into the rhetoric; nothing is more important than the life of a child!

Carole Davis
812-477-0660
kiddosfirst@hotmail.com

CSIC
October 11, 2012
Attachment 16

CSIC
3020 Lake Stream Drive
Columbus, IN 47201
October 8th, 2012

To Whom It May Concern,

We write this correspondence today in order to outline our experience, or lack thereof, with the Department of Child Service of Decatur County. We will be completely honest and forthcoming in this letter. It is the only way to get the point across, and hopefully start the winds of change. The old adage, "we can't fix it, if we don't know it's broken", won't apply after this letter is read in its entirety. We would like to believe that our situation is one in a million, or an exception to the normal. It is sad however, because we feel our experiences ARE the normal....especially in Decatur County.

Our first contact with DCS of Decatur County (from here on known as DCSDC) occurred in the spring 2012, March 23rd to be exact. We learned that DCSDC was notified of an incident between our oldest daughter and her father. The report stated that during an argument, the father pushed the oldest daughter down some stairs. It was also reported that at one time, the father had slammed a cell phone down on the leg of the oldest daughter resulting in a red mark. This report was screened out for the following reasons...

- No statements or observations indicating sustainable injuries to the child
- The abuse to the child does not appear to be happening on a consistent basis
- Last incident occurred in January and there have been no other reports of abuse.

Let's break these down with the best interest of the child in mind, which from what I'm told is supposed to be the mind set of DCSDC. "No statements or observations ...sustainable injuries to the child." Isn't the caller giving a **statement** that indicates a sustainable injury? Red mark from a cell phone and being pushed down a flight of stairs are apparently not severe enough to invoke any kind of action on DCS' part. Maybe next time the shove down the stairs will result in a compound fracture or a severe concussion. On the other hand, if actions were taken to protect the child, there wouldn't be a next time. "Consistent basis." What is a consistent basis? Is it every week, every other, the second Tuesday of each month? How much abuse is enough consider it "consistent"? "Last incident." You mean there was one before this? What will the next report say? "Other than the last 2 reports, there hasn't been any other report of abuse." Really? The first report IS the "other "report they are speaking of. Report was screened out.

The next report that was taken in our case, concerning the children and their father, was taken on May 16th 2011. This report, in short, outlines the living conditions and yet another scenario concerning the oldest daughter and her father. This time physical abuse wasn't as present as the first 2 (yes, 2 prior) incidents. This report outlines the concerns centered on the mental and emotional well being of the oldest daughter. This time she was denied clean clothes and underwear. She was told she

could shower, but was going to be forced to put on her dirty underwear. I don't blame her for not wanting to shower. Why make the effort if you're just going to be wearing the same dirty, possibly soiled, etc. undergarments from days past. Cruel for a child at any age, but especially unfortunate for a girl. A girl who is going through the changes of puberty and has already received her menstrual cycle. Not only is she denied the opportunity to wear clean underwear every day, she is forced to sleep on the floor, air mattress, or couch of the father's residence. A child of that age, with that level of maturity, needs to be provided with her own space, her own level of privacy, and yes, CLEAN underwear. This report was, of course, screened out. No physical injuries results in no action. All the while, this child is stuck in an environment which subpar to say the least. This report, like the other, was screened out.

Report number 3 occurred June 17th, 2011. This report has multiple issues; we'll briefly outline them here, and then touch on the actions taken by DCSDC.

- When at the YMCA, the father requires the 3 youngest children, 2 boys and one girl, to shower in the men's locker room after workouts and other activities. The children reportedly are wearing their bathing suits in the shower, but unfortunately are forced to see grown men naked during their time spent in the locker room. The youngest girl (age 7)reported that she saw " big men, like daddy, naked & some naked with grey hair & it was really scary."
- Youngest girl of the children was pulled over while driving the father's vehicle ON the road. The child is 7 at the time. Let me say that again... 7 YEAR OLD GIRL WAS PULLED OVER WHILE DRIVING THE FATHER'S VEHICLE ON THE ROAD.
- Briefly touched on the fact that the father not only left the 3 small children in his residence (a trailer) during a tornado/sever storm, they were left alone!
- Again, touches on the oldest daughter being denied clean clothes as a punishment.

This report was again, screened out. Possible sexual abuse, child endangerment, and physical abuse....screened out.

Report number 4 was taken on June 20th, 2011. This report, again, touches on the continued emotional and physical abuse of the oldest daughter. Denial of clothing, hitting with a rolled up newspaper, isolating the child while taking the other children to dinner and remanding the oldest to eat pop-tarts for dinner, etc. This report was screened out due to lack of physical injury.

There was also a 5th report taken that focused on the father of the children allowing them to drive golf carts, 4 wheelers, and other motorized vehicles without supervision, or any sort of safety equipment. This report ended with a trip to the hospital and an injury to the youngest girl, who was 6 at the time. This report was also screened out for a list of reasons.

The next set of reports is where things start to come together and fall apart all at the same time. April 13th, 2011, the oldest daughter disclosed to her counselor that there had been incidents of being "inappropriately touched by her father". This report and investigation was spearheaded by FCM[redacted]. In the beginning of this investigation we were impressed at what[redacted]had to offer. He stated that he wanted to talk to the three little ones, many times. He wanted to speak with[redacted]and

I , he wanted to speak with the oldest daughter , he wanted to speak with the father, and he would speak with everyone multiple times in order to get as much information as possible. As time passed, and he talked to everyone ONCE, that seemed to be all we got. [redacted] wouldn't return phone calls, hadn't spoken with anyone beyond the first interviews, and generally fell of the face of the Earth. He never spoke with the 3 smaller children again, he only spoke with the oldest child once, he spoke with [redacted] once, he spoke with the father once, and I had to track him down, call him multiple times, and ended up getting his cell phone number in order to speak with him. We heard NOTHING from [redacted] for almost 4 months! Upon receiving a letter in the mail, postmarked August 1st, 2012, we found that the allegations against the father were found to be unsubstantiated. Furious at the lack of effort, lack of communication, and frustrated that a child finally comes forward and receives ZERO help, and now the allegations are UNSUBSTANTIATED. We were furious.....until we read [redacted] actual report...then furious didn't really come close to describing the emotions that poured out of us. There were 7 noted points of information in [redacted] report;

- Received the call where RS stated that there had been inappropriate touching between the father and the oldest daughter, mentioned previous reports where father had hit the children with rolled up coloring books, newspapers, verbal abuse, and the pushing down the stairs incident. Stated that the oldest daughter had run away from the father's care last summer and had not been back.
- [redacted] spoke with the little 3 children. This was on a Friday when they were supposed to go with their father for the weekend. All the children were scared to be late to their visitation, and didn't speak of anything out of the ordinary. I'm assuming that considering the timing, the circumstances, the previous reports of temper and abuse, the fact that [redacted] was a stranger to the children, and they were scared to be late, that they wanted to be done with [redacted] as quickly as possible. [redacted] stated that he would sit down with the children again to see if they would speak more freely....that never happened.
- [redacted] set up a forensic interview for the oldest Daughter.
- [redacted] conducted the forensic interview with [redacted] and the child in question.
- [redacted] spoke with the father. Father only spoke of his ex-wife, and his family. Nothing was said about his relationship with his daughter. He denied allegations.
- [redacted] spoke with Custody Evaluator from the divorce proceedings. She stated that the daughter's relationship had deteriorated to the point where the child felt her only remaining choice was to run away.
- [redacted] spoke with the child's counselor. She didn't relay any new information from the initial report that was made.
- [redacted] spoke with Det [redacted] of DCSD who reported that no charges would be filed due to inappropriate touching not being under the clothes.

Where to start? There is so much to say about this investigation and the things that happened, and even more to say about what DIDN'T happen. It seems from our end, that [redacted] did the absolute bare minimum in this investigation. He spoke with the other children one time (at the time of the interview

the children were 10, 7, & 5), at an unfortunate time, at the foot of a weekend with father, at a time where if they didn't speak quickly they would be late for father's weekend (which is a issue that would cause and has caused a temper flare up), and he was asking them to speak about a topic they wouldn't be comfortable, to a man they have met not more than 5 minutes before the conversation was forced to take place. [redacted] stated to [redacted] that the children didn't say anything, but seemed uneasy. Well, yes they were uneasy. They were questioned about an uncomfortable topic by a stranger, and they were staring down the barrel of a gun that was dad's temper for being late! [redacted] should have followed up with the children TIME AND TIME AGAIN! He should NOT have given up after the first time!

The most disappointing aspect of [redacted] report is that, NO WHERE IN HIS REPORT DOES IT DISCUSS THE PREVIOUS RELATIONSHIP BETWEEN OLDEST DAUGHTER AND HER FATHER! There are 5, yes 5 previous DCS reports concerning the oldest child and her father. NOT ONE of the previous reports where mentioned in the investigation, NOT ONE! I know I personally spoke with [redacted] about our oldest daughter's relationship with her father, what she's experiences, what she's shared with us, and what she's shared with her grandmother. That was not included in the investigation report. He also spoke with [redacted] about the same topic s as he did with me. She expressed concerns in the same areas. That was not included in the investigation report. [redacted] spoke with the child's grandmother. She explained the past relationship and problems. That was not included in the investigation report.

It seemed and still seems to us that the most vital of information, the most important of puzzle pieces needed to place all the right things into perspective, were ignored, dismissed, or swept under the rug. [redacted] felt that it was more important to mention the former relationship betwee [redacted] and the children's father, but didn't' mention a damn thing about his relationship with the child in question! They found that the father inappropriately touched the daughter, but it was above the clothing, which is apparently acceptable....inappropriate, but acceptable. What's the use of teaching young children "good touch, bad touch" if we have to add an "above clothes or under clothes" stipulation. Inappropriate is inappropriate!

As a former teacher, it is a normalcy for me to put the needs, emotions, and protection of a child first [redacted] is a CASA and is very informed and educated in the way that certain things involving DCS should be handled. From my perspective the emotions and protection of the father was the only thing that was focused on in [redacted] report, not the child's. In the perspective of [redacted] did NOT do the do-diligence required of a DCS Family Case Manager. He did not exhaust all options, all contacts, and all information that would make sure that the child's needs are placed first! In the legal system you are guilty until proven innocent. In the Child Welfare system, an Family Case Manager should not be looking for information or evidence to prove that the event or action DID happen, they should be focused on trying to prove that it DIDN'T happen. If an FCM is going to make an error, they need to error in favor of the child in order to protect them! It is easier to remove a child and make sure nothing has happened, as opposed to placing a child in an environment where the next time could be the last.

The saddest part of this whole situation is that we are currently in a second investigation for a similar allegation between the oldest daughter and her father. We are currently waiting a result from

the investigation, but we are going through the same thing. No contact from the FCM, no return calls, no return emails, and no communication. Multiple phone calls and messages have been made to the Decatur County DCS office, for the FCM and her direct supervisor. Again, we have received no call back, email, or any other contact. According to DCS the case is left open for 30 days & then a decision is made to be *unsubstantiated* or *substantiated* . We are past the 30 days & have no idea what they are doing to help the child who was abused since no one will return a call, text, or voicemail!!! We can only assume that nothing will be done, again, to help these children.

We are disheartened by the fact that we are going through this again, and we are still dealing with the unprofessionalism, the lack of communication, the inability to do ones job, yet still have the energy to put the blame, task, or effort off onto someone else. With [redacted] being a CASA, it is really difficult to sit back and know what DCS is supposed to, and can do, yet they choose to just not do it. Whether its incompetence, lack of motivation, or just a generally haphazard and carefree attitude, they only people that are left dealing with these things are the children who finally gather the courage to tell someone and ask for help, then get slapped in the face and the parents who have to deal with the aftermath of the let down. These children more times than not, decide to not speak of things that occur or have occurred in fear of humiliation or consequences. It's extremely disappointing to know that they are slapped in the face by the same people who are supposed to help them. As parents, what are we supposed to tell the child who comes forth and is given ZERO help? Are we supposed to keep telling them, "it's okay honey; you just keep telling when something bad happens. Someone somewhere will help you eventually." That is unacceptable.

The effort put forth by DCSDC in all the instances that concern our child/children is horrendous. It's painful, hurtful, disappointing, and disheartening as a parent to have to watch your children struggle through hard times and then be continuously let down and left floating in the issues left unresolved. Let us hope that our latest investigation results in some help for our children. Department of Child Services is an organization that is based on, works for, and is supposed to be activists for CHILDREN. Until that is placed back at the top of the list, children will continue to pay the price for lackluster effort, and subpar performance of Family Case Managers like the ones in Decatur County. We realize that there are guidelines in place for DCS to follow when they investigate a case and it seems IF that process is actually followed and the steps are taken, children will be kept safe. However, our dealings with them have shown that they DO NOT follow the guidelines and procedures that they have in place and their effort is lacking to say the least, in following through with the steps they say they will follow. Telling the mother of the child who has been sexually abused that they are there to help and will interview everyone involved MULTIPLE times, meet with the child(ren) on MULTIPLE occasions, and "don't hesitate to call us if you have questions or need additional help" .. To then have ALL communication with them stop after making that statement is very frustrating to say the least. We are anxious to hear from DCS on why our case(s) were handled in such a manner, what reasons they have for the lack of communication, and how we keep these innocent children safe, from this point on. DCS needs to be held accountable for their actions (or lack of), before another child dies in Decatur County.

The oldest child has been ordered to go back to having visitation with her father, in December of 2012. We are very fearful for her safety if this actually happens. She is an amazing child who has been through a lot and she just wants someone to stand up for her & help her not have to go through continued abuse. She is currently an A-B student, active in school & church, on the basketball team, & has a great group of friends. The issues with her father take her to a dark place and she has voiced to us and others that if she is forced to go back to her abuser that she will run away or hurt herself. As her mother and step-father, that is heartbreaking to hear and heartbreaking to know that we can't help her feel safe. We are begging for someone to help us keep her and her siblings safe.

Thank you,

Justin and Miranda Burt

CSIC
October 11, 2012
Attachment 17

Rep. Cindy Noe,

Re: Child Services Interim Study Committee

Recently, a 3-year-old died in Johnson County of an apparent intentional drowning during an overnight, unsupervised visit with his mother who was on probation and had a history of drug abuse and mental health issues.

According to media reports, a court-appointed special advocate (CASA) had been appointed. But the judge did not wait for the recommendations from the CASA volunteer before making the decision for an overnight unsupervised visit that resulted in a tragic ending.

I'm Dick Huber, a retired physician, and a former CASA volunteer for several years who finally had enough. Female CASA volunteers seem to tolerate the "system" much better than male volunteers. Females stay focused on the children. Male volunteers finally say "They are not going to treat me that way" and leave the program. Our program had very few male volunteers and that is probably the situation in most counties.

I had planned to attend one of the committee hearing meetings but was not sure where CASA matters really fit in. Therefore this e-mail.

