



DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D.C. 20201

DEC - 8 2016

Mary Beth Bonaventura, Director
Indiana Department of Child Services
302 W. Washington Street
Room E306-MS47
Indianapolis, Indiana 46204-2739

Dear Director Bonaventura:

Thank you for submitting Indiana's Annual Progress and Services Report (APSR), including the annual report on the use of funds under the Child Abuse Prevention and Treatment Act, and the CFS-101 forms requesting funding for fiscal year (FY) 2016 to address the following programs:

- Title IV-B, subpart 1 (Stephanie Tubbs Jones Child Welfare Services) of the Social Security Act (the Act);
- Title IV-B, subpart 2 (Promoting Safe and Stable Families Program and Monthly Caseworker Visit Grant) of the Act;
- Child Abuse Prevention and Treatment Act (CAPTA);
- Chafee Foster Care Independence Program (CFCIP); and
- Education and Training Vouchers (ETV) Program.

These programs provide important funding to help state child welfare agencies ensure safety, permanency, and well-being for children, youth and their families. The APSR facilitates continued assessment, development, and implementation of a comprehensive continuum of services for children and families. It provides an opportunity to integrate more fully each state's strategic planning around use of federal funds with its work relating to the Child and Family Services Reviews and continuous program improvement activities.

The Children's Bureau (CB) has reviewed your APSR for FY 2016 and the annual report on the use of CAPTA funds and finds them to be in compliance with applicable federal statutory and regulatory requirements. Therefore, we approve FY 2016 funding under the title IV-B, subpart 1; title IV-B, subpart 2; CAPTA; CFCIP; and ETV programs.

Counter-signed copies of the CFS-101 forms are enclosed for your records. The CB may ask for a revised CFS-101, Part I, should the final allotment for any of the approved programs be more than that requested in the Annual Budget Request.

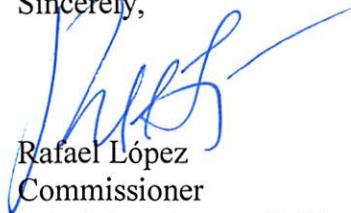
The Administration for Children and Families (ACF) Office of Grants Management (OGM) will issue a grant notification award letter with pertinent grant information. Please note that OGM requires grantees to submit additional financial reports, using the SF-425, at the close of the expenditure period according to the terms and conditions of the award.

This approval for the FY 2016 funding for title IV-B, subpart 1; title IV-B, subpart 2; CAPTA; CFCIP; and ETV programs does not release the state from ensuring that training costs included in the training plan and charged to title IV-E comply with the requirements at 45 CFR 1356.60(b) and (c) and 45 CFR 235.63 through 235.66(a), including properly allocating costs to all benefiting programs in accordance with the state's approved cost allocation plan.

Pursuant to Section 424(f) of the Social Security Act, states are required to collect and report on caseworker visits with children in foster care. The FY 2015 caseworker visit data must be submitted to the Regional Office by December 15, 2015 and states that wish to sample must obtain prior approval from the Regional Office.

The CB looks forward to working with you and your staff. Should you have any questions or concerns, please contact Kendall Darling, Child Welfare Regional Program Manager in Region 5 at (312) 353-9672 or by e-mail kendall.darling@acf.hhs.gov. You also may contact Ruby Flagg, Children and Families Program Specialist, at (312) 886-4202 or by e-mail ruby.flagg@acf.hhs.gov.

Sincerely,



Rafael López
Commissioner

Administration on Children, Youth and Families

Enclosure(s)

cc: Gail Collins, Director; CB, Division of Program Implementation; Washington, DC
Deborah M. Bell, Financial Management Specialist; ACF, OA, OGM; Washington, DC
Kendall Darling, Child Welfare Regional Program Manager; CB, Region 5; Chicago, IL
Ruby Flagg, Child and Family Program Specialist; CB, Region 5; Chicago, IL

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

Fiscal Year 2016, October 1, 2015 through September 30, 2016

1. State or Indian Tribal Organization (ITO): INDIANA		2. EIN: 35-6000158	
3. Address: Department of Child Services 402 W. Washington Street, Rm E306, MS08 Indianapolis, IN 46204-2739		4. Submission: [X] New [] Revision	
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds		\$ 6,456,658.00	
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)		\$ 645,665.80	
6. Total estimated title IV-B Subpart 2, Provides Safe and Stable Families (PSSF) Funds. This amount should equal the sum of lines a - f.		\$ 5,908,388.00	
a) Total Family Preservation Services		\$ 1,181,677.60	
b) Total Family Support Services		\$ 1,181,677.60	
c) Total Time-Limited Family Reunification Services		\$ 1,181,677.60	
d) Total Adoption Promotion and Support Services		\$ 1,181,677.60	
e) Total for Other Service Related Activities (e.g. planning)		\$ 590,838.80	
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)		\$ 590,838.80	
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)		\$ 371,803.00	
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)		\$ 37,180.30	
8. Re-allotment of title IV-B subparts 1 & 2 funds for States and Indian Tribal Organizations:			
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS \$ 0.00, PSSF \$ 0.00, and/or MCV(States only)\$ 0.00.			
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS \$ 0.00, PSSF \$ 1,772,516.00, and/or MCV(States only)\$ 111,354.00.			
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)		\$ 529,086.00	
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds		\$ 4,059,701.00	
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)		\$ 1,217,910.30	
11. Estimated Education and Training Voucher (ETV) funds		\$ 1,311,812.00	
12. Re-allotment of CFCIP and ETV Program Funds:			
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out CFCIP Program		\$	
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program		\$	
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program		\$ 500,000.00	
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for ETV Program		\$ 200,000.00	
13. Certification by State Agency and/or Indian Tribal Organization.			
The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.			
Signature and Title of State/Tribal Agency Official		Signature and Title of Central Office Official	
<i>Dr. B. Jhi / Chief of Staff</i>		<i>[Signature]</i>	

CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services
State or Indian Tribal Organization (ITO) INDIANA

For FFY OCTOBER 1, 2015 TO SEPTEMBER 30, 2016

SERVICES/ACTIVITIES	TITLE IV-B			(d) CAPTA*	(e) CFCIP	(f) ETV	(g) TITLE IV-E**	(h) STATE, LOCAL, & DONATED FUNDS	(i) NUMBER TO BE		(j) POPULATION TO BE SERVED	(k) GEOG. AREA TO BE SERVED
	(a) Subpart I- CWS	(b) Subpart II- PSSF	(c) Subpart II- MCV *						Individuals	Families		
1.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	\$0.00	\$ 1,181,677.60		\$ 29,086.00			\$ 219,317.00	\$ 47,657,460.48	47255	36050	Children/Families at Risk AB/NE	Statewide
2.) PROTECTIVE SERVICES	\$ 5,200,753.84			\$ 500,000.00			\$ 569,252.70	\$ 19,645,135.68	212800	0	Reports of AB/NE	Statewide
3.) CRISIS INTERVENTION (FAMILY PRESERVATION)	\$0.00	\$ 1,181,677.60		\$0.00			\$ 24,667.03	\$ 1,915,369.17	0	5895	AB/NE	Statewide
4.) TIME-LIMITED FAMILY REUNIFICATION SERVICES	\$0.00	\$ 1,181,677.60		\$0.00			\$0.00	\$ 3,911,956.42	9950	0	Children in Foster Care & their families	Statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	\$0.00	\$ 1,181,677.60					\$ 216,527.36	\$ 573,529.41	0	420	Families referred to Post Adoption Svcs	Statewide
6.) FOR OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	\$0.00	\$ 590,838.80					\$ 19,083.17	\$ 15,875,008.05	N/A	N/A	N/A	Statewide
7.) FOSTER CARE MAINTENANCE:	\$0.00											
(a) FOSTER FAMILY & RELATIVE FOSTER CARE	\$0.00						\$ 21,360,075.27	\$ 79,505,069.00	9893	0	Children in Foster Care	Statewide
(b) GROUP/INST CARE	\$0.00						\$ 40,707,547.41	\$ 173,965,056.36	673	0	Children in Foster Care	Statewide
8.) ADOPTION SUBSIDY PMTS.	\$0.00						\$ 64,230,916.02	\$ 57,578,131.84	12822	0	Adoptive Children	Statewide
9.) GUARDIANSHIP ASSIST. PMTS.	\$0.00						\$0.00	\$ 4,330,806.78	240	0	Assisted Guardianships	Statewide
10.) INDEPENDENT LIVING SERVICES	\$0.00	\$0.00			\$ 4,059,701.00		\$ 151,647.34	\$ 840,170.94	615	0	All eligible Children	Statewide
11.) EDUCATION AND TRAINING VOUCHERS	\$0.00				\$0.00	\$ 1,311,812.00	\$0.00	\$ 50,360.00	222	0	Children Ages 18-20	Statewide
12.) ADMINISTRATIVE COSTS	\$ 645,665.80	\$ 590,838.80	\$ 37,180.30				\$ 23,450,706.52	\$ 147,282,942.61				
13.) STAFF & EXTERNAL PARTNERS TRAINING	\$ 528,104.16	\$0.00		\$0.00	\$0.00	\$0.00	\$ 2,007,414.66	\$ 1,770,497.20				
14.) FOSTER PARENT RECRUITMENT & TRAINING	\$ 8,610.65	\$0.00		\$0.00			\$ 16,822.25	\$ 544,882.02				
15.) ADOPTIVE PARENT RECRUITMENT & TRAINING	\$ 8,610.65	\$0.00		\$0.00			\$ 16,833.05	\$ 502,289.34				
16.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	\$0.00						\$0.00	\$0.00	0	0	Nothing reported	Statewide
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	\$ 64,912.90	\$0.00	\$ 334,622.70				\$ 1,864,849.43	\$ 226,014.20				
18.) TOTAL	\$ 6,456,658.00	\$ 5,908,388.00	\$ 371,803.00	\$ 529,086.00	\$ 4,059,701.00	\$ 1,311,812.00	\$ 154,855,659.21	\$ 556,174,679.50	294470	42365	N/A	

* These columns are for States only; Indian Tribes are not required to include information on these programs.

** Only states or tribes operating an approved title IV-E waiver demonstration may enter information for rows 1-6 in column (g), indicating planned use of title IV-E funds for these purposes.

CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence (CFCIP) and Education And Training Voucher (ETV) : Fiscal Year 2013: October 1, 2012 through September 30, 2013

1. State or Indian Tribal Organization (ITO): INDIANA		2. EIN: 35-600158		3. Address: Dept of Child Services, 402 W. Washington Street, RM E306-MS08, Indianapolis, IN 46204-2739			
4. Submission: <input checked="" type="checkbox"/> New <input type="checkbox"/> Revision							
Description of Funds	Estimated Expenditures	Actual Expenditures	Number served		Population served	Geographic area served	
			Individuals	Families			
5. Total title IV-B, subpart 1 funds	\$ 6,309,324.00	\$ 6,309,323.93	212,800	0	Reports of AB/NE	Statewide	
a) Total Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	\$ 630,932.00	\$ 591,970.65					
6. Total title IV-B, subpart 2 funds (This amount should equal the sum of lines a - f.)	\$ 6,038,541.00	\$ 6,038,541.00	47,255	36,050	Childre/Families at risk AB/NE	Statewide	
a) Family Preservation Services	\$ 1,207,708.20	\$ 1,207,708.20					
b) Family Support Services	\$ 1,207,708.20	\$ 1,207,708.20					
c) Time-Limited Family Reunification Services	\$ 1,207,708.20	\$ 1,207,708.20					
d) Adoption Promotion and Support Services	\$ 1,207,708.20	\$ 1,207,708.20					
e) Other Service Related Activities (e.g. planning)	\$ 603,854.10	\$ 603,854.10					
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment after October 1, 2007)	\$ 603,854.10	\$ 603,854.10					
7. Total Monthly Caseworker Visit Funds (STATE ONLY)	\$ 381,693.00	\$ 381,693.00					
a) Administrative Costs (not to exceed 10% of MCV allotment)	\$ 38,169.30	\$ 17,231.24					
8. Total Chafee Foster Care Independence Program (CFCIP) funds	\$ 3,588,775.00	\$ 3,584,394.20					
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	\$ 1,076,632.50	\$ 948,345.10	615	0	All eligible Children	Statewide	
9. Total Education and Training Voucher (ETV) funds	\$ 1,126,505.00	\$ 1,126,505.00	222	0	Children ages 18-20	Statewide	
10. Certification by State Agency or Indian Tribal Organization (ITO). The State agency or ITO agrees that expenditures were made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.							
Signature and Title of State/Tribal Agency Official		Date	Signature and Title of Central Office Official		Date		
 / Chief of Staff		11/17/2015			DEC - 8 2015		



Michael R. Pence, Governor
Mary Beth Bonaventura, Director

Indiana Department of Child Services
Room E306 – MS47
302 W. Washington Street
Indianapolis, Indiana 46204-2738

317-234-KIDS
FAX: 317-234-4497

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

June 30, 2015

Ruby Flagg
Children's Bureau – Region V
Administration of Children and Families
233 North Michigan Avenue, Suite 400
Chicago, IL 60601-5519

Dear Ms. Flagg:

In accordance with Program Instruction ACYF-CB-PI-15-03, enclosed please find Indiana's 2016 Annual Progress and Services Report (APSR) and request for funding for FFY 2016. This APSR is an update to Indiana's 2015-2019 Child and Family Services Plan (CFSP), submitted on June 30, 2014.

We are requesting consideration for any additional FFY 2016 funding that may become available in PSSF (IVB2) and MCV (IVB2 Caseworker Visits) in the coming year. This is due to a 27.69% increase (4,691 additional cases) from April 2014 to April 2015 in the areas of In Home and Out of Home CHINS and Informal Adjustments. The requested increase is included in the CFS 101- Part I.