We often want to throw more money into programs hoping for improvements. Hopefully you will also look at the CASA programs which I believe could be more beneficial in protecting our children. Apparently there are at least two types of CASA programs - one supervised by the courts and one by an outside agency. Please look and compare the two types of programs.

As a CASA volunteer who experienced concerns about the handling of some children's affairs by the court and child services, I would talk to the CASA director but not much ever changed.

Example #1: a teenager stated that her mother's boyfriend had sexually molested the daughter. I brought the concern to the court hearing and an attorney was appointed. Two months later, nothing had been investigated and nothing had changed. Example #2: I made a foster home visit when three children were initially placed in the home. One week later upon returning for a visit, I was informed that the children had been relocated to another unknown foster home. Example #3: During a visit to the school in another county of two children, I learned of excessive absences, only to discover the judge/court had closed the case without any notification to the school, CASA director or volunteer.

I realized later that the director might find it difficult to bring concerns to her boss, the judge, in fear of jeopardizing her own position/employment. This situation might be avoided if the CASA director were not an employee of the court or supervised by the

judge. Please address this issue.

I often experienced the court and child services making decisions, changing orders or closing a case without the CASA director or volunteer ever being notified or aware of such action. I was asked for my report at court hearings but not notified of concerns and actions until the next court hearing.

CASA volunteers can provide a valuable service. But if the court/judge/child protective service makes decisions without input or recommendations from the CASA volunteer, tragic event may occur as it did in our county.

Please address the issue of better utilizing the CASA program and whom has direct supervision of the CASA program. Valuable services of findings and recommendations for the children can be offered by the CASA volunteer but the courts, attorneys and child services often find it difficult to include the CASA workers, or choose to exclude CASA input.

Thanks for listening and please provide more safety for our abused and neglected children.

Dick Huber, M.D.
31 N. Restin Rd.
Greenwood, IN 46142
317-885-9078

October 11, 2012
Attachment 18

CSIC

From: Tom Bell [mailto:tbell0706@hotmail.com]
Sent: Monday, October 01, 2012 7:11 PM
To: h87@in.gov
Subject: CPS testimonial

To whom it may concern;

I am a very frustrated and loving father whose daughter was molested and CPS failed to do anything about it. There exact words were: "Unless you are masturbating anyone can touch a child anywhere they want. And since she was only touched once its not a crime it has to happen more then once." I, also, found out the reason why they did not investigate this as serious as they should have. Supposedly it is rare rare rare rare that females molest children especially when they are little girls. That is unacceptable behavior done by the so called professionals that are supposed to be there for the children. I have been fighting this since November 2010. My daughter arrived at my house for a visit and within 15 minutes of her being at my house I called the police out and took her statement. He found sufficient enough evidence and that she was not coerced into saying anything and turned it in. Families Victims Unit, which is part of CPS when children are involved, were supposed to take over and they turned it over to CPS and they failed to do any proper investigation. I have been fighting with CPS for over 2 and a half years now. They are one sided and when they pick a side they hold to it no matter what the real truth is or not. October of 2011 my daughter told her school teacher that [redacted] was rubbing her boobies and the teacher misunderstood that she said rubbing her hoohoo. The school turned it in to CPS. When they picked my daughter up for the interview my daughter told them that [redacted] touched her by calling her over to the edge of the bed and sit next to [redacted] and [redacted] put her hands up my daughter's shirt and proceded to rub her boobies. I confronted CPS and they told me she said nothing. I asked to see the tapes and they refused to show them to me. I fought for months to get those tapes and by the time I could get them they were destroyed. Parents or their attorney's should have the right to see the tapes. Plus it should not be able to be destroyed with in 6 months of the incident. It should never be destroyed. I refuse to let this go. Something needs to be done to protect our children from people who cover up incidences that harm children because they have an agenda. Because I refuse to let this go I have been threatened by Family Victims Unit and CPS that if I do not let this go they will arrest me. I told them then arrest me I am not letting this go and I continued to fight for my daughter. Finally, late this spring I confronted CPS and Family Victims Unit and they admitted to me that she was touched by [redacted] (rubbing her boobies) and they still won't do anything because she wasn't masturbating and that she only did it to put her to sleep and that she has done it several times and that I have always been Ok with it. My daughter tells me it only happened once. So I have been being lied to by CPS since the beginning. This isn't the first time that I reported wrongful touching of my daughter by [redacted] April 2010 [redacted] [redacted] went into the bathroom with my daughter's mother and wiped my daughter's but. Unacceptable when the parent is present and my daughter has been potty trained since she was 2 1/2 years old and was almost 5 years old.

CPS has tried to strip my parental rights away from since they been involved. They went as far as and got caught trying to force my daughter to tell them that I molested her in the spring of 2010 and my daughter fought back and told them over and over and over that isn't what happened.

They allowed her mother to give her sleeping pills that was not supposed to be given to children unless given by a professional. I found out about it 3 months after she had been taking the drug. I kept questioning that there was something wrong with my daughter she wasn't looking good and very lathargic. Her mother told me she got permission from two pediatricians. I called them and they denied giving her permission. I turned it in and was told that "there was nothing they could do about it because she can lie to you but not us and you need to have a note from a doctor stating she isn't suppose to have it." They told me that my daughter's mom told them that my daughter's therapist her permission. I called every therapist that my daughter had. They told me that they never gave her permission because they would lose their license. They are not allowed to recommend or prescribe medication. I got the note from

my daughter's pediatrician to put a stop to her being on these sleeping pills. Less than a month later (July 2011) I found out that my daughter was back on them. CPS still wouldn't do anything. They said it was a custody issue not a safety issue.

They have even broke their own rules to protect the mother. There has and always will be an order not to allow anyone to use corporal punishment of any sort on my daughter. One of the major rules when you are a state ward is at no time are you allowed to use corporal punishment on a child or they will be pulled immediately. They allowed her to beat my child over a half a dozen times and lock her in her room (literally locked her in by holding the door handle) in the 11 months they were involved. They started saying that I was just making it up and my daughter was just telling me things I wanted to hear then the truth came out. They came after me with everything that they had to take my daughter away from me. I fought back and proved that what my daughter's mother has been saying was nothing but lies and when the truth finally came out. Instead of them admitting they were wrong and protecting my child they decided to say "Well this is a custody issue we no longer need to be involved." Everything that has been said about me and my daughter by her mother, CPS and Families Victims Unit has been proven to be false. I have never done anything ever to hurt my daughter in any way. But they fought hard to prove it. So you tell me if I am supposedly this bad dad and they still want to talk crap about me then why did they back out. I will tell you because they got caught in a huge cover up and they packed up and ran. The sad thing is I went through the same exact thing that my daughter is going through now. 35 years ago I went through the same thing. CPS calling me a liar because I turned in one of their foster homes for trying to molest me. 10 to 15 years ago this foster home was finally caught. In the 42 years that they were foster parents they estimated approx. 600 kids were molested by them. When is it going to change. More children are molested and die under CPS's hands then any other.

Something needs to change before more kids are hurt or killed. Children in the state of Indiana re safer staying in an abusive home without CPS involvement then they are when they are involved. My daughter deserved and deserves better then what she has been given. There is absolutely no protection for kids in Indiana. When I am told that you must be masturbating or it to happen more then once or you can touch a kid anywhere you want is opening the door for pedophiles to come and make their homes here in Indiana. The pedophiles are protected not the children. If that is how the law is written then shame on the law makers who allow it to happen. Our children should not have to go through this sort of hell. Our lawmakers need to appoint real professionals to over see protecting our children. You can't teach someone how to protect our children from a book you need people who have gone through this sort of turmoil to teach people what really to look for. I refuse to sit back and allow this crap to happen anymore to my child and I will do whatever it takes to help other children. I spent my whole childhood life putting up with being molested and nobody being there to protect me. I will be damned if I am going to let it happen to my daughter and everyone turn a blind eye.

I have more information if you need it and I will be a great advocate for protecting our children in Indiana. Please feel free to contact me anytime. Here is my address and phone number.

Thomas Martin Bell
1143 East Donald Street
South Bend, IN 46613
(989)205-2902

Maureen Gordin

From: Pezzarossi <lpezzarossi@opendooryouthservices.com>
Sent: Monday, September 24, 2012 11:44 AM
To: Senate District19
Subject: Contact Form: Department of Child Services Study Committee

Categories: Sent

<APP>CUSTOM
<MSG>My name is Leah Pezzarossi and I am the Executive Director of OpenDoor Youth Services in Southern Indiana. I have been in my currentposition for nine years, and working with children and families for 16years. As a provider of both residential and outreach services tochildren, I have noticed a number of areas in which DCS practicescould be improved or modified to better serve children.
First, Iâ d like to praise DCS for taking in feedback about itschild abuse reporting hotline. Over the past six months, staffmembers at my agency have noticed a huge improvement in the level ofresponsiveness by those answering the hotline.

Level and timing of services:
In my experience over the past few years, there has been anincreasing focus on giving children the lowest level of servicepossible when DCS and/or Juvenile Probation must become involved. When a level of service doesnâ t appear to be improving thesituation, the child slowly progresses through incrementallyincreasing levels of treatment. The model seems to mirror one ofpunishment where one would start with the least severe punishment andslowly increase it if the negative behavior doesnâ t stop. I believeservices to children involved with DCS and Juvenile Probation shouldactually mirror medical services. Services should adequately addressthe needs of children and families, when theyâ re needed, no matterwhat level of service is required. An ER would treat a head traumawith an adequate response, not a minimum level of care that is slowlyincreased as itâ s discovered the treatment isnâ t working.
My agency saw the current model play out for a child we served. A 12year-old girl was placed in our facility five times over one year forrunning away from home. Her mother was desperate for help and herprobation officer really believed she needed more intensive servicesthan what a short stay in an emergency shelter program could provide. Home-based counseling was tried with no improvement noted. Placementin a residential treatment program was requested by the childâ sprobation officer, but she was told by the DCS consultant who mustapprove such placements that it would not be approved for any childunder the age of 13. Although there is an appeal process regardingplacement disagreements, probation officers have expressed reluctanceto approach a Judge asking him or her to make a ruling in disagreementwith DCS. The young girl ran away a sixth time and was missing forseveral weeks. When she was found, she had tattoos of menâ s names,was being prostituted out by an older man, and had contractedChlamydia. She was finally allowed to be placed in a residentialtreatment program, but only after turning 13 in a juvenile detentionfacility. The system failed to help this child in two ways: thedecision about treatment based upon an arbitrarily selected age didnot protect her, and the removal of the decision-making by theprobation officer meant that the person who knew her and had regularcontact with the family was not the one making treatment decisions. Ibelieve this type of situation would be less likely if decisions wereplaced back at the local level. It is understandable that DCS wouldhave concerns about 92 different counties having 92 differentstandards regarding level of services, but I believe greaterconsistency could be achieved with more training for caseworkers andprobation officers. Local decision-making would allow those mostfamiliar with a childâ s case to have the greatest impact, and itwould also allow the flexibility needed between various counties basedupon the circumstances that exist in each. The level of poverty,availability of drugs and alcohol, and whether a community is urban orrural are circumstances that must be taken into consideration whenhelping a particular child, and those are not consistent across thestate. I believe DCS can maintain a level of excellence (which Isincerely believe to be its goal) across the state without a one sizefits all approach.

Transitioning children:

Another area that I believe would benefit from modifications is theprocess by which children are transitioned between placements. Itseems that most often placement decisions are made with little noticeto the child, the childâ s family, and the current placementprovider. I have witnessed several occasions during which a childplaced with us and then transferred to a foster home, and parents didnot receive notification of the change until after the child actuallymoved. One case in which my agency was involved is representative ofour experience with regards to transitioning between placements. A 13year-old boy was placed in our residential program for several months. He had a history of placements in both foster care and residentialprograms (including ours) since the age of eight. He had a diagnosisof Reactive Attachment Disorder, a result of severe trauma as a smallchild, and he exhibited aggressive behaviors when angry. Thiscondition had only been exacerbated by his dozens of placements. Hehad been adopted, but his adoptive parents were now refusing to takehim back into the home. We recommended therapeutic foster care to hisprobation officer, who proceeded with that plan. We learned on aMonday that there was a prospective therapeutic foster parent, whenshe came by our agency and met with this child for about ten minutes. He was moved the following day to her care. Our concern was that theabrupt change, the lack of familiarity with his new foster parent, andthe lack of opportunity to say goodbye to our staff would preventsuccess of the new placement. About six weeks later, this boy cameback to us. We learned that we would be his sixth placement in thosesix weeks. He had been at three foster homes, a psychiatric hospital,and a juvenile detention center during that time. Of course, theleast restrictive and most home-like setting is the ideal for anychild. However, the individual circumstances of a child shoulddictate the handling of placement. Acknowledgement that an adjustmentperiod for this child was needed could have resulted in a stable homefor him. I would like to see a protocol for transitioning childrenbetween placements that includes adequate time for bonding with afoster parent, adequate time to become familiar with a new placement,an opportunity for children to say goodbye to staff to which they areclosely bonded when appropriate, and a plan which considers mentalhealth diagnoses. Additionally, prospective foster parents needadequate time to learn about a child and the childâ s needs. Ibelieve this protocol should include situations in which a child istransitioning back home after a long placement out of the home. Thiscould further the DCS goal to have children in safe and stable homes.

Emergency shelter care:
Since the 20 day limit has been placed upon shelter care, I believeservice quality for children in emergency shelter care has declinedfor a simple reason - that restriction does not allow the timenecessary in many cases, for accurate assessment of a childâ scircumstances. To give some context to this limitation, DCSâ service standards for Diagnostic and Evaluation Services allows 15days from the date of referral for a clinical interview and assessmentand 30 days from the date of referral for a psychological testingreport to be submitted to the referral source. In order for aclinical assessment report to be back to the referral source within a20 day placement in emergency shelter care, the following would haveto occur:
1) The referral source must submit the referral for the clinicalinterview at the same time as the referral for placement. This can beimpossible when children are brought to a facility by the police or anon-call caseworker due to an actual emergency.
2) The clinician must have the available time in the first fivedays of placement to conduct the clinical assessment, so that a reportcan be completed before the end of a 20 day placement.
When 30 days are needed for a full-scale psychological assessment the process cannot possibly be completed in a 20 day time frame. Afull-scale assessment involves testing with various diagnosticinstruments for several hours, so an appointment for this cannot beconducted on command â it has to be scheduled in advance. After thetesting is conducted, the various instruments must be scored and athorough report has to be written which best practice dictates willhave numerous recommendations for resources and interventions. Manycaseworkers and probation officers use these assessment and testingreports to determine how to proceed with a childâ s case
Our agency has seen a steady stream of children who stay exactly 20days. That indicates to us that the 20 day limit is arbitrary and notalways adequate to address the emergent needs of a child. Forinstance, the Indiana Coalition Against Domestic Violence identifiesemergency shelter as 30-45 days without change and with intensiveservices.
This is another situation in which I believe the decision-makingpower should lie with the local agencies and their staff. I believeDCS caseworkers and juvenile probation officers can be trusted todetermine the amount of time needed in emergency shelter care. Children should not languish in emergency shelter care, but adequateand more appropriate safeguards against that can be determined. Emergency shelter care facilities can offer a number of quickinterventions. Perhaps DCS could compile a list of commonly neededinterventions and allow their completion before a child must

ɔedischarged from emergency shelter care. Caseworkers and juvenileprobation officers could select from a limited menu of service optionsset forth by DCS and the focus would not be on the number of days incare, but rather the child receiving what services are needed.