The CFSP and previous APSR's for 2012 – 2014 can be found on the DCS website under Reports and Statistics at <http://www.in.gov/dcs/2329.htm>. The 2016 APSR will be added to the website as soon as we receive your approval.

The State of Indiana continues to make great strides in furthering its mission of protecting children from abuse and neglect by partnering with families and communities to provide safe, nurturing and stable homes. We are excited about continued implementation of Continuous Quality Improvement (CQI) and our work on the goals and objectives outlined in the CFSP. If you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in blue ink that reads "Kimberley S. Miller".

Kimberley S. Miller
Attorney/Federal Compliance Manager
(317) 512-8536
Kimberley.Miller@dcs.in.gov



Protecting our children, families and future



Michael R. Pence, Governor
Mary Beth Bonaventura, Director
Indiana Department of Child Services
302 West Washington Street, E306
Indianapolis, IN 46204
www.in.gov/dcs

INDIANA
CHILD AND FAMILY SERVICES PLAN
2015 - 2019

ANNUAL PROGRESS AND SERVICES REPORT
JULY 1, 2015-JUNE 30, 2016

Submitted to Children's Bureau
Administration for Child and Families
U.S. Department of Health and Human Services
on
June 30, 2015



Protecting our children, families and future

TABLE OF CONTENTS

I. General Information.....	7
A. Agency Information.....	7
B. Mission and Vision Statements.....	8
1. Mission	8
2. Vision	8
C. Update On Collaboration	8
1. Regional Service Councils & Biennial Regional Services Strategic Plan.....	8
2. Community Mental Health Centers	8
3. Service Specific Workgroups	8
4. Commission on Improving the Status of Vulnerable Youth	9
5. Older Youth Services Collaboration	10
6. Youth Advisory Board	11
7. Additional Collaborations	11
II. Compliance with P.L. 113-183, the Preventing Sex Trafficking and Strengthening Families Act	12
A. Successor Guardian:	13
B. Parents of Siblings Notifications	13
C. Successful Adulthood.....	13
D. Reasonable and Prudent Parent Standard	14
E. Another Planned Living Arrangement (APPLA).....	14
F. 14+ Youth Case Involvement.....	15
G. Documentation required for children leaving Foster Care	15
H. Human Trafficking	15
II. Update on Assessment of Performance.....	16
A. Safety	16
1. Federal Safety Measures.....	16
2. Update on Child Welfare Information System Data.....	17
3. Update on QSR (Case Record Review).....	20
4. Update on Additional Information on System Performance Related to Safety Outcomes ..	21
5. Summary of Additional Strengths and Concerns	23
B. Permanency	26
1. Federal Safety Measures.....	26
2. Child Welfare Information System (MaGIK) Data	27
3. Case Record Review - QSR.....	30
4. Summary of Additional System Strengths and Concerns	33
C. Well-Being.....	33
1. Child Welfare Information Systems (MaGIK) Data.....	34
2. Case Record Review System Data	35
3. Additional System Strengths and Opportunities for Improvement.....	36
III. Systemic Factors.....	40
A. Information System	41
1. Status of the Child	42
2. Demographic Characteristics.....	42



3. Location (child’s physical location).....	42
4. Goals for Permanency.....	43
5. Identification of Every Child in Foster Care	43
B. Case Review System.....	43
1. Written Case Plan.....	43
2. Periodic Reviews.....	45
3. Permanency Hearings	45
4. Termination of Parental Rights (TPR).....	46
5. Notice of Hearings and Reviews to Caregivers	46
C. Quality Assurance System.....	47
1. Foundational Administrative Structure.....	47
2. Quality Data Collection	49
3. Method for Conducting Ongoing Case Review	55
4. Analysis and Dissemination of Data.....	56
5. Feedback to Stakeholders and Decision-makers	57
D. Staff Training.....	57
1. Initial Staff Training	58
2. Experienced Employee Training	59
3. Foster and Adoptive Parent Training	60
E. Service Array	61
1. Statewide Data Presentation and the Biennial Regional Strategic Services Plan	62
2. Safety and Risk Assessment Data	63
3. Child and Adolescent Needs and Strengths Assessment.....	63
4. Service Mapping and Continuous Quality Improvement.....	63
F. Agency Responsiveness To The Community.....	66
G. Foster and Adoptive Parent Licensing, Recruitment, and Retention.....	67
1. DCS Licensed Foster Homes	68
2. Licensed Child Placing Agencies	71
3. Residential Treatment Facilities	74
4. Stakeholder Feedback.....	76
5. Background Checks and Case Planning	76
6. Interstate Compact on the Placement of Children	77
IV. Update to the Plan For Improvement and Progress Made to Improve Outcomes	78
A. Safety Goals, Objectives and Interventions.....	78
Goal 1: Ensure the safety of Hoosier children through informed decision-making beginning from initial assessment.....	78
B. Permanency Goals, Objectives and Interventions	85
Goal 2: Promote safe, timely and stable permanency options for children.....	85
C. Well-Being Goals, Objectives and Interventions.....	93
Goal # 3: Ensure the well-being of Indiana children by integrating a trauma-informed care approach to our child welfare practice.....	93
D. Continuous Quality Improvement (CQI) Goals, Objectives and Interventions	96
Goal #4: Promote a culture of learning whereby staff at all levels of the agency consider ways to improve practice, programs and policy.....	96
1. CQI Structure.....	97
2. Organizational Structure.....	97
3. CQI Steering Committee	98
4. Data Analysis.....	98

5. Indiana University (IU)	99
6. Deloitte Consulting LLP	101
7. Work Groups	101
V. Update on Service Description	103
A. Child and Family Services Continuum (45 CFR 1357.15(n))	103
1. Prevention Services	104
2. Preservation and Reunification Services	106
B. Service Coordination (45 CFR 1357.15(m))	114
1. Indiana State Department of Health	114
2. Family and Social Services Administration (FSSA):	118
3. Additional Collaborations Furthering Service Coordination	119
4. Provider Workgroups	121
C. Service Description (45 CFR 1357.15(o))	122
1. Family Preservation (20%)	124
2. Family Support (20%)	124
3. Time Limited Family Reunification (20%)	124
4. Adoption Promotion and Support Services (20%)	125
D. Service Decision-Making Process for Family Support Services (45 CFR 1357.15(r))	126
E. Populations at Greatest Risk of Maltreatment (section 432(a)(10) of the Act)	126
1. Healthy Families Indiana (HFI)	126
F. Services for Children Under the Age of Five (section 422(b)(18) of the Act)	127
1. Fatherhood Initiative	128
2. Substance Abuse Treatment and the START Program	128
3. Service Mapping	128
4. Child Parent Psychotherapy	129
5. Parent Child Interactive Therapy	129
6. Attachment and Bonding Assessment	129
G. Services for Children Adopted from Other Countries	129
VI. Program Support	129
VII. Consultation and Coordination Between States and Tribes	130
1. Ongoing Coordination and Collaboration with Tribes	131
2. Child Welfare Services and Protections for Tribal Children	132
3. Assessment of Ongoing Compliance with ICWA	132
4. Notification of State Proceedings	132
5. Tribal Right to Intervene	132
6. Continued ICWA Compliance	133
7. Discussions regarding Chafee Foster Care Independence Program	133
8. Exchange of CFSP and APSR	133
9. Title IV-E Funding for Foster Care, Adoption Assistance and Guardianship Assistance Programs	133
VIII. Monthly Casemanager Visit Formula Grants and Standards for Casemanager Visits	134
IX. Adoption and Legal Guardianship Incentive Payments (section 473A of the Act)	135
X. Child Welfare Waiver Demonstration Activities (applicable States only)	135
A. Waiver Framework and Activities	135
1. Communications and Training	138
2. Fiscal Accounting and Reporting	138
3. Evaluation	138
B. Coordination with Title IV-B	140

XI.	Child Abuse Prevention and Treatment Act (CAPTA) State Plan Requirements and Update	140
	A. Substantive Changes to Law and Regulations Effecting Eligibility for CAPTA.....	140
	B. Significant Changes in Approved CAPTA State Plan.....	140
	C. Use of CAPTA Funds	140
	D. CRP Annual Reports.....	140
	1. Foster Care Advisory Board	140
	2. Child Fatality Team	141
	3. Child Protection Team	141
	E. State Liaison Officer Information	141
XII.	Chafee Foster Care Independence Program (CFCIP)	141
	A. Agency Administering CFCIP (section 477(b)(2) of the Act)	141
	B. Description of Program Design and Delivery	142
	1. Current Practice	142
	2. Service Delivery	142
	3. Specific Accomplishments	143
	4. Future Planning	146
	C. Serving Youth of Various Ages and States of Achieving Independence.....	147
	D. Serving Youth Across the State	149
	1. State’s Definition of “room and board”	149
	2. Housing Options	150
	3. Education and Employment	150
	4. Young adults who are pregnant and parenting	151
	5. Young adults with histories of substance abuse.....	151
	6. Young adults with mental health and/or trafficking histories.....	152
	7. Youth with Criminal Histories.....	152
	8. Young adults with disabilities.....	153
	E. Collaboration with Other Private and Public Agencies	153
	1. Federally funded Transitional Living Programs	155
	2. Abstinence Programs	155
	3. Local Housing Programs.....	155
	4. Programs for disabled Youth	155
	5. School to Work Programs.....	155
	6. Plan to coordinate services with local youth shelters and other programs serving young adults at risk of homelessness	156
	F. Determining Eligibility for Benefits and Services (section 477(b)(2)(E) of the Act)	156
	1. CFCIP Services	156
	2. Collaborative Care	156
	G. Cooperation in National Evaluations.....	157
	H. Education and Training Vouchers (ETV) Program	157
	I. Consultation with Tribes (section 477(b)(3)(G)).....	157
	J. CFCIP Program Improvement Efforts	157
	K. CFCIP Training.....	157
	L. Education and Training Voucher Program	158
XIV.	Targeted Plans within the CFSP	159
	A. Foster and Adoptive Parent Diligent Recruitment Plan	159
	B. Health Care Oversight and Coordination Plan	159
	C. Disaster Plan.....	159
	D. Training Plan.....	159

XV. Statistical and Supporting Information.....	159
A. Information on Child Protective Service Workforce:.....	159
B. Juvenile Justice Transfers.....	163
C. Sources of Data on Child Maltreatment Deaths:.....	163
D. Education and Training Vouchers.....	163
E. Inter-Country Adoptions:.....	164

ATTACHMENTS (Separate Document)

1. Commission on Improving the Status of Children Organization Chart.....	1
2. Foster and Adoptive Parent Diligent Recruitment Plan.....	3
3. Health Care Oversight Plan (updated 2015).....	9
4. Indiana Psychotropic Medication Guidelines 2014 Final.....	32
5. 2015 Training Plan.....	108
6. 2014 Citizens Review Panel Report – Marion County.....	143
7. 2014 Citizens Review Panel Response – Marion County.....	156
8. 2014 Citizens Review Panel Report – Hendricks County.....	159
9. 2014 Citizens Review Panel Response – Hendricks County.....	164
10. 2014 Citizens Review Panel Report – Switzerland County.....	166
11. 2014 Citizens Review Panel Response – Switzerland County.....	170
12. Education and Training Vouchers Awarded.....	175
13. CFS-101, Part I.....	180
14. CFS-101, Part II.....	182
15. CFS-101, Part III.....	185
16. DCS Child Welfare Policy Manual Policies:.....	187
a. 4.0 Diligent Search.....	188
b. 4.28 Involuntary Removals.....	193
c. 5.07 Child and Family Team Meetings.....	201
d. 5.08 Developing a Case Plan.....	208
e. 6.8 Three Month Progress Report.....	217
f. 6.10 Permanency Plan.....	221
g. 6.11 Permanency Hearing.....	225
h. 6.14 Children Attending Court.....	229
i. 8.09 Placing and Child in Out-of-Home Care.....	233
j. 8.16 Resource Parent(s) Role.....	236
k. 8.23 Extracurricular Activities.....	239
l. 8.26 Authorization for Health Care.....	241
m. 8.27 Maintaining Health Records.....	245
n. 8.29 Routine Health Care.....	249
o. 8.41 Transitioning from Out-of-Home Care.....	252
p. 8.48 Relative Placements.....	254
q. 11.1 Older youth Services.....	260
r. 11.6 Transition Plan for Successful Adulthood.....	263
s. 11.15 Secondary Education.....	269
t. 11.18: Eligibility to Participate in Collaborative Care.....	273
u. 11.19 Entry into Collaborative Care.....	277
v. 11.20 Youth Adjudicated as Juvenile Delinquents Accessing CC.....	280
w. 11.21 Collaborative Care Case Transfer.....	283
x. 11.22 Voluntary Collaborative Care Agreement.....	288
y. 11.27 Permanency for Older Youth.....	290

z. 13.1 Conducting Background Checks.....	292
aa. 14.1 Guardianship Assistance Program (Overview).....	298
bb.14.2 Negotiations for GAP Assistance.....	304
cc.14.3 Modifications/Continuation of GAP Agreement.....	309
17.DCS Forms	314
a. SF2956 - Case Plan	315
b. SF55106 - Relative Home Environment Checklist.....	321
c. SF55211 - Notice to Relative.....	322

I. GENERAL INFORMATION

A. AGENCY INFORMATION

The Department of Child Services was established in January 2005 by an executive order of Governor Mitch Daniels. DCS protects children who are victims of abuse or neglect and strengthens families through services that focus on family support and preservation. The Department also administers child support, child protection, adoption, and foster care throughout the state of Indiana.

Judge Mary Beth Bonaventura was appointed by Governor Michael R. Pence to lead the Department in 2013. Director Bonaventura brings a wealth of knowledge and experience to DCS, having served as Senior Judge of the Lake County Superior Court, Juvenile Division—one of the toughest juvenile divisions in the state. Judge Bonaventura was appointed Senior Judge in 1993, by then Governor Evan Bayh, after having served more than a decade as a Magistrate in the Juvenile Court.