Local control:
A reoccurring theme with regard to DCS policies has been a shift awayfrom local control and decision making. DCS has a very difficult taskin striking the best balance between consistency and individualizedservices for children and families. It seems though, that DCS centraloffice staff are making more and more micro decisions as opposed tomacro. For example, there is one contact person to request anextension of emergency shelter care for any child in the state. Aclinical team from the central office, not a childâ s caseworker,makes the decision about whether psychological assessment is neededfor a child. So much responsibility for the care of children has beenremoved from the local DCS and juvenile probation offices, I amconcerned that the needs of individual communities and their childrenare being overlooked. I would also like to see the Regional ServicesCouncils have a larger role in determining what services are needed intheir areas. It would be helpful if probation officers, caseworkers,providers, and community members had the opportunity to help set theagenda for these meetings.

I want to express my sincere gratitude at the opportunity to share mywritten testimony with you and the other members of the studycommittee. Please feel free to contact me with any questions you mayhave.
</MSG>
<SUBJECT>Department of Child Services Study Committee</SUBJECT> <PREFIX>Ms.</PREFIX> <FIRST>Leah</FIRST>
<MIDDLE>A</MIDDLE> <LAST>Pezzarossi</LAST>
<ADDR1>2524 Corydon Pike</ADDR1>
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</APP>

Maureen Gordin

From: Rhye, Shirley <srhye@usw.org>
Sent: Tuesday, September 11, 2012 2:21 PM
To: s19@in.gov; Dolly Starnes
Subject: DCS Interim Study Committee - October 11th Foster Care ...

REGARDING INTERIM STUDY COMMITTEE

I will not attend the committee meeting on Friday, September 14th which I understand will take place at the same location in Indianapolis and will focus on foster care and residential placement centers. I also understand that public testimony is still scheduled for October 11th and would appreciate confirmation of this schedule.

Additionally, I would like to share my condensed version of foster care and residential placement centers.

FOSTER CARE

My four grandchildren were taken from their homes (the oldest removed during school) and placed in another county last March. DCS told us they were placed in Jasper County to be closer to their father (both mother and father(s) lived in Lake County). When asked why they wouldn't place the two oldest boys in the same town so they would not have to start their 5th school in six years we were told that DCS felt it important to keep all four children even though there is a 12 year age difference between the oldest and youngest child. The children were placed in a small community where the accused molester's mother works as an editor of a newspaper. I have an email from a private investigator indicating that the grandmother and foster parents know one another. Furthermore the children spoke of their father's new trailer during supervised visits. When complaining to DCS on a recorded conversation that the children were in their father's new home I was told by the supervisor that monitoring the foster parents is not their problem. Five months later we received court papers that stated the father had moved to a trailer in Lowell during the same time of the complaint. Furthermore, we have learned that the youngest children continue to see the foster parents on Sundays at church. It is appalling that possible political connections between the step grandfather and DCS allowed this to take place and DCS ignored the evidence.

RESIDENTIAL PLACEMENT

My oldest grandson was ripped out of math class, had his cell phone taken from him, and the same assessor that lied to the police would not tell him why he couldn't call his mother, father, or me (grandmother). He allegedly made a threatening remark to the foster parents (this was a 14 year old honor roll student with no record who believed his siblings were not properly cared for). For five months, with DCS ignoring my requests for emergency placement even after approved by CASA and handprinting approved the placement, this young man remained at the Crisis Center where he was repeatedly threatened he would be shanked or raped. The Director told me he didn't fit in because

he read. The Crisis Center visits are supervised by a secretary with no qualification and who lost her own child in a custody battle. I emailed those in charge about the threats and was ignored. The counselor told me I had no business interfering and said he was safe because kids aren't allowed knives. But as [redacted] said, "they aren't allowed cigarettes either but they all smoke." The Crisis Center is anything but safe. I can honestly say the only thing Donnie learned as this dangerous facility that feeds the children horrible meals and doesn't allow meals in (three different explanations provided) is how to gamble and play poker. And yes, at one time Donnie was beat up but the police did remove the teenager from the facilty. I have 20 pages of documentation regarding the Crisis Center available if anyone would like more information including recorded conversations with DCS caseworker and supervisor ignoring pretty much everything.

Thanks for providing me your emails. I will see you on October 11th – oh and an update: Jasper County has agreed to interview the children – hopefully including the little boy who also lives in this man's home. I don't want one of those scary FAB interviews. These children are afraid to speak – literally afraid. That was two weeks ago and we still wait for it to be completed.

See you October 11th unless you change the date or the location to Northwest Indiana.

Shirley Rhye
219-384-4155

Make no little plans. They have no magic to stir men's blood and probably themselves will not be realized. Make big plans. Aim high in hope and work. Remembering that a noble, logical diagram once recorded will not die. **Burnham, Daniel H.**

my name is madelene bell, iam [redacted] mother. i was at his home on easter sunday 2010 when a worker from c.p.s. came to his home to remove [redacted] from his home for medical abuse. the worker that came out was rude and nasty. [redacted] tried to tell her that he had his daughter to the e.r. that morning because she was sick, and the doctor said she had a virus and that she did not need an antibotic. that he was to give her some cough medicine and juice and have her rest and let the virus run its course. the worker told him that she did not care about his paper work and pushed his hand out of the way. he again tried to tell her about the papers that he had and again she told him that she did not care about the papers she was removing the child. she finilly did take the paper work but did not read it. than she started yelling at me to get [redacted] ready. i must not been moving fast enough because again she told me to hurry up. [redacted] was only four at the time and i was trying to make it as peaceful as possible. but the worker kept telling me to hurry up. i did not see any need for her rudeness or her bad attuide. thank you madelene bell. if you need to contact me my phone number is 989 429 1256.

CSIC
October 11, 2012
Attachment 22

Dear Honorable Rep. Noe and Senator Holdman,

I would like to submit this letter as written testimony to be attached to the DCS forum held on Oct.11. I was unable to attend. I have been holding off writing this letter because I had submitted an email to our FCM [redacted] and had been waiting for her response to send with this email. I told her when I was sending this and I have not received any response from her. A month ago, I requested a meeting with her, her supervisor and the regional director, that has not happened either.

My name is Ernestine Wells. I live in Monroe County. My husband and I are foster relative placement for our two granddaughters, 4 and 6. We have been placement since July 28, 2011. The children were removed from the home because of neglect and a meth. lab being present.
Each child has a different father [redacted] and [redacted]. My daughter, [redacted] is their mother.
DCS was called over 20 times to my daughter's residence for suspicion of drug use and other issues.

At the time of removal, [redacted] and [redacted] were involved with the actual removal of the children. [redacted] had a warranty out for his arrest because of an incident involving bath salts and walking nude down the street, which ended up being a violation of his probation. All parents have an extensive history of very serious problems. All parents have a history of drug use [redacted] has never been arrested. Both dads are felons. [redacted] has a long criminal history for drug use and theft. [redacted] has a long criminal history involving theft, which he spent 5 of a 10 year sentence. Three domestic battery arrests. All three were in the presence of children. The last two were in the presence of my two granddaughters. On one of those incidents [redacted] (one of my granddaugthers involved in this case) had blood splattered on her face from [redacted] hitting her father, [redacted] That is how close they were to the violence. The last domestic battery involved him beating my daughter, in Oct. 2010. [redacted] child [redacted] has not lived with him since that time. Before that, he and my daughter had an off and on relationship. So he hasn't really lived with [redacted] consistently since she was 2. He did serve some jail time for his last domestic battery arrest in Oct. 2010. When he was released, he had to see a judge about parenting time. The judge ordered only 2 hours a week, that was to be supervised and he was to pay for that visit with [redacted] In fact, he had not seen [redacted] his daughter, for two months prior to removal and DCS contacting him.

There was also, a no contact order in place between [redacted] and [redacted] DCS did not obey this no contact order until late Dec. 2011. The FCM [redacted] was told about the parenting time order and the no contact order at the very beginning of this case. As far as the parenting time order set in place by the judge, she said DCS overrules any other court orders put in place. So that is why DCS did not obey them. [redacted] turned himself in and immediately starting getting more visitation than any of the other parents. In fact, during this whole process, he has been treated differently (meaning better) than all the other parents. He has received more, even though, at times, it has been felt by other service providers and the CASA that he should go back in some privileges. [redacted] has blown up on two different CFTMs. He has stood up, yelled at me, pointed his finger at me. Left the room. Has returned saying that he was over it and that I could have his daughter, that he did not need this anymore. Once in Feb.2012 and the latest June 11, 2012. On Aug. 8, he met with DCS and stated he was over everything and ready to sign adoption papers. Proir to him approaching DCS, DCS was going to seek placement of [redacted] with him. I am appalled that this would even be considered. On July 1, new laws were put into place where you could look and use someone's criminal history when considering placement. On Aug. 2, [redacted] and [redacted] ran into each other. At that time, [redacted] told [redacted] that he was going to f***ing kill my daughter, my husband and myself. Along with his girlfriend that he had broken up with briefly. Even after this statement, DCS did not want to change his visitation or anything. DCS didn't really feel like this was of any concern. This is not the first time that [redacted] had threatened to harm us. In Oct. 2010, he told [redacted] a DCS employee from Morgan County, who interviewed him in jail after the domestic battery arrest, that he was going to get out and kill all of us. This was told to [redacted] at the beginning of this case, and she has yet to contact [redacted] I have not asked [redacted] to take my word alone on any of these issues. I have provided court documents and contacts of people that she can address to confirm this information. She was also made aware that [redacted] was diagnosed at [redacted] Hospital as paranoid schizophrenia, that goes untreated. She has not verified that either.

I received court documents today, DCS is filing a change from adoption to reunification with [redacted] My daughter, the children's therapist, myself and I am sure the others on the team were not made aware of this change. [redacted] promised me that I would be notified if there were ever any changes in DCS's recommmendations. This is not the first time that she has lied to me. She promised that I would get a chance to speak on behalf of the children at the permancy hearing. I was not allowed.

[redacted] has a five other children with five different women. He and his current girlfriend have a five month old son. He has only married one woman. He and his current girlfriend have already broken up and have gotten back together since his latest child has been born. Just like at CFTMs, when things aren't going his way, he gets upset and leaves. I have seen that behavior the whole time that I have known him. That behavior hasn't really changed. The last couple of months, he hasn't blown up because he didn't have CFTM for two months, July and Aug. And now, it looks like he is getting what he wants, so his behavior is better. DCS and [redacted] don't view his blowups as bad because he grew up in the system,and that is how he deals with his frustration. His therapist is helping him with this. No one tries to stop him when he is acting out like this with me, even though, it is stated in DCS foster parent manual, that everyone, including me, is to be treated with respect. Where I work, if I displayed that type of behavior, I would be fired immediately for intimidation. Even in our schools, this behavior would be considered bullying, for which there is ZERO tolerance. I really worry that if [redacted] is placed with her father, the behavior that she would witness. He has never hurt her, but he hasn't stopped hurting someone else even with her in the room. I don't want her growing up thinking that this type of behavior is acceptable and should be tolerated. I want her to grow up in a home that is safe, secure, stable, in every area, not just physical. I want her to grow up in a home where everyone treats each other with love and respect. A family that puts other's needs before your own, like the needs of your children. They stay together no matter how hard it gets.

I can give you names of service providers who can verify some of this information if you would like. The CASA on this case, [redacted] would totally support everything that I am telling you. When we have CFTMs, DCS is usually on a side by itself, except for [redacted] therapist. I don't understand why the state would spend the money and waste people's time, if the professionals' opinions, are not going to be considered or supported by DCS. What a waste of taxpaper's money. My main worry is that it will end up being a waste of my granddaughter's lives. I have not seen this to be about the children. It is all about the parents and providing them with service. At the court hearing last week, DCS said that while all parents had gone backwards,but they were going forward again. So that while they are asking for adoption, they are still going to allow the parents more time. No one wants to talk about the past or history, but what they are failing to see, is that this is exactly what their whole lives have been. That is all my granddaughters have seen. Things going well, then things going bad, going well, going bad, etc.

DCS will walk away someday and my granddaughters will be left with whatever it is that the judge decides, which is probably what DCS presents. I know reunification looks great!! Looks like a job well done on DCS's part, but each case is different. I would hate to see my granddaughters separated. While their whole lives, their parents may not have put them first and done the right thing. Different dads coming in and out of the picture, the ONE thing they have ALWAYS had is each other. They have been each other's support and comfort. I would hate to think that any one or any agencies would take that away from them. My oldest granddaughter has been traumatized so much already, that her therapist will tell you that she hides so many of her feelings and emotions. Her little life has witnessed so much pain and disapppointment. She does not want to talk about it. To give her something else, to me is unforgiveable.

I am forwarding a couple of emails that I have sent to [redacted] I have asked for a response. I told her that I would wait until Wed. Oct.17. She did not respond. I did not want to misrepresent [redacted]
I would like to thank Ben, from Rep. Noe's office, for getting back to me on my previous statement. I would really appreciate a response from this one as well. I do want to make things better for my granddaughters but also for all the other children that unfortunately have to go through this process. I do want to join others in Shattering the Silence. I do want my voice to be heard. You can contact me through this email or call me at [redacted].
Thank you for your time and efforts in this matter.

Respectfully,
Ernestine Wells

CSIC
October 11, 2012
Attachment 23

P.O. Box 843 • Goshen, IN 46527-0843
phone: (574) 875-5117 fax: (574) 875-5284

October 5, 2012

DEPARTMENT OF CHILD SERVICES
INTERIM STUDY COMMITTEE
Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789

To Whom It May Concern ,

Enclosed please find my written testimony which I request be submitted to the Department Of Child Services Interim Study Committee.

I can be reached at 574-875-5117 or dphillips@bashor.org should there be need for additional information or other concerns.

Your assistance in this matter is greatly appreciated.

Thank you,

Don Phillips
President / CEO

DCS Study Committee Testimony
Regarding DCS and Provider Relationship Recommendations

October 5, 2012

Bashor Children's Home is a faith based agency providing fifteen different residential programs, day programs and community based services primarily serving the northern and central part of Indiana. We are a contracted provider of residential and foster care services for the Department of Child Services (DCS) .

As the President / CEO of Bashor, I recognize and fully appreciate the progress DCS has made in improving the quality of services provided to children and families throughout the state. The centralization has brought clearer focus, practice improvement, greater consistency, and increased accountability. However, I am also aware of the difficulties such dramatic and rapid changes have created. There is one issue, in particular, which I feel the need to explore.

There have been concerns raised regarding provider's hesitancy to express criticism of DCS, feeling intimidated, and even being concerned about retribution. Many would say the lack of provider's appearing at the study committee hearings reflects this apprehension.

I have heard DCS officials state emphatically that they welcome feedback from providers and no such reprisals will occur. I have also heard the study committee members state in no uncertain terms they urge those with concerns to bring them to the committee and reprisals will not be tolerated. Despite what I personally believe are sincere assurances, I informally polled a significant group of providers recently and found most remain very hesitant.

There are several factors which have contributed to this dynamic. The primary factor is that providers operate in what is largely a single payer system. Providers naturally feel very vulnerable because DCS issues their licenses, establishes the regulations, conducts on site regulatory compliance reviews, establishes administrative policy, decide the terms of and contracts for services, investigates allegations of institutional abuse and neglect, establishes measurements and evaluates outcomes, places children or authorizes placements, initiates administrative holds on placements, sets rates of payment, reviews billing and provides payments. **The basic structure of the relationship whether intended or not, places any provider at a natural disadvantage**. The structure does not have a system of checks and balances for even the broader decisions being implemented by DCS and it restricts the provider's ability to advocate for the children and families served.

When county responsibility for funding was moved to the central office this brought greater consistency in terms of policy and the allocation of resources. At the same time, communities lost the ability to determine their local needs and to allocate resources based on local factors. As a result, resources have not been available to meet identified need and local discretion has been removed. This has created service gaps in some areas and administrative procedures have been instituted which are too often seen as being ineffective.

DCS initiated sweeping changes in an effort to improve what had previously been a rather fragmented system. DCS clearly felt the failures of the previous system mandated swift action. While it may not

have been intentional, the speed and scope of these changes caused a great deal of uncertainty among providers who felt they were being unfairly blamed for many of the problems. Regulatory and administrative directives were developed with minimal input from providers. Provider's perception was that DCS felt including providers more fully in the process would merely encourage resistance, complicate the process and delay DCS reforms.

As DCS put into practice its reforms, it stated its desire to safely reduce the number of out of home placements. This goal was shared by foster care and residential providers, so long as the child's wellbeing was protected. Understandably, there have been situations in which DCS and providers have not always agreed on what is best for a child. In this debate, DCS officials and providers have unfortunately accused the other of being overly concerned with the financial impact of these decisions.

As residential placements were being reduced, DCS also reduced rates paid to providers in order to decrease what DCS felt was unnecessary spending. Later DCS initiated a rate setting process which placed caps on various costs. Rates were dramatically reduced for most providers. DCS has recently acknowledged that in their desire to move quickly, they did not have a thorough understanding of provider's operations and the effect rate setting would have. Likewise, providers became frustrated and began to question DCS motives. About this same time, DCS communicated its desire to reduce the number of providers it contracted with in order to reduce costs associated with unused capacity. The rate reductions that went into effect put severe stress on providers forcing them to underwrite program costs and to close programs even when the service was needed and being used.

During this time, legal action was taken by IARCCA (the provider's state association) in federal court to challenge the rate cuts and the provider selection process. The relationship between DCS and providers became increasingly oppositional.

DCS has made dramatic and rapid changes to the child welfare system. Unfortunately, they have done so at the expense of their relationship with providers. They seemed to view too many providers as overly resistant to change and purely protective of their organization's self serving financial interests. Providers felt the dramatic changes which took place were being orchestrated by those far removed from the community needs of children and yet threatened the community's very ability to provide services. The perceptions and misperceptions of the other party seemed to continually deteriorate, regardless of intentions, as a result of these dynamics.

Recently, there have been increased efforts on both sides to resolve differences and to work towards a true partnership based upon a shared concern for children and families. Improved communication and better understanding has resulted from these efforts. A renegotiation of rate caps is being conducted. This and other discussions have given providers greater optimism that DCS is gaining an appreciation for the provider's situations. DCS has become more accepting of the provider's shared desire to further DCS objectives. Assurances have been made to continue these discussions in the hope that a stronger relationship will further advance the service system.

Despite these positive steps, many providers remain fearful because of how drastic the changes have been. They also continue to be guarded because of how powerless they feel. There is reluctance on the part of many providers to be confident that this recent positive movement will continue into the future. Providers feel vulnerable and worry they have little leverage with which to advocate for children and to defend their missions in this relationship.

Recommendations:

Given its charge and by intentional design, DCS is a powerful agency. The responsibility it bears for the care and safety of our most precious citizens can not be overstated. DCS must be permitted to direct significant resources and to be decisive in carrying out its mission. However, power can have an isolating effect and perceptions can be misguided in that isolation. Given this dynamic and that the need to be responsive to the citizens is so imperative; there must be an established process which facilitates incorporation of additional, alternative and external perspectives. Monitoring of this process can only be truly assured from structures outside the DCS organization.

I would therefore recommend a child welfare advisory council be established (as exist in other states) to provide this feedback and to support collaborative information sharing. This proposal has been made by numerous individuals and interested parties. Various community organizations could be brought into planning discussions to assist in the design and development of this committee.

I would also recommend that regional service council membership be reconsidered to more fully reflect the broader community parties and that they be empowered to more effectively determine local priorities.

Finally, I applaud and would recommend that DCS continue to reach out to providers to dialogue in partnership and resolve differences and in order to work more collaboratively toward advancement of common concerns for children.

Respectfully Submitted,

Don Phillips
Bashor Children's Home
President / CEO

Indiana Disproportionately Committee

3737 N. Meridian St. Indianapolis, IN 46208 317.920.4915 d.jani@imhc.org

CSIC
October 11, 2012
Attachment 24

9/28/12

To: Members of the DCS Interim Study Committee

Our committee is re-issuing the letter that we hand-delivered to committee members on September 24 (see attached). That original letter dated September 24 listed partnering organizations at the bottom of the letter. I am writing to clarify that the policy positions advocated in the September 24th letter are supported by the Indiana Disproportionality Committee as a whole, and do not represent policy positions adopted by individual organizations or agencies that participate on the Indiana Disproportionality Committee.

We apologize for the confusion this may have caused, and appreciate your attention to this matter.

Respectfully Submitted

Devina J. Jani, MSW
Chair, Indiana Disproportionality Committee

Indiana Disproportionately Committee

3737 N. Meridian St. Indianapolis, IN 46208 317.920.4915 d.jani@imhc.org

To: Members of the DCS Interim Study Committee

We write as representatives of the Indiana Disproportionality Committee (IDC). IDC is a statewide collaborative network of public and private entities working together to address racial disparities within the child welfare, education, health, juvenile justice and mental health and addictions systems. IDC collaboratively promotes and advances the elimination of racial and ethnic disparities so that ALL children have equal opportunity for positive and equitable outcomes in Indiana's child welfare, education, health, juvenile justice, and mental health and addictions systems through commitment to data-driven advocacy, and evidence-informed, culturally-responsive practices. The IDC supports maintaining IC 31-34-1-6 (CHINS 6) so that our most vulnerable children, those with severe mental and emotional health issues, can receive services that are most appropriate for their needs. We support the use of this provision, not because it solves all the issues of care for this population, but because it serves as an important safety measure, protecting children with serious mental illness from being handled through punitive-type responses.

Children who exhibit serious or severe mental health issues risk entry into the juvenile justice system. The juvenile justice system is not equipped to handle children with these types of special needs, and in fact, placing a child in this situation may worsen his or her condition. This scenario is not good for the child, his or her family, or society as a whole. It may prolong or prevent the child from receiving the correct help. That in turn can lead to poor outcomes for these individuals that have tremendous economic impact collectively for society, as they are at risk of continual involvement in multiple, publicly-supported systems throughout their lifetimes. Children of color are disproportionally represented in the juvenile justice system. Moreover, researchers have found a direct correlation between the number of children of color underserved by the mental health system and the number entering the juvenile justice system. Disproportionality refers to the situation where a particular racial and/or ethnic group is represented within a social system at a rate or percentage that is not proportionate to their representation in the general population. We support measures that prevent children who have been diagnosed with severe mental health issues from entering into the juvenile justice system, as we feel they would be better served in a therapeutic setting, and we urge efforts at reform to be responsive to the multicultural needs of Indiana's children.

Though the CHINS 6 provision is still law, our concern extends to how it has been and will continue to be implemented. We have concerns that children are either being screened out, or not being assessed properly for this category, especially during the critical intake process through the DCS hotline. In order to correct these problems, policies and practices that result in systematic failures to investigate and assess these cases, and thus to file petitions for services pursuant to CHINS 6, should be changed. Further, additional training and oversight during the taking of reports at the hotline is warranted to make sure that when local officials and concerned individuals make reports, that those reports are being promptly and appropriately handled and assessed at the local level, with interagency cooperation.

We applaud the collaborative efforts that DCS is making toward working on improving access to care for those children and families who most likely "fit" the CHINS 6 situation. We are aware of a potential pilot project, supported by both DMHA and Community Mental Health Centers, that will hopefully help bridge the gap for children and families who are living with mental illness and who need appropriate services and supports, and not punitive measures.

Cost is a barrier to care, and children and families of color are disproportionately impacted by this issue. African Americans, Latino/ Hispanic Americans and other groups are 2-3 more likely to be uninsured than Caucasians. Moreover, these groups are disproportionately represented on Medicaid. We urge that this pilot project be developed in a manner that is responsive to the needs of children of color and achieves equity in all children accessing services.

Researchers have documented various issues involved in providing mental health services for multicultural children, including under- identification of need, under-utilization of services, shortage of providers, financial barriers to care and lack of cultural competency training requirements. DCS and other state agencies should adequately address these issues, and oversee a transparent system of consistent collection of ethnic/racially disaggregated data for reporting outcomes and results. Multicultural stakeholders should be involved in the development, implementation and reporting of program initiatives, pilot projects and reforms, that are ultimately pursued on behalf of Indiana's children.

We want to thank you for your time and attention to this very important issue that impacts so many of Indiana's children and families.

Respectfully Submitted,

Devina J. Jani

Devina J. Jani, MSW
IDC Chair

Hotline Tools

Presentation to the Department of Child Services Interim Study Committee
October 11, 2012

Dave Judkins
Deputy Director of Field Operations

INDIANA DEPARTMENT OF CHILD SERVICES

DCS Hotline

- Purpose:
  - Provide a central-point of contact for all child-abuse and neglect reports throughout Indiana.
  - More consistent and effective management of reports.
- Challenge:
  - Consistent application of law.
  - Consistent method of gathering information.

INDIANA DEPARTMENT OF CHILD SERVICES

DCS Hotline Tools

- Hotline tools:
  - Intake Guidance Tool.
  - Structured Decision Making Tool.

- Purpose of tools:
  - Apply Indiana law consistently to each report.
  - Ensure accurate gathering of information.

INDIANA
DEPARTMENT OF
CHILD
SERVICES

Intake Guidance Tool

INDIANA DEPARTMENT OF CHILD SERVICES

Intake Guidance Tool

- Purpose:
  - Solicit key facts on a child abuse and neglect report.
    - Who? What? Where? When? Why?
  - Gathers as much information as possible from report source.
    - May only get one chance to talk to report source.
  - Identify safety concerns for child, family and DCS Family Case Manager's.

INDIANA DEPARTMENT OF CHILD SERVICES

Intake Guidance Tool

- Before the Hotline:
  - Implemented in 2006.
  - But before the Hotline tool was inconsistently utilized at county level.
- After the Hotline:
  - Consistently utilized for all reports of child abuse or neglect.

INDIANA DEPARTMENT OF CHILD SERVICES

Intake Guidance Tool

- Gathers information on:
  - Child information.
  - Parent/guardian/custodian information.
  - Alleged perpetrator information.
  - Physical abuse, sexual abuse and neglect allegations.
  - Additional questions.
  - Safety issues.

INDIANA DEPARTMENT OF CHILD SERVICES

Intake Guidance Tool

- Shortened set of questions used when gathering information from:
  - Law enforcement
  - Hospitals
  - Prosecutors

INDIANA
DEPARTMENT OF
CHILD
SERVICES

Structured Decision Making Tool

INDIANA DEPARTMENT OF CHILD SERVICES

Decision Making

- Before the Hotline:
  - Indiana law applied 92 different ways.
- After the Hotline:
  - Consistent approach statewide.
  - April 2012 Structured Decision Making tool implemented.

INDIANA DEPARTMENT OF CHILD SERVICES

Structured Decision Making Tool

- Purpose: Organizes answers from Intake Guidance Tool.
- Collaborated with Child Research Center to create tool:
  - Utilizing evidence based practices.
  - In-line with Indiana law, policies and practices.
- Accredited tool.
- Utilized in 3 different countries and 30 different states.

INDIANA DEPARTMENT OF CHILD SERVICES

Structured Decision Making

- An approach that uses clearly defined and consistently applied decision-making criteria.
- Structured Decision Making Tools:
  - Evaluate risk and determine whether assessment is needed.
  - Used to guide recommendations.
  - Used in 30 states and 3 countries.

INDIANA DEPARTMENT OF CHILD SERVICES

Structured Decision Making Tool

- Override of recommendation in the following instances:
  - Court requests assessment.
  - Prosecutor requests assessment.
  - Law enforcement requests assistance.
  - DCS regional administrator or other administrator requests referral to be screened in.
  - Other.

INDIANA
DEPARTMENT OF
CHILD
SERVICES

Tools in Hotline Process

INDIANA DEPARTMENT OF CHILD SERVICES

Hotline Process

- Report source calls Hotline.
- Intake Specialist answers phone.
- Intake Specialist uses Intake Guidance Tool to gather information.

INDIANA DEPARTMENT OF CHILD SERVICES

Hotline Process

- Information is documented in case management system.
- Intake Specialist uses Structured Decision Making tool to assess.
- Intake Specialist makes a recommendation.

INDIANA DEPARTMENT OF CHILD SERVICES

Hotline Process

- Supervisory review of report.
- Report sent to Local Office.
- Local Office has final decision to assess or not assess report.