DCS’ infrastructure includes local offices in all ninety two (92) Indiana counties, organized into eighteen (18) geographical regions. In SFY 2013, DCS created an additional region to encompass central office Family Case Managers (FCMs) from the Institutional Assessment Unit and the Collaborative Care Unit, for a total of 19 regions. In 2010, DCS added a centralized hotline, located in Indianapolis, and in 2013, added three regional hotline sites located in Blackford, Lawrence and St. Joseph counties. A fourth regional hotline site opened in Vanderburgh County in June 2014.

Prior to 2005, child welfare services were provided by the Division of Family and Children (DFC), a division within an umbrella agency, the Family and Social Services Administration (FSSA). As a new cabinet-level Department, DCS was charged with providing more direct attention and oversight of two critical areas: protection of children and child support enforcement. The former mission statement, “helping families help themselves,” was changed to “The Indiana Department of Child Services (DCS) protects children from abuse and neglect. DCS does this by partnering with families and communities to provide safe, nurturing, and stable homes.” In December 2005, DCS initiated a major shift in how Indiana provided services to children and families called the “New Practice Model.”

The DCS practice model was founded on five core competency areas: Teaming, Engaging, Assessing, Planning and Intervening (TEAPI). The practice model incorporates an approach which includes engaging families, teaming and planning with families, and supporting families when possible, while still holding parents accountable for their children. This model operates through Child and Family Team Meetings, in which a DCS Family Case Manager facilitates an individualized team including the family members, informal supports, and relevant service providers that reviews strengths, risks, and needs, and develops and monitors the implementation of a collaborative service plan.

B. MISSION AND VISION STATEMENTS

1. Mission

The Indiana Department of Child Services (DCS) protects children from abuse and neglect, and works to ensure their financial support.

2. Vision

Children thrive in safe, caring, and supportive families and communities.

C. UPDATE ON COLLABORATION

Ongoing collaboration and communication with stakeholders is vital to obtaining improved outcomes for children and families in Indiana. Feedback from stakeholders was used to identify system strengths and challenges when setting goals and objectives for the 2014 Child and Family Services Plan (CFSP). These stakeholders are identified below.

1. Regional Service Councils & Biennial Regional Services Strategic Plan

Regional Service Council's (RSC) are in the second year of their Biennial Regional Services Strategic Plan. Planning for the next Biennial plan is expected to begin in January of 2016.

2. Community Mental Health Centers

During 2014-2015, DCS continued its strong collaborative work with Indiana Community Mental Health Centers (CMHCs). Meetings with the CMHC Workgroup occur monthly with a focus on improving access and the effectiveness of services for DCS clients. The Indiana Council of Community Mental Health Centers partners with DCS to provide an annual conference which includes CMHC leadership and DCS local and central office leadership. In July 2014, the conference focused on Substance Use Disorder Treatment. The keynote speaker was Ken DeCerchio with Child and Family Futures. He presented on the specific child welfare issues related to substance abuse disorders. The day also included presentations regarding the Sobriety Treatment and Recovery Teams and Drug Court programs. Each region was provided data showing timelines to assessment and treatment as well as length of participation in treatment. Regional DCS staff and CMHC staff met to complete a fishbone diagram looking at the root cause of clients successfully completing treatment. Regional teams were instructed to carry this information back to their regions and to continue to meet to discuss the next steps for developing plans for improvement.

3. Service Specific Workgroups

DCS facilitates ongoing collaborative meetings to improve the implementation of specific services such as:

- Family-Centered Treatment,
- Community Partners for Child Safety
- Healthy Families
- Father Engagement
- Child Parent Psychotherapy

- Home Based Services
- Cross Systems Care Coordination
- Homebuilders
- Sobriety Treatment And Recovery Teams (START)

This facilitation includes monthly calls, yearly conferences, and break-out workgroups. DCS will continue collaborating with existing statewide associations such as Indiana Council of Community Mental Health Centers Child and Adolescent Committee, Coalition of Family-Based Services, and the Indiana Chapter of National Children's Alliance.

4. Commission on Improving the Status of Vulnerable Youth

DCS continues to collaborate with the Commission on Improving the Status of Vulnerable Youth (Commission). Indiana law defines “vulnerable youth” as a child involved with the Department of Child Services, Family and Social Services Agency (FSSA), Department of Correction (DOC) or Juvenile Probation. The Commission was created to bring together all governmental agencies that work with vulnerable youth to address:

- Access, availability, duplication, funding and barriers to services.
- Communication and cooperation by agencies.
- Implementation of programs or laws concerning vulnerable youth.
- The consolidation of existing entities concerning vulnerable youth.
- Data from state agencies relevant to evaluating progress, targeting efforts and demonstrating outcomes.

The goal of the Commission is to promote information-sharing, best practices, policies, and programs concerning vulnerable youth. In addition to cooperating with other child focused commissions, the executive branch, the judicial branch, stakeholders and members of the community.

Executive Committee

The Commission is comprised of an Executive Committee and several subcommittees. The Executive Committee has 18 members from the executive, judicial, and legislative branches, and local government officials. Members of the Executive Committee include Mr. Sean Keefer from the Office of the Governor (Chair), Loretta Rush - Chief Justice of Indiana, Mary Beth Bonaventura - Director of the Indiana DCS, Representative David Frizzel, and Senator Travis Holdman. A list of additional members can be found in Attachment 1.

Child Services Oversight Committee

Mary Beth Bonaventura, Director of the Indiana DCS, also serves on the Child Services Oversight Committee. Some of the other members serving include Senator Carlin Yoder (Chair), Senator Broden, Hon. Christopher Burnham, and executives of the Division of State Court Administration, the Indiana Public Defender Council, the Indiana Department of Education, and the Indiana CASA/GAL program. The top priority for the Child Services Oversight Committee is “to support the well-being of Hoosier children by strengthening the Indiana Department of Child Services (DCS).”¹ Their 2014-2015 Annual Report discusses the numerous steps that DCS has taken to increase the quality of service, including the requirement that DCS family case managers have college degrees,

¹ Child Services Oversight Committee 2014-15 Annual Report, <http://www.in.gov/children/2359.htm>

the expansion of the Child Abuse and Neglect Hotline to include 5 additional call centers, and the fact that the hotline no longer requires callers to provide their names or contact information. It also addresses DCS' intent to add new positions requiring expansion of staff training in both capacity and programming and the need for additional space planning for local offices. Additional items discussed by this subcommittee include DCS child abuse prevention and reporting, a review of each DCS Quarterly Data Report, a DCS Hotline Screening Process, an overview of the Adoption Study Committee, discussion about State Adoption Subsidies, removal of status offenders from the delinquency code, family case manager turnover and a discussion of the Deloitte Consulting field workload analysis.² DCS executives will continue to work with the subcommittee on ways to improve the lives of children in Indiana.

Other Committees

Don Travis, the DCS Deputy Director of Juvenile Justice Initiatives and Support, serves on the Cross-Systems Youth Subcommittee which addresses issues affecting youth who are involved in both the juvenile justice and the child welfare systems and children involved in multiple systems.

Dr. Cynthia Smith, the DCS Director of Research and Evaluation, serves on the Data Sharing and Mapping Subcommittee which focuses on sharing of data between agencies.

Reba James, the DCS Deputy Director of Permanency and Practice Support, serves on the Educational Outcomes Task Force which addresses education issues affecting children in the juvenile justice and child welfare systems.

Jane Bisbee, DCS Deputy Director for Field Operations, Gil Smith, DCS Asst Deputy Director of Field Operations, and Kelly Moore, DCS Fatality Team, serve on the Infant Mortality and Child Health Subcommittee which identifies and addresses issues involving the multi-factorial issue of infant mortality including NAS, SIDS and suffocation, and improved newborn screening, to name a few, and related child health issues.

Lisa Rich, DCS Deputy Director of Services and Outcomes, serves on the Substance Abuse and Child Safety Subcommittee. Their mission is to "Explore best practices and evidenced-based research to create positive, lasting outcomes for children who abuse drugs, live in households where drug abuse exists, or who are in need of mental health treatment".³

Annual reports, member lists, meeting agendas, minutes, PowerPoint presentations, handouts, and other resources can be found on the website for the Commission on Improving the Status of Children, <http://www.in.gov/children>.

5. Older Youth Services Collaboration

In an effort to continue to evolve and improve upon older youth services programming, DCS meets with key stakeholders routinely to seek feedback on older youth programs to make adjustments/improvements. The Older Youth Services (OYS) Community is made up of youth accessing services, those who recently aged out of

² Child Services Oversight Committee 2014-15 Annual Report

³³³ <http://www.in.gov/children/files/cisc-substance-abuse-2015-annual-report.pdf>

services, the DCS Older Youth Initiatives (OYI) team (program staff), the DCS Collaborative Care Case Management Team (3CM staff), older youth service providers, and other key stakeholders.

The DCS OYI team will be implementing continuous quality improvement (CQI) to provide a structured process for ensuring that older youth / successful adulthood programs and services are systematically and intentionally improving and increasing positive outcomes for youth. Training sessions are planned for July 2015 to introduce CQI to the Older Youth Services team and begin implementation of these processes within the program.

6. Youth Advisory Board

The Indiana Youth Advisory Board (YAB) consists of youth that are currently or have been a part of the Indiana foster care system. The YAB is comprised of current and former foster youth from the 18 regions within the State of Indiana. The YAB meets at least four times per year to develop and implement their mission to positively impact the foster care system in Indiana. In efforts to increase YAB participation and meet the needs of youth, YAB meetings are held in different locations across the State.

7. Additional Collaborations

In addition to the work occurring with the RSCs, DCS holds regular meetings with provider workgroups to monitor data, assess areas for improvement, and implement strategies to improve outcomes for families and children.

The current areas of focus for current provider workgroups include:

Community Mental Health Centers

- Improve access to mental health services for children outside the child welfare system through the Children's Mental Health Initiative.
- Improve access and effectiveness of substance abuse treatment services.

Fatherhood Providers

- Improve engagement of fathers through inclusion in case planning, Child and Family Team Meetings, visitation, and services.

Home-based Providers

- Improve training for home-based workers. The group piloted a core set of curricula that will be required for all home based workers. The group plans to implement this program for new hires the summer of 2015.
- Update qualifications for home based providers and supervisors.
- Improve communication and information sharing between providers and DCS.

Indiana Association of Resources and Child Advocacy (IARCA)

- Address residential and LCPA rate setting issues
- Address capacity building within the public and private sector

Licensed Child Placing Agencies

- Improve quality of services provided to children placed in licensed foster home settings.

- Improve relationship and communication between DCS and LCPAs.

Multi Disciplinary Team (DCS, Division of Mental Health and Addictions, Bureau of Developmental Disabilities Services, Division of Aging)

- Improve the access and effectiveness of services for children who have developmental delays/intellectual disabilities.
- Improve service availability for children with very complex mental health, physical health and/or developmental delays/intellectual disabilities.

Residential Providers

- Improve access to high quality residential services
- Improve relationship and communication between DCS and residential providers.

CANS Steering Committee (DCS and Dr. Betty Walton, Division of Mental Health and Addictions)

- Education development and implementation of CANS
- Development of reports for evaluation and tracking
- Continuous review of CANS projects such as the Breakthrough Series
- Specialized modification of CANS for DCS including the addition of the Trauma module in 2014.
- Participants on Steering committee include: Services and Outcomes Deputy, Field deputy, Managers of Data Management, Clinical Manager, Field Regional Managers – and the outside partner is Dr. Betty Walton from DMHA.

Mexican Consulates

- Monthly Meetings with the Mexican Consulate in Indianapolis (Consul, Javier Abus Osuna)
- Quarterly Meetings with the Mexican Consulate in Chicago (Consul, Carlos Martin Jimenez Macias) which serves the northern portion of Indiana
- Development and modifications, as needed, to Memorandums of Understanding
- Consultation regarding cases and ways to improve collaboration

SNAP Council (DCS, SAFY, Children’s Bureau, Villages, and Wendy’s Wonderful Kids recruiters)

- Review of children eligible for adoption and adoptive parent licenses

An update of DCS Goals, Objectives, and Interventions is discussed below. Changes in Indiana law and DCS policy and procedures to implement the requirements in P.L. 113-183, the Preventing Sex Trafficking and Strengthening Families Act is also included below.

II. COMPLIANCE WITH P.L. 113-183, THE PREVENTING SEX TRAFFICKING AND STRENGTHENING FAMILIES ACT

DCS is compliant with all sections of P.L. 113-183, the Preventing Sex Trafficking and Strengthening Families Act (Act), that are currently effective.

Section 207 of the Act - Successor Guardianship: DCS is compliant with the provisions regarding successor guardians and the Indiana Title IV-E State Plan Amendment on this issue has been approved.

Section 209 of the Act - Notification to Parents of a Child’s Siblings: Indiana law has been amended to revise the definition of relative to ensure proper notifications as required under the act. A Title IV-E State Plan Amendment

is being submitted on June 30, 2015, to address compliance with this section of the Act.

DCS has taken steps to address and ensure timely compliance with additional provisions in the Act that have future effective dates. Additional information regarding future provisions is included throughout this report. IV-E Plan Amendments will be submitted as required to show compliance.

Additional changes made to DCS Policy as a result of P.L. 113-183 and related changes to Indiana law in House Enrolled Act 1434 are listed below. Copies of the policies and forms discussed below are included as Attachments 16 a through cc.

A. SUCCESSOR GUARDIAN:

The following policies were revised to add information regarding the ability to include a successor guardian in guardianship agreements (these changes are retroactive to January 1, 2015).

- 14.1 Guardianship Assistance Program (Overview) – Attachment 16aa.
- 14.2 Negotiations for GAP Assistance, Attachment 16 bb
- 14.3 Modifications/Continuation of GAP Agreement – Attachment 16 cc.

IC 29-3-5-1.5 was added to Indiana law and several other statutes were amended to permit criminal background checks for successor guardians.