Indiana Department of Child Services

Intake Guidance Tool

Reporter's Number	
Reporter's Basis for Making the Report	☐ Witnessed Alleged Incident ☐ Told by Child ☐ Told by Third Party ☐ Suspicion ☐ Observed by Physical Evidence ☐ Other
Referring From	☐ Hospital/Clinic ☐ Community Mental Health ☐ Referring Physician ☐ School ☐ Dentist ☐ Licensed Psychologist ☐ Managed Care Provider ☐ All Others (Non-Professional Reporters)
Child Information	What are the name, age, DOB, and gender of the child(ren) that you are calling about? What is the child(ren)'s primary address? Where is the child(ren)'s current location (specific address)? Who is caring for the child? Does the child(ren) need medical treatment? If so, is the child(ren) currently receiving medical treatment? If so, where and how often? If so, is the child(ren) on a ventilator and in the ICU/NICU? Is there anything we need to know about the child regarding medication, known disability? Obtain the name, age, and primary address of any other child(ren) that were either present at the time **or** reside at the home on either a full or part time basis.

Parent/Guardian/Custodian Information	Who are the child's parents/guardians/custodians? • Name, Address, telephone number, aliases • Do they know about this call? • Are there behavioral issues we should know about? Substance abuse • Type • Frequency • Children's awareness/participation • How does the parent's substance abuse affect the parent's ability to care for their children? • Do the child(ren) have access to the drug(s) or drug paraphernalia?) Violence • Type • Frequency • Children's awareness/participation Mental Heath • Diagnosis • Treatment (past/current) • Medications Criminal History • Past/Current charges • Convictions and incarcerations Child Protection History • Past/Current allegations and/or involvement General level of functioning • Parental Capacities (ability/willingness to perform parental duties) • Parental Expectations are or are not consistent with the child's development • Parental attitude towards child. Any family members, friends, or neighbors who may be helpful or have additional information? Current stressors (Document any issues of financial stress (unemployment), heavy child care responsibility, unhealthy relationships, housing, medical issues and legal issues.)
Alleged Perpetrator Information	What can you tell me about the perpetrator? • Name, address, telephone number, aliases

Alleged Perpetrator Information Cont...	• Relationship to the child(ren) of the alleged perpetrator (if you know name please use person's name and not "alleged perpetrator"). • Does the alleged perpetrator have access to the child(ren)? • Do you know when and how often the child(ren) will be in the presence or care of the alleged perpetrator? Are there other children to which the perpetrator may have access and who may be at risk of immediate harm? Behavioral issues • Substance abuse • Violence • Mental health issues • Criminal • Child protection history) General level of functioning/Caretaking capacities • Ability/willingness to perform caregiver duties • Caretaking expectations are or are not consistent with the child's development • Caretaking attitude towards child. Current stressors - Document any issues of financial stress • Unemployment • Heavy child care responsibility • Unhealthy relationships • Housing • Medical issues • Legal issues	
Physical Abuse Allegations	Does the child have any physical injuries? If so, describe: Location, length, and shape such as a circle, line, handprint etc, and size such as softball size, baseball size or quarter/dime size, color). How long has the injury been present? Have you seen the injuries or were you informed of the injuries? Who informed you? Do you know how the child sustained the injuries? Does the child need current medical attention? Please describe what happened? Where and when did the alleged physical abuse occur (type,	

Physical Abuse Allegations, Cont...	extent, severity, duration and frequency)? In detail, what words did the child use in describing what happened to him/her? (Specific terminology for example, body parts, identifying information such as nicknames and his/her emotions or feelings.) Has anyone given any explanation regarding how the injuries occurred? If so, who? Have there been any other incidents of physical abuse towards this child? Do you know if it was reported?	
Sexual Abuse Allegations	Please describe what happened? Where and when did the alleged sexual abuse occur? In detail, what words did the child use in describing what happened to him/her? (Specific terminology for example, body parts, identifying information such as nicknames and his/her emotions or feelings.) Have there been any other incidents of sexual abuse towards this child(ren)? Do you know if it was reported? Has the child had a medical exam? If so, where and when? Have the police been notified	
Neglect Allegations	Please describe the circumstances that concern you? (Based on circumstances described screen for: • Untreated medical conditions • Exposure and or involvement in domestic violence • Drug exposed infant • Educational neglect • Child's basic needs of food, clothing and shelter Are there any specific conditions of the home that make the home unsafe for the child? Are the children being left alone, without adult supervision? • What are the circumstances? • For what period of time? Did the alleged perpetrator (or if known, the person's name) attempt to explain the circumstances? If so, what did he/she say happened?	
Additional Questions	Are there any other people that have may have witnessed or	

Additional Questions, Cont…	have more information about the alleged incident(s)? (Obtain names if possible along with contact information.) Could you provide me any family resources (je relatives such as grandparents, aunts, uncles, etc) that are available to the child(ren) you are calling about? Has any action already been taken (medical attention, removed from home, other professionals involved)? Has any action already been taken (medical attention, removed from home, other professionals involved)?
Safety Issues	Are there any weapons in the home? If so, indicate type if known. Are there any animals in the home that may pose a danger to a worker? Does anyone in the home use drugs/alcohol? If yes: • What type? • How often? • Is a Meth Lab suspected? Does anyone in the home have a communicable disease? Is he/she contagious? Have any family members been involved in domestic violence? If yes, ask the following questions: • Has anyone in the family been hurt or assaulted? (past or present) • Who has been hurting the family or child? • How is the family violence affecting the child? • Have the police ever been called to the home? If so, was anyone arrested/charged? • Where is the child when the violence occurred? • Who is caring/protecting the child right now? • What is the parent/caretaker's ability to protect him or herself along with the children? • What steps are being taken to prevent the perpetrator's access to the home? (shelter, police, restraining order, etc) • How can we contact the non-offending caretaker alone? • Have there been any threats of kidnapping or extreme violence up to and including death? Are any family members involved in any criminal activity? If so, indicate?

	Is the home in a remote area?
Hospitals **Hospitals Cont...**	• Have the medical notes forwarded to local office. • Has the hospital called LEA to make a report? • Was the perpetrator caught /arrested or currently at the hospital? • Known prior CPS history. • Do parties appear to be under the influence of drugs/alcohol? • Make sure the note the name of the report source and their job title. • What injuries/medical treatment are the victims receiving? Is anyone being admitting to the hospital?
Law Enforcement Agency (LEA)	• District/township they are calling from. • Full name & Badge and 2 contact numbers. • Do parties appear to be under the influence of drugs/alcohol? • Has a breathalyzer been administered? • Are you calling a victim assistance or advocate to the scene? • Is anyone injured? • Is the perpetrator on the scene or being arrested?
Prosecutor's Office	• Get name two contact numbers and an email address. • Are there pending charges? • What are the charges? • Is there a history of violence?
Non-Offending Parent/Child	• Have you already called 911/called for help? • Am I the first person you called? • Do you have a protective order/no contact order? • Was the protective order filed in another state or county? • What is the address and phone number? • Where are the children currently? • Are there any weapons in the home? • Ammunition? • Location of guns and ammunition. • Known drug use? • Do you have a plan? • Are you going to follow your plan? • Who helped you develop your plan? • Are you/children in a safe place right now? • Has the perpetrator been arrested or left the scene? • Do you know where he is or when he's coming back? • Do you need medical help? • Does the boyfriend/husband/perpetrator live in the

	home? • Does he care for the children? • Are there any witnesses?
Male Non-Offenders	• How often does this happen? • Has she been arrested? • Have you obtained a protective order? • Have you called the police? • Where are the children now? • Are you in a safe place? • Are there any weapons/ammunition in the home? • Where are they located?
Points to Remember	• Protective Order--Civil order that is filed by the person being protected. This can be dropped at any time by the person filing the protective order. Protective orders are valid crossing state and county lines. Protective orders can be in effect for many years. Perpetrator must be served with this order for it to be enforced. • No contact order--Criminal order that is filed when criminal charges have been filed. No contact orders can only be dropped by the judge issuing the no contact order. Perpetrator is notified of no contact order at the court hearing. • If you are hearing strange background noise (breaking glass, screaming, things being thrown) get the attention of co-worker or supervisor and have them call 911. • When interviewing children let them talk. Ask open ended questions (help me understand, and then what happened next) Pick up on key things that the child repeats. Do reflective listening and focus on the child. • Screen out if the perpetrator is not a household member or not a parent/guardian/custodian/caregiver.
Additional Information	• Is there anything else you want to tell me about this child and family? • Closure comments/review of narrative for accuracy • Can we call you again if we need clarification? Can we get your name? (This would help encourage callers to know that giving their name would help with follow up when and if assigned to an assessment FCM.)
Closing	"Thank you for your concern and providing this information to us, we appreciate your efforts in helping us to protect children….if

Closing Cont...	you have future concerns please do not hesitate to contact us again." If the caller asks what happens from this point then the intake specialist responds with the following: "This information will be given to a supervisor for review. If assigned, the report will be routed to the county where the incident occurred. " If a professional, the intake specialists needs to ensure the professional that if assigned the report will be routed to the county where the incident occurred and assigned to a Family Case Manager to assess. If the report is not assigned, then a follow-up call to the reporter will be done to advise that the report wasn't assigned for an assessment. A brief explanation as to why can be given.

CSIC
October 11, 2012
Attachment 27

SDM®
Structured Decision Making®
Improving Outcomes Through Research

The Structured Decision Making® System
for Child Protective Services

Policy and Procedures Manual

Manual Date: August 2011

Updated: May 2012

Indiana Department of Child Services
Screening and Response Time Assessment

CRC Children's Research Center
Advancing Research...Improving Outcomes

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Children's Research Center is a nonprofit social research organization and
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INDIANA DEPARTMENT OF CHILD SERVICES r: 5/12

SDM® CHILD ABUSE AND NEGLECT SCREENING AND RESPONSE TIME ASSESSMENT

Report Name (last, first): _____ **Referral Date:** _____/_____/_____

MAGIK #: _____ **Referral Time:** ____:____ ☐a.m./ ☐p.m.

Hotline Worker : _____

SECTION 1. PRELIMINARY SCREENING

One or more elements of the child abuse/neglect (CA/N) policy are not met:

☐ No victim is currently a child
☐ Child/young person was allegedly abused/neglected outside Indiana and there is no current risk of harm
☐ Alleged perpetrator is not a parent, guardian, or custodian as defined by Indiana law AND the report does not include allegations of sexual abuse

Report does not require screening, but does require a non-investigatory response by the agency:

☐ Service request/courtesy interview for another jurisdiction
☐ Safe Haven case
☐ Other: _____

If any item in Section 1 is marked, the screening and response time assessment is complete.

SECTION 2. MALTREATMENT TYPE

SUSPICIOUS DEATH OF A CHILD

☐ Suspicious death or near fatality of a child before his/her first birthday
☐ Suspicious death of a child and there is concern of abuse or neglect

PHYSICAL ABUSE

☐ Injury that appears non-accidental, suspicious, or is inconsistent with explanation
☐ Caregiver action that will likely cause injury

SEXUAL ABUSE

☐ Rape of a child
☐ Criminal deviate conduct
☐ Child molestation
☐ Child exploitation
☐ Child pornography
☐ Child seduction
☐ Sexual misconduct with a minor
☐ Public indecency
☐ Prostitution
☐ Incest

NEGLECT

General Neglect

☐ Drug-exposed newborn
☐ Giving child toxic chemicals, alcohol, or drugs
☐ Inadequate food, or signs of malnutrition
☐ Exposure to unsafe conditions in the home
☐ Inadequate clothing or hygiene
☐ Lack of supervision
☐ Unaccompanied minor in a shelter
☐ Exposure to domestic violence (violence between intimate partners) in the home
☐ Known sexual perpetrator has unsupervised or unrestricted access to child
☐ Sexual predator in the home

Failure to Protect

☐ The caregiver does not intervene despite knowledge (or reasonable expectation that the caregiver should have knowledge) that the child is being harmed (includes physical or sexual abuse, neglect, or mental injury) by another person

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Abandonment

☐ A child of any age has been abandoned

☐ A child is being discharged from a facility and parents refuse to accept the child back or make appropriate alternate arrangements

Risk of Harm

☐ Current open case and a new child is now living in the home

☐ Prior failed case and a new child is now living in the home

☐ Prior death or serious injury of a child due to child abuse or neglect, services were not offered or successfully completed, and a new child is now in the home

☐ Child's basic needs are likely to be unmet due to caregiver impairment

Medical Neglect

☐ The unreasonable delay, refusal, or failure on the part of the caregiver to seek, obtain, and/or maintain necessary medical, dental, or mental health care

Educational Neglect

☐ A child age 5 or 6 is currently or was previously enrolled in school, and the parent is now refusing to allow or failing to support the child in attending school or receiving homeschooling

☐ A child is age 7–12 and there is unreasonable delay, refusal, or failure on the part of the caregiver to seek, obtain, and/or maintain education for the child

☐ A child is age 13 or older, enrolled in school, and not attending to the extent that educational neglect is present

EMOTIONAL INJURY

☐ A child has an observable, identifiable, and substantial impairment of his/her mental or psychological ability to function as a result of an act or failure to act by a parent, caregiver, or household or family member

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SECTION 3. RECOMMENDATION AND OVERRIDES

Initial Screening Recommendation

○ Screen out (select only if no maltreatment type is marked in Section 2. One or more of the sub-items must be selected.)

☐ Allegation does not reach threshold of abusive or neglectful behavior by parent/caregiver. Community resource information provided to reporter, if appropriate.

☐ Family has a currently open case; information indicates possibility of a failed safety plan. Provided to ongoing case worker for response.

☐ Multiple reports of the same incident from the same reporter; information will be included in previously accepted report.

☐ Criminal matter that will be handled exclusively by the police.

☐ Other, specify: _____

_____

○ Screen in (one or more maltreatment types are marked)

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Overrides (must select one of the items below)

O No overrides apply: Initial screen-in or screen-out recommendations will be followed.

O Screen out: Initial recommendation is to screen in, but referral will be screened out because (*mark all that apply*):

- ☐ Insufficient information to locate child/family.
- ☐ Report of historical event and no current risk of harm described. (Time since alleged incident: _____)
- ☐ Current report includes only neglect allegations AND alleged victim has a current open case type for similar neglect concerns
- ☐ Allegations previously assessed for the same incident of alleged physical abuse, sexual abuse, or neglect.
- ☐ Meets statutory definition of sexual abuse but consideration of factors (age differential, cognitive functioning, behavior, force, parental response) do not warrant an assessment.
- ☐ Other (specify): _____

O Screen in: Initial recommendation is to screen out, but referral will be opened and assigned for child protective services (CPS) assessment because (*mark all that apply*):

- ☐ Court requests assessment
- ☐ Prosecutor requests assessment
- ☐ Law enforcement requests assistance
- ☐ DCS regional administrator or other administrator requests referral be screened in
- ☐ Other (specify): _____

Final Screening Decision *(after consideration of overrides)*

O Screen out: No maltreatment type is marked AND no screen-in overrides apply OR a screen out override is marked..

O Screen in: At least one maltreatment type OR screen-in override is marked. Complete Section 4, Response Time Decision.

SECTION 4. RESPONSE TIME DECISION *(Complete for all screened-in reports. Review immediate response criteria for all allegations and expedited response criteria for neglect allegations. Mark all that apply. Quickest response time marked will be assigned response time.)*

O **Immediate response required based on one or more criteria below** (*mark all that apply*):

- ☐ Child fatality or near fatality
- ☐ Serious injury to child, and that child or other children remain in home
- ☐ Child left alone/abandoned and requires immediate care
  Age of youngest child in years: _____
- ☐ Sexual abuse; perpetrator lives with or has access to the child
- ☐ Active meth lab
- ☐ LEA requests immediate assistance
- ☐ Other (specify): _____

O **Neglect allegation, within-24-hours response time required**

- ☐ Neglect allegation, and domestic violence incident occurred within past 48 hours
- ☐ Domestic violence incident that involved a deadly weapon is part of the allegation
- ☐ Parent victim or child reporting domestic violence
- ☐ Alleged victim has an open or pending case type for a different allegation
- ☐ Child in hospital or emergency room
- ☐ Unattended minor in a shelter
- ☐ Other (specify): _____

O **No immediate or expedited response criteria exist. The report includes the following allegation type(s) and requires quickest identified response time:**

- ☐ Physical abuse—**response within 24 hours**
- ☐ Sexual abuse—**response within 24 hours**
- ☐ Neglect—**response within 5 days**
- ☐ Screen-in override—**indicate response time** _____

Worker: _____ Date: _____/_____/_____

Supervisor: _____ Date: _____/_____/_____

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INDIANA DEPARTMENT OF CHILD SERVICES
SDM® CHILD ABUSE AND NEGLECT
SCREENING AND RESPONSE TIME ASSESSMENT
DEFINITIONS

SECTION 1. PRELIMINARY SCREENING

One or more elements of the child abuse/neglect (CA/N) policy are not met:

No victim is currently a child.

Child/young person was allegedly abused/neglected outside Indiana and there is no current risk of harm.

Alleged perpetrator is not a parent, guardian or custodian as defined by Indiana law AND the report does not include allegations of sexual abuse. Any report that includes sexual abuse allegations requires screening against the sexual abuse criteria and the different relationships between alleged perpetrator and alleged victims detailed in those criteria. For non-sexual abuse allegations, the alleged perpetrator must have a parental, guardian, or custodial relationship with the alleged victim as defined in Indiana law, which includes but may not be limited to biological and adoptive parents; court-appointed guardians; foster parents; owners, operators, employees, and volunteers of residential child care facilities, child care centers, child care homes, child care ministries, and school; child caregivers (babysitters or nannies); or household members of non-custodial parents.

Report does not require screening, but does require a non-investigatory response by the agency:

Service request/courtesy interview for another jurisdiction. Another state or county child protection agency is completing an investigation of child abuse or neglect, and is requesting a courtesy interview of an alleged perpetrator, child victim, or sibling of an alleged child victim who is currently in Indiana.

Safe Haven cases.

Other.

SECTION 2. MALTREATMENT TYPE

SUSPICIOUS DEATH OF A CHILD

Suspicious death or near fatality of a child before his/her first birthday. Report of a child death OR near fatality that is sudden, unexpected, AND unexplained, AND victim has not yet reached his/her first birthday.

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Suspicious death of a child and there is concern of abuse or neglect. Report of a child death that is sudden AND unexpected, AND there is concern that abuse or neglect by a caregiver contributed to or caused the child's death.

PHYSICAL ABUSE: Act committed by parent, caregiver, or custodian.

Injury that appears non-accidental, suspicious, or is inconsistent with explanation. Child has a concerning physical injury (bruise, cuts/laceration, burns, scalds, fractures, dislocations, sprains, strains, displacements, hematomas, concussions or other head injuries, pain, or other indicators of internal injuries) and available information meets one or more of the following:

1. Injury appears to have been inflicted by the caregiver, regardless of motive. Include injury that results from a domestic violence incident, but exclude injuries that result from sexual abuse (record under appropriate sexual abuse allegation).

2. Caregiver or child provides details of an incident that are inconsistent with the injury; may be a pattern of injuries.

3. Extent, location, and type of injury or injuries are concerning, or consistent with abuse.

Caregiver action that will likely cause injury. It is not necessary for a reporter to determine that an injury occurred. Consider the child vulnerabilities (children under age 7 and/or disabled children are more vulnerable than older children) in combination with caregiver action. Examples of caregiver action that likely to cause injury include but are not limited to the following:

- Shaking, shoving, or throwing an infant or young child;

- Choking, torture, suffocation, tying child up, or the use of dangerous objects (e.g., whips) to strike child;

- Striking a child in the head, stomach, or other areas where internal injury may occur;

- Manufacturing of drugs in the home or in the presence of children that has or will likely impact the physical health or cause injury to the child;

- The caregiver has made threats to cause physical harm to the child that, *if carried out, would constitute child abuse*, and information suggests that without intervention the child will be harmed.

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SEXUAL ABUSE

Rape of a child. Report includes allegations that a child of any age was compelled by force or imminent threat of force to have sexual intercourse with a member of the opposite sex. This includes situations when a child is:

- Of an age and reasoning ability that consent for sexual intercourse cannot be given;
- Under the influence of drugs, alcohol, or other controlled substances.

Criminal deviate conduct. Report includes allegations that a child of any age was compelled by force or imminent threat of force to perform or submit to deviate sexual conduct. This includes situations when a child is:

- Of an age and reasoning ability that consent for sexual intercourse cannot be given;
- Under the influence of drugs, alcohol, or other controlled substances.

Child molestation. Child under the age of 14 has been the victim of or subject to any of the following sexual acts:

- Sexual intercourse;
- Deviate sexual conduct;
- Fondling or touching, with the intent to arouse or satisfy sexual desires.

Child exploitation.

- A person knowingly or intentionally manages, produces, sponsors, presents, exhibits, photographs, films, videotapes, or creates a digitized image of any performance or incident that includes sexual conduct by a child under the age of 18.
- A person disseminates, exhibits, offers to disseminate or exhibit, or brings to Indiana for dissemination or exhibition matter that depicts or describes sexual conduct by a child under 18.
- A person makes available to another person a computer, knowing that the computer's fixed drive or peripheral device contains matter that depicts or describes sexual conduct by a child under 18.

Child pornography. A person knowingly or intentionally possesses a picture, drawing, photograph, negative image, undeveloped film, motion picture, videotape, digital image, or any pictorial representation that depicts or describes sexual conduct by a child whom the person knows to be less than 16 years old, or who appears to be less than 16 years old; and that lacks serious literary, artistic, political, or scientific value.

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Child seduction. A guardian, adoptive parent, adoptive grandparent, custodian, or stepparent of; child care worker for; or a military recruiter who is attempting to enlist a child at least 16 years of age but less than 18 years of age, engages with the child in sexual intercourse, deviate sexual conduct, or any fondling or touching with the intent to arouse or satisfy the sexual desires of either the child or the adult.

Sexual misconduct with a minor. A person at least 18 years of age engages in one of the following sexual acts with a child who is 14 or 15 years of age:

- Sexual intercourse;
- Deviate sexual conduct;
- Fondling or touching with the intent to arouse or satisfy sexual desires.

Public indecency.

- A person at least 18 years of age who knowingly or intentionally, in a public place, appears in a state of nudity with the intent to be seen by a child less than 16 years of age.

- A person who, in a place other than a public place, with the intent to be seen by persons other than invitees and occupants of that place:

  » Engages in sexual intercourse;

  » Engages in deviate sexual conduct;

  » Fondles the person's genitals or the genitals of another person; or

  » Appears in a state of nudity where the person can be seen by persons other than invitees and occupants of that place.

Prostitution. For money or other property, a child performs, or offers or agrees to perform, sexual intercourse or deviate sexual conduct; or fondles, or offers or agrees to fondle, the genitals of another person.

Incest. Sexual intercourse or deviate sexual conduct by person 18 years of age or older with a minor to whom he/she is biologically related as a parent, child, grandparent, grandchild, sibling, aunt, uncle, niece, or nephew.

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NEGLECT is an act of omission by a parent, guardian, caregiver, or legal custodian in failing to provide for the adequate care and attention of the child's needs, resulting in physical or mental harm to the child or substantial risk of physical or mental harm to the child.

General Neglect
Consider age/developmental status of the child. Injury need not have occurred.

Drug-exposed newborn. Infant is born drug-exposed, as indicated by a positive toxicology screen for scheduled drugs or alcohol, symptoms of withdrawal, mother's admission of recent drug use, or other indicators as determined by medical personnel.

Giving child toxic chemicals, alcohol, or drugs (forcing, allowing, feeding, or otherwise encouraging consumption or introduction into the body) that caused or could cause harm, such as the following:

- Poison, gasoline, kerosene, bleach, cleaning agents;
- Prescription medication that has not been prescribed to the child; or
- An inappropriate dosage of medication that caused or could cause harm.

Inadequate food, or signs of malnutrition. The caregiver does not provide sufficient food to meet minimal nutritional requirements for the child. The child experiences an ongoing pattern or significant lack of food, or unmitigated hunger due to lack of food. Exclude fasting for religious reason.

Exposure to unsafe conditions in the home. The child's house is significantly unsanitary and/or contains hazards that have led or could lead to injury or illness of the child if not resolved. Consider age, developmental ability, and functioning of the children in the home. Examples may include the following:

- Housing that is an acute fire hazard or has been condemned;
- Unsafe sleeping arrangements;
- Exposed heaters;
- Gas fumes;
- Faulty electrical wiring;
- No utilities or access to an alternative (e.g., heat, water, electricity);
- Broken windows, doors, or stairs;
- Vermin or human or animal excrement; and
- Accessible drugs or hazardous chemicals.

Inadequate clothing or hygiene. Caregiver has failed to meet a child's basic needs for clothing and/or hygiene to the extent that the child's daily activities are adversely impacted (unable to attend school due to lack of clothing, not allowed to participate in activities due to poor hygiene) and/or the develops or suffers worsening injury or illness (e.g., sores, infection, tooth loss, severe diaper rash, physical illness, hypothermia, or frostbite). Consider age, developmental ability, and functioning of the children in the home.

Lack of supervision. Child is not supervised to the extent that he/she has been injured, or avoided injury despite lack of attention or supervision by the caregiver. This includes situations where a

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parent knowingly placed his/her child in the care of an inappropriate caregiver. Consider age, developmental ability, and functioning of the children.

- A child has been left alone or without support systems for periods of time or with responsibilities beyond his or her capabilities:

  » For longer than brief periods, without information about personal safety; and what to do in an emergency;
  » To care for children younger siblings;

  » With responsibilities beyond his or her capabilities.

- A child age 12 or over is left alone in the following circumstances:

  » For long hours, including overnight, without information about personal safety; and what to do in an emergency; or

  » With responsibilities beyond his or her capabilities.

Unaccompanied minor in a shelter. A child (under age 18) has entered a homeless or emergency shelter without the presence or consent of a parent, guardian, or custodian.

Exposure to domestic violence (violence between intimate partners) in the home. Screen in reports that meet any of the following criteria:

- Child is present during one or more domestic violence incidents. This includes incidents of physical conflict and/or verbal altercation that include threats of violence, coercion, or unreasonable control. If the alleged incident occurred more than six months ago, consider age of the child, pattern of parental behavior, and impact of the incident on child's ability to function.

- The alleged domestic violence offender has killed, kidnapped, or substantially harmed, or is making a believable threat to kill, kidnap, or substantially harm anyone in the family, including extended family members and pets.

- The alleged domestic violence offender has made threats of homicide or suicide and has access to weapons or other means of carrying out this threat.

- The alleged domestic violence offender does not allow non-offending parent and/or child access to basic needs, impacting their health and safety.

- Non-offending parent has sustained serious injury at the hands of the alleged domestic violence offender (examples: broken bones, internal bleeding or injury, extensive bruising or lacerations, poisoning, suffocating, strangling, shooting or severe malnourishment).

- Alleged domestic violence incident involved the use or threatened use of weapons.

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Known sexual perpetrator has unsupervised or unrestricted access to child. Caregiver allows a registered sex offender or a prior substantiated perpetrator of sexual abuse against the child to have unsupervised and/or unrestricted access to the child.

Sexual predator in the home. A person known to be a registered sexual offender is living in the same home as a minor child.

Failure to Protect

The caregiver does not intervene despite knowledge (or reasonable expectation that the caregiver should have knowledge) that the child is being harmed (includes physical or sexual abuse, neglect, or mental injury) by another person. Report includes information that, if true, indicates that child is being harmed by someone other than the caregiver, and the caregiver was made aware or reasonably should know of the harm, and there is no information or indication that the caregiver has acted to protect the child from further harm. If the person causing harm is a caregiver, parent, or other household member, consider also screening in a referral of physical or sexual abuse or neglect on the alleged maltreater.

Abandonment

A child of any age has been abandoned. A child of any age has been left alone and without a willing and able adult to care for or support him or her. Examples include the following:

- A child left alone in a public place, without means of identifying him/herself or his/her parent/caregiver.
- Child left with family members or friends with no means of support or contact from the parent/caregiver.

Unharmed infants (45 days or younger) surrendered under the Safe Haven statute should not be investigated unless there are questions regarding the infant's care since birth. The law allows for unharmed infants 45 days old or younger to be relinquished to a responsible individual, who in turn must give the infant to law enforcement or a hospital. The infant may also be relinquished directly to law enforcement or a hospital by the parents (mother, father, or both) of the child. Such situations should not be handled as investigations and should be referred for a CPS intervention.

A child is being discharged from a facility and parents refuse to accept the child back or make appropriate alternate arrangements. Parent refuses to accept the child back into his/her home AND refuses to allow for or arrange alternate placement of the child. Consideration should be given to the need for continued treatment; risk to the child; family, community, and resource availability.

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Risk of Harm
Conditions exist that create a substantial likelihood that the child will be harmed due to caregiver's neglect. It is not necessary for injury to have occurred.

Current open case and a new child is now living in the home. A family has a currently open case in Indiana or there is credible information that the caregiver has a currently open case in another jurisdiction and there is a new child now living in that home.

Prior failed case and a new child is now living in the home. All three of the following elements must be present for a report to be screened in on this criterion.

1. There is credible information that a current caregiver has had a child permanently removed from his/her care due to a child abuse or neglect concern.

2. Rehabilitative services for that incident were either not offered to the caregiver at the time OR the caregiver did not successfully complete rehabilitative services that were offered. Services may not have been offered because the caregiver voluntarily removed him/herself from a caregiving role (e.g., transferred custody of other children to a family member or moved out of the home), was involuntarily removed from a caregiving role (e.g., incarcerated), made him/herself unavailable for services (e.g., unable to locate), or no other children resided with him/her at the time.

3. There is now a new child living in the home.

Prior death or serious injury of a child due to child abuse or neglect, services were not offered or successfully completed, and a new child is now in the home. All three of the following elements must be present for a report to be screened in on this criterion.