B. PARENTS OF SIBLINGS NOTIFICATIONS

The following policies were revised to reflect changes to the definition of “sibling” to clarify that the sibling relationship remains intact in cases where parental rights have been terminated. The definition of “relative” has been revised to include “a parent of a child’s sibling if the parent has legal custody of the sibling”. The amendment allows DCS to notify the parent of a child’s sibling if the parent has legal custody of the sibling within 30 days of a child being removed from his or her parent, guardian, or custodian.

- 4.0 Diligent Search – Attachment 16a
- 4.28 Involuntary Removals, - Attachment 16b
- 8.48 Relative Placements – Attachment 16p
- SF55211 - Notice to Relative – Attachment 17c
- SF55106 - Relative Home Environment Checklist – Attachment 17b

IC 31-9-2-107 was amended to modify the definition of relative to include “a parent of a child's sibling if the parent has legal custody of the sibling” and IC 31-9-2-117.3 was amended to add “(2) any other individual who would be considered a sibling if parental rights had not been terminated” to the definition of sibling.”

C. SUCCESSFUL ADULTHOOD

The following policies were revised to add the definition of “successful adulthood services” and to replace “independent living services” with “successful adulthood services”.

- 11.1 Older Youth Services – Attachment 16q
- 11.6 Transition Plan for Successful Adulthood – Attachment 16r
- 11.15 Post-Secondary Education – Attachment 16s
- 11.21 Collaborative Care Case Transfer – Attachment 16w

- SF2956 - Case Plan – Attachment 17a

IC 31-9-2-123.5 was added to Indiana law to define “successful adulthood services’ for purposes of IC 31-25 and IC 31-28, as services for youth that are designed to assist youth who will age out of foster care with the skills and abilities necessary or desirable to be self-reliant, including housing and educational support, career exploration, vocational training, job placement and support, daily living skills, budgeting and financial management skills, substance abuse prevention, preventative health activities, and counseling.”

D. REASONABLE AND PRUDENT PARENT STANDARD

The following policies were revised to add the definition of the reasonable and prudent parent standard.

- 8.16 Resource Parent Role – Attachment 16j
- 8.23 Extracurricular Activities – Attachment 16k
- SF2956 - Case Plan – Attachment 17a

IC 31-9-2-8.5 was added to Indiana law to define “age or developmentally appropriate for purposes of IC 31-34 and IC 31-37, to mean:

“(1) activities or items that are generally:

- (A) accepted as suitable for children of the same chronological age or level of maturity; or
- (B) determined to be developmentally appropriate for a child based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and

(2) in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.”

IC 31-9-2-101.5 was added to Indiana law to define “Reasonable and prudent parent standard’, for purposes of IC 31-27, IC 31-34, and IC 31-37, means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child.” Additional sections were added to the law to require licensees to apply the reasonable and prudent standard, including IC 31-37-4-20.5, IC 31-27-5-17.5, and IC 31-27-6-14.5.

E. ANOTHER PLANNED LIVING ARRANGEMENT (APPLA)

The following policies were revised to ensure that the permanency plan of APPLA is only available for youth age 16 and older, to include new case plan and case review requirements applicable to APPLA:

- 4.0 Diligent Search – Attachment 16a
- 5.07 Child and Family Team Meetings – Attachment 16c
- 5.08 Developing a Case Plan – Attachment 16 d
- 6.8 Three Month Progress Report – Attachment 16e
- 6.10 Permanency Plan – Attachment 16f
- 6.11 Permanency Hearing – Attachment 16g
- 6.14 Children Attending Court – Attachment 16h
- 11.6 Transition Plan for Successful Adulthood – Attachment 16r
- 11.21 Collaborative Care Case Transfer, – Attachment 16w
- 11.20 Youth Adjudicated as Juvenile Delinquents Accessing Collaborative Care – Attachment 16v
- 11.22 Voluntary Collaborative Care Agreement, – Attachment 16x
- 11.27 Permanency for Older Youth – Attachment 16y

- SF2956 - Case Plan – Attachment 17a

F. 14+ YOUTH CASE INVOLVEMENT

The following policies were revised to address requirements for the active involvement of children age 14 and older in the development of their case plan and transition planning. Planning is in consultation with up to two (2) members of the Child and Family Team (CFT) with the child choosing one (1) of the individuals as their advisor/advocate with respect to application of the reasonable and prudent parent standard. The policies also include the availability of older youth services to children age 14 and older, credit reports for all youth 14 and older and the Bill of Rights.

- 5.07 Child and Family Team Meetings – Attachment 16c
- 5.08 Developing a Case Plan – Attachment 16d
- 6.8 Three Month Progress Report – Attachment 16e
- 6.10 Permanency Plan, – Attachment 16f
- 6.11 Permanency Hearing – Attachment 16g
- 6.14 Children Attending Court – Attachment 16h
- 8.16 Resource Parent(s) Role – Attachment 16j
- 11.1 Older youth Services – Attachment 16q
- 11.6 Transition Plan for Successful Adulthood – Attachment 16r
- 11.15 Secondary Education – Attachment 16s
- 11.18: Eligibility to Participate in Collaborative Care – Attachment 16t
- 11.19 Entry into Collaborative Care – Attachment 16u
- 11.20: Youth Adjudicated as Juvenile Delinquents Accessing Collaborative Care – Attachment 16v
- 11.21 Collaborative Care Case Transfer – Attachment 16w
- SF2956 - Case Plan – Attachment 17a

IC 31-34-15-2 was amended to add new requirements for inclusion of the child representative in case planning. IC 31-34-21-7 was amended to contain requirements for testimony and required findings for APPLA permanency options. IC 31-25-2-7 was amended to allow credit reports for children age 14 and older. IC. 31-25-2-21 was amended to address requirements related to the transitional services plan .

G. DOCUMENTATION REQUIRED FOR CHILDREN LEAVING FOSTER CARE

The following policies have been revised to require local offices to provide specific documents to an individual who is at least 18 yrs old, and has been in foster care for at least six (6) months prior to leaving DCS foster care or placement.

- 8.09 Placing and Child in Out-of-Home Care – Attachment 16i
- 8.26 Authorization for Health Care – Attachment 16l
- 8.27 Maintaining Health Records – Attachment 16m
- 8.29 Routine Health Care – Attachment 16n
- 8.41 Transitioning from Out-of-Home Care – Attachment 16o

H. HUMAN TRAFFICKING

DCS is working on an Indiana Profile for Child Victims of Human Trafficking and is developing a computer assisted training for all DCS employees that is expected to be released in November, 2015. DCS has also partnered with other Indiana agencies as a member of Indiana Protection for Abused and Trafficked Humans (IPATH) Task Force. Members of IPATH task force include:

- Indiana Office of the Attorney General
- Department of Homeland Security (DHS), Homeland Security Investigations
- Federal Bureau of Investigations (FBI)
- Indiana Metropolitan Police Department (IMPD)
- Greenwood Police Department
- Elkhart Police Department
- Indiana Department of Child Services (DCS)
- Internal Revenue Services (IRS), Criminal Investigations
- Indiana State Police (ISP)
- Johnson County Juvenile Probation Department
- Marion County Prosecutor's Office (MCPO)
- Neighborhood Christian Legal Clinic
- Restored
- Purchased
- The Salvation Army DHQ, (the Ruth Lily Women and Children's Center)
- US Department of Labor, Wage and Hour Division
- United States Attorney's Office, Northern District (USAO – ND)
- Ascent 121

DCS is working with IPATH to provide training on Human Trafficking throughout the state of Indiana. DCS also works with members of IPATH on individual cases to ensure collaboration regarding interviews and services for victims and to assist in investigations and prosecution. DCS is tracking human trafficking victims manually and human trafficking victims and children missing from foster care are identified in MaGIK. Additional efforts are in progress to make system improvements in MaGIK for reporting trafficking victims.