1. There is credible information that a current caregiver was responsible for the death or serious injury of a child due to neglect/abuse.

2. Rehabilitative services for that incident were either not offered to the caregiver at the time OR the caregiver did not successfully complete rehabilitative services that were offered. Services may not have been offered because the caregiver voluntarily removed him/herself from a caregiving role (e.g., transferred custody of other children to a family member or moved out of the home), was involuntarily removed from a caregiving role (e.g., incarcerated), made him/herself unavailable for services (e.g., unable to locate), or no other children resided with him/her at the time.

3. There is now a new child living in the home.

Child's basic needs are likely to be unmet due to caregiver impairment. Caregiver's ability to parent appears to be substantially impaired to the extent that the caregiver would be unable to respond to or meet the basic needs of the child (food, clothing, shelter, education, health care) and the caregiver has not made other arrangements for supervision or care of the child. Impairment may be caused by mental or physical health conditions or active substance use.

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Medical Neglect

The unreasonable delay, refusal, or failure on the part of the caregiver to seek, obtain, and/or maintain necessary medical, dental, or mental health care when caregiver knows, or should reasonably be expected to know, that such actions may cause adverse impact on the child's health and welfare, and a caregiver's inattention or alternative treatment is causing the condition to worsen. Such actions may include but are not limited to the following:

- Missed appointments, therapies, or other necessary medical and/or mental health treatments;
- Withholding or failing to obtain or maintain medically necessary treatment for a child with life-threatening, acute, or chronic medical conditions;
- Failing to provide comfort measures to infants and children with life-ending conditions;
- The child has been diagnosed as having non-organic failure to thrive or has indicators of failure to thrive, and a caregiver's inattention or alternative treatment is causing the condition to worsen;
- Caregiver is aware of serious mental health issues, including suicidal threats, actions, or ideations, and is delaying, refusing, or failing to seek, obtain, or maintain mental health care.

Educational Neglect

A child age 5 or 6 is currently or was previously enrolled in school, and the parent is now refusing to allow or failing to support the child in attending school or receiving homeschooling. Consider number of absences in the current year (less than 10 unexcused absences should not be considered educational neglect), attempts to engage the parents, and parents' response to these attempts.

A child is age 7–12 and there is unreasonable delay, refusal, or failure on the part of the caregiver to seek, obtain, and/or maintain education for the child. Consider number of absences in the current year (less than 10 unexcused absences should not be considered educational neglect), attempts to engage the parents, and parents' response to these attempts.

A child is age 13 or older, enrolled in school, and not attending to the extent that educational neglect is present.

- Child has over 10 unexcused absences during the current school year;
- Caregiver has been made aware of the situation; AND
- Information provided indicates that the caregiver refuses to allow or appears unable to support the child in attending school.

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EMOTIONAL INJURY is an observable, identifiable, and substantial impairment of a child's mental or psychological ability to function as a result of child abuse or neglect.

A child has an observable, identifiable, and substantial impairment of his/her mental or psychological ability to function as a result of an act or failure to act by a parent, caregiver, or household or family member. These acts may include the following:

- Implied or overt threats of death or serious injury of the child or others;
- Implied or overt threats in the form of pet or animal torture; or
- Constant denigration.

Failure to act may include the following:

- Extensive emotional or physical isolation;
- Confinement;
- Severe lack of engagement or stimulation.

SECTION 3. RECOMMENDATION AND OVERRIDES

Initial Screening Recommendation

Screen out (no maltreatment type is marked)
Mark this decision if no maltreatment type in Section 2 is marked, which means that the referral does not meet statutory requirements for an in-person response.

Screen in (one or more maltreatment types are marked)
Mark this decision if any maltreatment type in Section 2 is marked, which means that at least one reported allegation meets statutory requirements for an in-person response.

Overrides

No overrides apply.

Screen out: Initial recommendation is to screen in, but referral will be screened out because *(mark all that apply)*:

- Insufficient information to locate child/family. The caller was unable to provide enough information about the child's identity and/or location to enable an in-person response. *Do not mark this item if partial information is available.* Screener should either follow up on information to establish child's identity/location or forward screened-in referral for investigation.

- Report of historical event and no current risk of harm described. (Time since alleged incident: _____)

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- Current report includes only neglect allegations AND alleged victim has a current open case type for similar neglect concerns.

- Allegations have been assessed for the same incident of alleged physical or sexual abuse.

- Other (specify).

Screen in: Initial recommendation is to screen out, but referral will be opened and assigned for child protective services (CPS) assessment because *(mark all that apply)*:
Mark this decision if no maltreatment types in Section 2 are marked, which means that the referral does not meet statutory requirements for an in-person response. However, a referral will be opened and assigned for assessment for one or more of the following reasons:

- Court requests assessment;
- Prosecutor requests assessment;
- Law enforcement requests assistance;
- DCS regional administrator or other administrator requests referral be screened in;
- Other (specify).

Final Screening Decision *(after consideration of overrides)*

Screen out: No maltreatment type is marked AND no screen-in overrides apply OR a screen out override is marked. Mark this decision if no maltreatment type in Section 2 is marked, which means that the referral does not meet statutory requirements for an in-person response, AND no screen-in overrides in Section 3 are marked or a maltreatment type in Section 2 is marked, which means that the referral meets statutory requirements for an in-person response but a screen-out override has been marked.

Screen in: At least one maltreatment type or screen-in override is marked. Mark this decision if any criteria in Section 2 are marked, which means that at least one reported allegation meets statutory requirements for an in-person response, or at least one screen-in criterion was identified AND no screen-out criteria were marked. For all referrals in which the final screening decision is to screen in, a response time must be identified.

SECTION 4. RESPONSE TIME DECISION

For all screened-in referrals, review criteria for immediate response and mark all that apply. If any apply, immediate response is required by the local agency. If no immediate response criteria exist, mark the type(s) of maltreatment that were identified in the allegations. Response time will be based on the most severe type of maltreatment alleged.

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INDIANA DEPARTMENT OF CHILD SERVICES
SDM® CHILD ABUSE AND NEGLECT
SCREENING AND RESPONSE TIME ASSESSMENT
POLICY AND PROCEDURES

Which Cases: The CA/N screening and response time assessment is completed on all referrals. This includes new referrals of child abuse and neglect on open cases.

Who: The hotline worker completes the assessment and the supervisor reviews and approves.

When: The screening and response time assessment is completed upon receipt of information that constitutes a referral. This generally occurs while the screener is talking with the reporter making a referral (either over the phone or in person). Occasionally the screener may need to gather information from additional sources as part of the screening process. For these referrals, the screening assessment is completed as soon as all necessary information is gathered.

Decision: The screening and response time assessment determines whether a referral requires an investigation. If an investigation is required, the immediate response criteria identify if an immediate response is required.

Appropriate Completion

SECTION 1. PRELIMINARY SCREENING

Complete this section based on information provided by reporter. If any items in this section are selected, the report does not meet criteria for an investigation. A non-investigatory response by the agency may be identified.

SECTION 2. MALTREATMENT TYPE

Proceed with review of screening criteria and mark all applicable maltreatment types, using the definitions to ensure that the referral information meets criteria.

SECTION 3. RECOMMENDATION AND OVERRIDES

If any maltreatment type in Section 2 is marked, check "Screen in." If no maltreatment type is marked, check "Screen out."

There are some instances when the initial screening recommendation, based on the presence of maltreatment criteria, does not apply. If the initial screening recommendation is "Screen in," the worker should review only the override reasons for "screen out" to see if any apply. Likewise, if the initial screening recommendation is "Screen out," the worker should review only the override reasons for "screen in." Check any override reasons that apply.

Record the final screening decision based on the impact of any overrides.

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SECTION 4: RESPONSE TIME DECISION

For all referrals in which the final screening decision is to investigate, the immediate (within 24 hours) response criteria must be reviewed. If any of the immediate response criteria are present in a given referral, the response time for the referral is immediate.

Referrals that do not include criteria that meet the need for immediate response will be assigned the statutory response time based on the most severe allegation reported.

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CSIC
October 11, 2012
Attachment 28

A New Practice Model for Indiana

INDIANA DEPARTMENT OF CHILD SERVICES

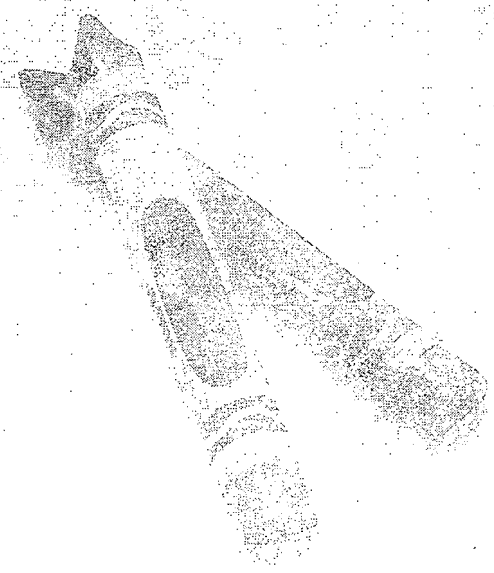
CSIC
October 11, 2012
Attachment 28

A New Practice Model for Indiana

INDIANA
DEPARTMENT OF
CHILD
SERVICES

How Are the Children in Indiana?

They are well.



Moving Forward in The Practice

Maria Wilson
Indiana Practice Model Director

The Indiana Department of Child Services Practice Model has grown tremendously since its inception in 2006. Moving forward, the State of Indiana is encouraged that we can share our successes and lessons learned with other governments and public child welfare agencies undergoing reform.

The Indiana Practice Model continues to work on initiatives such as Engaging Fathers; Addressing Language Barriers with Hispanic Families; Services for Independent Living; Domestic Violence within CFTMs; Substance Abuse; and Mental Illness. In addition, DCS is committed to being transparent and open to any refinement needed in order to achieve our ultimate vision that our children thrive in safe, caring, supportive families and communities. One way of achieving this goal is to maintain strong partnerships with our stakeholders, including communities, service providers, courts, schools and families.

DCS would like to give special thanks to the Casey Strategic Consulting Group, the Child Welfare Policy and Practice Group; the State of Utah and the Indiana University School of Social Work for assisting with our reform efforts. Also, we would like to acknowledge our wonderful staff that dared to shift from the "old way of doing business" to embracing a new practice model simply because it was the right thing to do. Because of all this, we can say that the children are well in the State of Indiana.

For more information, please contact:

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765-213-6959
Maria.Wilson@dcs.in.gov

or: MB Lippold
Deputy Director of Staff Development
Indiana Department of Child Service
302 W. Washington, E306 MS47
Indianapolis, IN. 46204
317-234-3925
MB.Lippold@dcs.in.gov

Practice Positions and Expectations

Practice Model Director

The Practice Model Director monitors all aspects of the Indiana Practice Model statewide and collaborates with internal and external partners to ensure model fidelity in daily operations.

Regional Practice Consultants

There are eighteen Regional Practice Consultants who serve as liaisons for the practice between Central Office, field, the community and stakeholders. In addition, the Practice Consultants lead the practice within their region and support peer coaches.

Peer Coach Consultants

There are six Peer Coach Consultants. These positions serve as the experts in the Indiana Practice Model. They assist with bridging gaps between field, policy, Quality Service Reviews, training, legal, fiscal, or other areas that have an impact on the practice. Peer Coach Consultants train all Peer Coaches.

Peer Coaches

Peer Coaches train all Family Case Managers to become facilitators of Child and Family Team Meetings. The number of Peer Coaches per region is dependant upon the volume of Family Case Managers in the region. Peer Coaches are Family Case Mangers that are considered to be champions within their current position and receive additional training and support to serve in this role. There are a few regions where supervisors serve as Peer Coaches.

P-FACT (Practice, Field and Clinical Team)

P-FACT is a team of individuals from Staff Development and Field Operations that come together to brainstorm critical issues identified within regions which impact the practice.

All DCS positions and responsibilities have changed dramatically to reflect the Indiana Practice Model. While there are some positions that are allocated solely to the Practice Model, all positions have the expectation to fulfill the mission of the Practice Model.

Practice Model Testimonials

Jeff Lozer

General Counsel

Child and family team meetings and the TEAPI model are ways in which DCS can address child abuse and neglect while affirming and protecting the constitutional rights of parents to raise their children.

Ann Houseworth

Director of Communications

The Practice Model provides an opportunity to truly engage the children and families we serve. During Child and Family Team Meetings we bring together family members and key friends to discuss the needs of the family. This open dialogue allows the team to evolve into a support network on which the family can rely to help provide a safe, nurturing and stable home for their children.

Tatiana Alvarez

Hispanic Initiative Manager

The implementation of the Practice Model has impacted the way our immigrant families' cultural behaviors and traditions are better understood and respected. This model also serves as a bridge which allows them to cross over and learn the acceptable American ways without having to renounce everything they know.

Testimonials

Lisa Rich

Deputy Director of Programs and Services

The DCS practice model has empowered families to have a voice in decision making about the services they need to best meet the needs of their family. The model allows for service provision to be individualized, addressing the core issues surrounding the family.

Angela Green

Deputy Director of Practice Support

Indiana has taken a multifaceted strategic approach that has transformed every structural component of child welfare. By centrally focusing on our TEAPI practice model as the impetus of our change process, we are witnessing improved practice and positive results in the lives of children and their families.

Katie Rounds

Deputy Chief of Staff

By identifying and building on the strengths of the family, the DCS Practice Model and the use of Child and Family Team Meetings allow DCS to partner with and support families involved with our system.

Practice Model

John Ryan

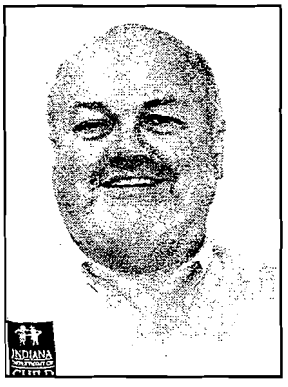
Chief of Staff

The Department of Child Services has made a commitment to children and families by adopting a standard, consistent model of practice, proven to achieve results that are directly tied to the agency's vision, mission and values. Recent data obtained indicates clearly that the course of action is an appropriate one and that the established model, together with appropriate resources and support, is working.

MB Lippold

Deputy Director of Staff Development

Partnering with families to develop their roadmap based on their unique needs was a concept that made a lot of practice sense when our new department started in 2005 and this still holds true today. It has been an enormous training challenge, but through effective partnerships, that challenge has been met.



Dave Judkins

Deputy Director of Field Operations

By successfully ingraining the TEAPI practice skills into our partnership with families, DCS fulfills an expectation that families rightfully have a say in their future and that children indeed thrive in safe, caring, supportive families and communities.

Practice Indicators

Reduced substitute care: (increased children placed in their own home)

The safety of a child is non-negotiable. As appropriate services are available, we can provide services for the family with the child in the home and maintain child safety as our primary focus.

Increased use of relative care:

Relatives should be given a higher priority in consideration for the placement of children.

Increased placement in own community:

When a child must be removed from the home, out-of-home placement should occur in the same neighborhood and School Corporation, if at all possible. It is imperative that children experience the least disruption in their education.

Reduced use of residential placement: (increased use of least restrictive placement)

When services are provided to a child and family at the earliest intervention, the need for residential placement will be decreased significantly over time.

Reduced number of placement moves: (increased placement stability)

At the first placement, children should be placed to fit the needs of the child. The child and family should be provided support to maintain the initial placement, as every placement change is a disruption in the child's life and causes trauma to the child.

Increased sibling placements:

If siblings are removed, they should be placed together as a sibling group. Essential connections are critical to the healthy development of siblings.

Reduced length of stay:

When a child is placed in substitute care, early permanency is critical for the child. Permanent families should be identified early for those children who are unable to return to their families of origin.

Increased permanency:

Permanency for a child means a safe, stable, and secure home with a family that provides love, unconditional commitment, and lifelong support in the context of reunification, adoption, or legal guardianship where possible. No child should linger in foster care or leave the system at age 18 without a permanent family of their own.

Increased child & family visits:

Based on national reviews, positive outcomes for children and families are significantly influenced by the quality and quantity of Case Manager contacts with the child and family (i.e., original caretakers) and family visitation.

Reduced incidence of repeat maltreatment:

Thorough assessments and appropriate and timely services are a vital tool for ensuring that children are not subject to subsequent abuse or neglect.

Quality Service Review

The Quality Service Review (QSR) is a snapshot view of how the practice model is assisting children and families to reach permanency. Cases are pulled within each region of Indiana based on age, length of time in care, placement type and case type. This process also includes the review of assessment cases. QSR reviewers spend two days conducting in-depth interviews with key case contributors to determine how well the elements of the practice model are working towards sustainable safe case closure. This review was implemented in 2007 and is conducted throughout the state on a monthly basis.

The QSR evaluates Child Status, Parent/Caregiver Status and System Performance.

The Child Status indicators evaluate child Safety, Permanency and Well-Being. The Parent/Caregiver Status evaluates Parenting Capacities as well as Informal Supports. The TEAPI skills are evaluated in the System Performance section of the QSR review.

Following the QSR, each region develops a practice improvement plan that is tracked through the Continuous Quality Improvement (CQI) process. Regions have the opportunity to request support services to help move practice forward in their region. The CQI process allows a statewide systematic response to needs from each level of management.

What we've learned from the QSR

Indiana achieved the following as a result of less than three years of practice improvement:

- More children are now remaining in their birth homes or are placed with relatives.
- Field staff are recognizing the importance of teaming with each family.
- Assessment of underlying needs have improved through utilizing practice model skills.
- There remains an opportunity to engage fathers to have a more meaningful role in the lives of their children.
- Indiana is also tracking whether the parents who are currently involved are previous wards. This information is important when program planning for Independent Living skills with a goal of providing youth with the skills needed to be successful in life.

- Case/Service Planning ("Informal Adjustment" development, recommendations for disposition, case plan, education needs, medical needs, etc)
- Reunification Planning

The following are triggers to prompt a CFTM to occur during the case management phase:

- Case/Service Planning (implementation, tracking and adjusting)
- Prevention of Removal (child remains safely in the home)
- Placement (exploring relatives, non-custodial parents, local placement, placement with siblings, ensuring the stability of placement to avoid disruption)
- Visitation Planning (parents, siblings, relatives, essential connections)
- Permanency Planning
- Reunification Planning
- Case Closure

Child and Family Team Meetings are coordinated and facilitated by the Family Case Manager. The purpose of these meetings is to hear the family's voice, expedite permanency, ensure safety and support the child's well-being. Results of the meetings include more effective plans and interventions because of a greater richness of family support and more inclusive decision-making. Families are empowered to lead the meetings by selecting team members, location and time, and goals to work on at the meeting.

Child and Family Team Meetings (CFTM) are held at all key decision-points in both assessment and on-going case management phases. The following are triggers to prompt a CFTM to occur in the assessment phase:

- Safety Planning (identifying family strengths, needs so that risks can be mitigated or removed)
- Prevention of Removal (child remains safely in the home)
- Placement (exploring relatives, non-custodial parents, local placement, placement with siblings)
- Visitation Planning (parents, siblings, relatives, essential connections)

Indiana Practice Model-TEAPI

DCS's desired case practice was captured in a "practice model", or the description of the practice principles and essential skills to effectively implement its vision, mission and values. These principles and skills are built upon case practice reform efforts that have significantly improved child safety and family reunification in other states. After researching other States' best practices, Indiana identified five essential practice skills. These skills are:

Teaming The skill of assembling a group to work with children and families, becoming a member of an established group, or leading a group to bring needed resources to the critical issues of children and families. Child welfare is a community effort and requires a team.

Engaging The skill of effectively establishing a relationship with children, parents, and essential individuals for the purpose of sustaining the work that is to be accomplished together.

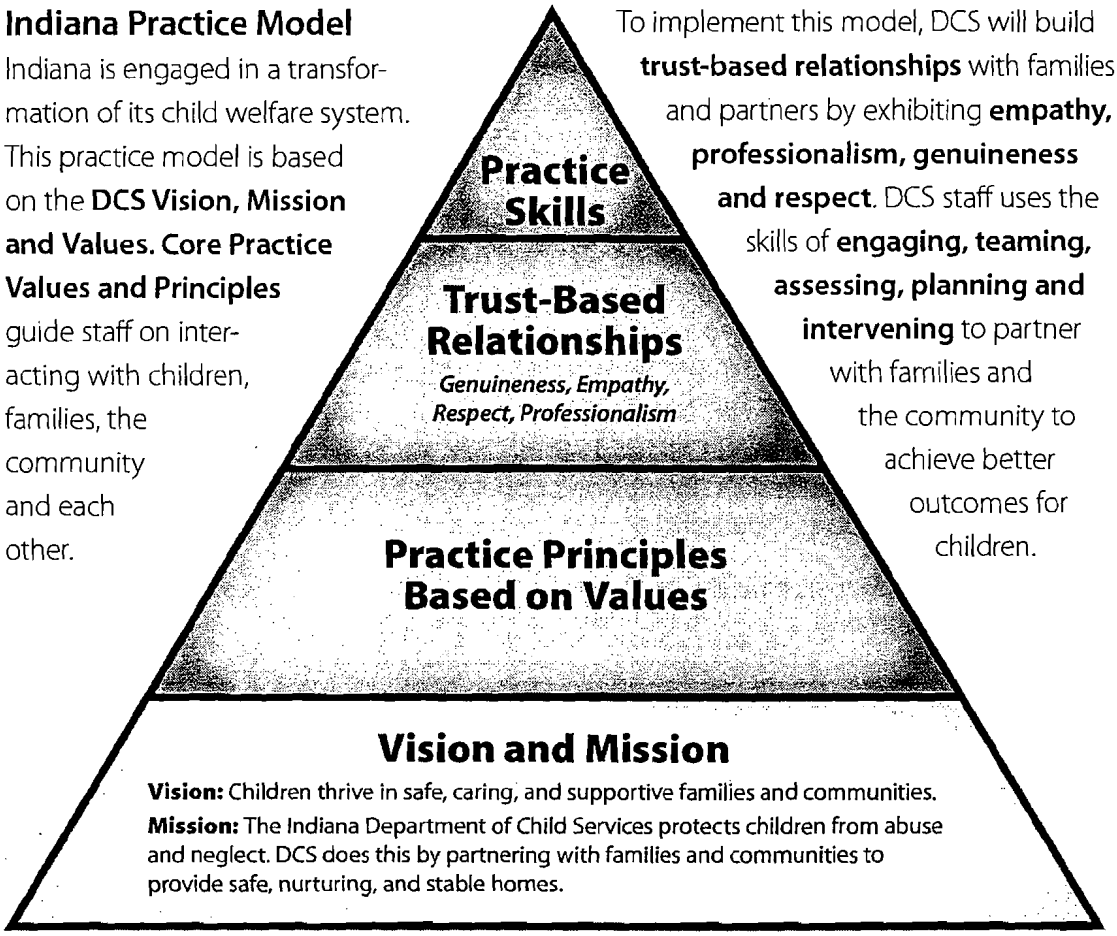
Assessing The skill of obtaining information about the salient events that brought the children and families into our services and the underlying causes bringing about their situations. This discovery process looks for the issues to be addressed and the strengths within the children and families to address these issues. Here we are determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being for children.

Planning The skill necessary to tailor the planning process uniquely to each child and family is crucial. Assessment will overlap into this area. This includes the design of incremental steps that move children and families from where they are to a better level of functioning. Service planning requires the planning cycle of assessing circumstances and resources, making decisions on directions to take, evaluating the effectiveness of the plan, reworking the plan as needed, celebrating successes, and facing consequences in response to lack of improvement.

Intervening The skill to intercede with actions that will decrease risk, provide for safety, promote permanence, and establish well-being. These skills continue to be gathered throughout the life of the professional child welfare worker and may range from finding housing to changing a parent's pattern of thinking about their child.

Practice Model Pyramid

Indiana Practice Model
Indiana is engaged in a transformation of its child welfare system. This practice model is based on the **DCS Vision, Mission and Values. Core Practice Values and Principles** guide staff on interacting with children, families, the community and each other.



To implement this model, DCS will build **trust-based relationships** with families and partners by exhibiting **empathy, professionalism, genuineness and respect**. DCS staff uses the skills of **engaging, teaming, assessing, planning and intervening** to partner with families and the community to achieve better outcomes for children.

DCS Values

- **We believe every child has the right to be free from abuse and neglect.**
- **We believe every child has the right to appropriate care and a permanent home.**
- **We believe parents have the primary responsibility for the care and safety of their children.**
- **We believe the most desirable place for children to grow up is with their own families, when these families are able to provide safe, nurturing, and stable homes.**
- **We believe in personal accountability for outcomes, including one's growth and development.**
- **We believe every person has value, worth and dignity.**

Case Practice Reform History

Indiana's practice improvement efforts began in 2005 when Governor Mitch Daniels established the Department of Child Service (DCS) as a cabinet-level, independent agency. Governor Daniels sought to create a child welfare agency that could better serve and protect the children and families of Indiana. In order to start to carry out this mission, the Indiana legislature provided DCS the staff resources to cut caseloads to 12 new cases or 17 ongoing cases per worker, or under half of their previous average.

DCS's new leadership sought to ground their improvement efforts in strong principles and values and to translate these into caseworkers' every day actions and decisions. The mandate to double agency staff provided an opportunity to embed these principles and values and to improve practice. Leadership also understood that lower caseloads allowed caseworkers greater time to invest in family engagement.

DCS Practice changes included Child and Family Team Meetings; Clinical Supervision and five new essential practice skills.. In addition, supports for the practice change were implemented. These supports included:

- Introduction of Practice Model and reform vision to staff in local offices and service providers
- Training for all staff on the 5 core skills: **Engaging, Teaming, Assessing Planning and Intervening**
- Training and support for supervisors
- Coaching for all staff on child & family teaming (skills and process)
- Quality Service Reviews to provide regular practice improvement feedback
- Creation of flexible services for families
- Policy changes which support and promote the team meeting process
- Outcomes-focused strategic planning by regional managers
- Improvements to the state's information system, including opportunity to note team meeting occurrence
- Updated position profiles and staff performance measures
- Regional Service Councils for community involvement

From the Director

It has been my privilege to serve in the capacity of Director for the Indiana Department of Child Services (DCS) since 2005. DCS has managed to accomplish several milestones over the past few years; the greatest one has been recognizing change was needed in order to effectively make a difference in the lives of families and children. Thus, the Indiana Practice Reform movement began.

As the organizational structure took shape throughout 2005, it became apparent that child protection services lacked a specific focus in its approach to, and work with, families. The 92 local offices were all conducting assessments, working with families, and establishing permanency plans; however, the processing a case throughout its life varied, sometimes due to local practice, sometimes due to court practices, and many times due to overburdened workers with caseloads too high to focus attention on the family's underlying needs. Many contracts were in place with private providers, but coordination was lacking. We asked, "How Are The Children?", and it was not clear that we were doing all that we could to have the answer be "All Of The Children Are Well."

After establishing the Vision, Mission and Values of the agency, it seemed prudent to seek out the best possible model of practice that was known in child welfare and develop a plan for training it, supporting it, and ultimately implementing it in a uniform manner across the state. A model was developed and between 2006 and 2009, all 1,600 case manager staff as well as managers received training in the five core competency areas that are the foundation of the Indiana Practice Model including Teaming, Engaging, Assessing, Planning and Intervening (TEAPI). All of the staff were also prepared to effectively facilitate "Child and Family Team Meetings", a cornerstone of the Indiana Practice Model.

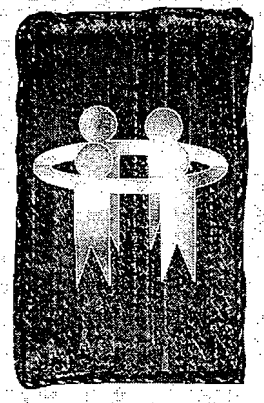
This brochure more fully explains that process. Our work is certainly not done. But this current approach of engaging with families, teaming and planning with them, and supporting them when possible, while still holding parents accountable for their children will bring Indiana to the goal of being able to say that "all of Indiana's children are well".

Sincerely,

James W. Payne, Director

A New Practice Model for Indiana

an overview



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October 11, 2012
Attachment 29

Who can the public contact for questions rel

DCS Interim Study Committee

If individuals from the public wish to contact DCS directly regarding ongoing concerns they have relating to the Department they can utilize one of the following options:

- If an individual has a concern about how a current case is being handled, they should speak with the Family Case Manager handling the case. The phone number for each local office can be found on the DCS website: http://www.in.gov/dcs/2372.htm

- If an individual wants DCS to look into a case or has general questions, they can contact DCS customer services at: DCS.CustomerService@dcs.in.gov

- If an individual has concerns about the way DCS handled a case and would like an independent review of the case, they can contact 317-234-7361 or DCSOmbudsman@idoa.in.gov

Who can the public contact for questions rel

DCS Interim Study Committee

If individuals from the public wish to contact DCS directly regarding ongoing concerns they have relating to the Department they can utilize one of the following options:

- If an individual has a concern about how a current case is being handled, they should speak with the Family Case Manager handling the case. The phone number for each local office can be found on the DCS website: http://www.in.gov/dcs/2372.htm

- If an individual wants DCS to look into a case or has general questions, they can contact DCS customer services at: DCS.CustomerService@dcs.in.gov

- If an individual has concerns about the way DCS handled a case and would like an independent review of the case, they can contact 317-234-7361 or DCSOmbudsman@idoa.in.gov