II. UPDATE ON ASSESSMENT OF PERFORMANCE

A. SAFETY

Child and Family Outcomes – Safety

1. Children are first and foremost, protected from abuse and neglect; and
2. Children are safely maintained in their own homes whenever possible and appropriate.

1. Federal Safety Measures

DCS' performance on the Child and Family Services Review (CFSR) measures has remained fairly consistent in recent years. DCS has consistently exceeded the national standard for Absence of Child Abuse or Neglect in Foster Care. The development and implementation of the new federal safety measures have affected DCS'

performance. Although DCS is exceeding the national standard for Maltreatment in Foster Care, DCS remains below the national standard for Absence of Recurrence of Maltreatment, which is a concern that is addressed in the CFSP Goals and Objectives. Programming in MaGIK is being completed to update reporting requirements for the new measures. The data below reflects information for Indiana provided in the CFSP Round 3 Statewide Data Indicators –Summary of State’s Performance on National Standards issued October 10, 2014.

CFSR Safety Measures	National Standard	Indiana Observed Performance 2014	Indiana Risk Standardized Performance 2014	Met/Not Met/No Diff
Maltreatment in Foster Care Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care? (victimizations per 100,000 days in foster care)	8.04	11.38	15.95	Not Met
Recurrence of Maltreatment Of all children who were victims of a substantiated or indicated maltreatment report during a 12-month reporting period, what percent were victims of another substantiated or indicated maltreatment report within 12 months of their initial report?	9.0%	8.8%	11.4%	Not Met

2. Update on Child Welfare Information System Data

In addition to the CFSR safety measures, DCS monitors performance in a number of other areas in an effort to continually assess how the agency is ensuring that children are protected from abuse and neglect, and whenever possible and appropriate, maintained safely in their own homes.

Indiana Child Abuse and Neglect Hotline

DCS efforts to ensure children are safe from abuse and neglect begin with the handling of reports made to the Indiana Child Abuse and Neglect Hotline (Hotline). The Hotline was implemented in Indiana to improve quality, consistency and accuracy. After implementation of the Hotline, DCS has seen the number of reports increase:

There was an increase in calls to the Hotline of over 71% between 2009 and 2013 and over 5% between 2013 and 2014.

CY 2009	109,489 reports
CY 2013	187,475 reports
CY 2014	198,684 reports

DCS attributes part of this increase in reporting to improved documentation of reports, increased awareness of how to make a report, and reporter confidence in the Hotline system. DCS is also studying whether there are other contributing factors, such as practice and policy changes, that could be impacting this increase.

Hotline staff utilize a number of reports to help monitor performance. These reports allow the Hotline staff to analyze a broad array of data including:

- number of calls received hourly, daily, weekly, monthly and annually;
- wait times for both law enforcement and non law enforcement reporters;

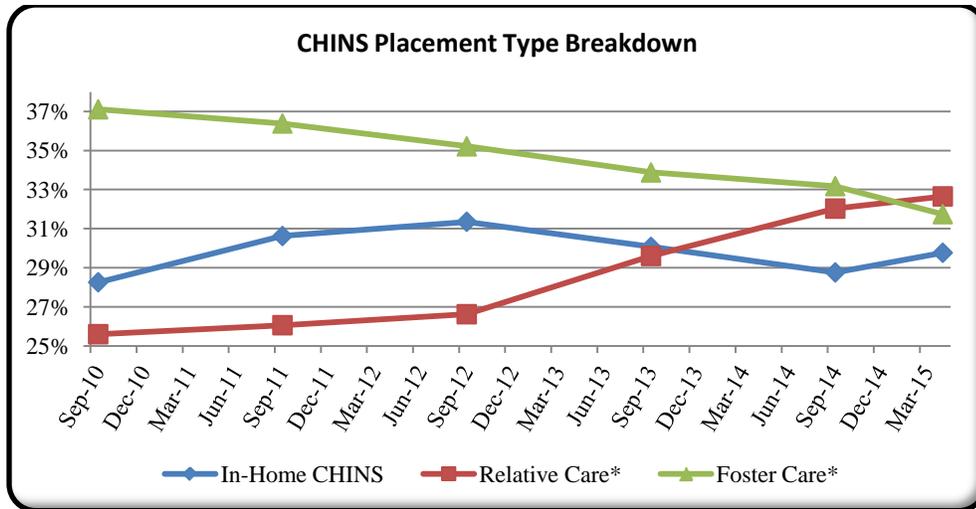
- call volume broken out by time of day; average length of call; average number of calls received per weekday vs. weekend;
- average speed of answer; and
- number of calls responded to by FCM.

Hotline Performance	CY 2013	CY 2014
Calls answered in less than 8 seconds.	47%	63%
Calls answered in less than 30 seconds.	62%	79%
Calls were answered in less than 1 minute.	65%	82%
Callers waited 5 minutes or longer.	8%	2%
Callers waited 10 minutes or longer.	0.7%	0.1%
Callers hung up before speaking to an agent - of those:	9%	5%
Abandoned the call after waiting less than 30 seconds,	11%	18%
36% abandoned the call after waiting less than 1 minute, and	36%	55%
12% abandoned the call after waiting 5 minutes or more.	12%	4%
Average hold time for callers who hung up before speaking to an agent		
Law Enforcement Agencies (LEA)	01:24	01:24
Non-LEA	02:27	01:36
The average speed of answer for calls		
Law Enforcement Agencies (LEA)	00:28	00:20
Non-LEA	01:19	00:32
Average minutes caller spent speaking with an intake specialist.	11:18	12:45
Average number of calls taken by Hotline per business day.	539	556
The hotline took an average of 182 calls per weekend day.	182	193

In comparison to CY 2013, the Hotline saw a rise in calls handled per business day (+17) and weekend day (+11). Despite the volume increase, the Hotline was able to improve on most measures. In CY 2013, the Hotline answered 62% of calls in less than 30 seconds, and 8% of callers waited five minutes or longer. In CY 2014, these numbers had improved to 79% of calls answered in less than 30 seconds and 2% of callers having waited five minutes or longer. In CY 2014, the average speed of answer for non-LEA calls improved by 47 seconds. As the Hotline continues to mature, it is the goal to maintain this positive improvement trend.

Safely Home, Families First

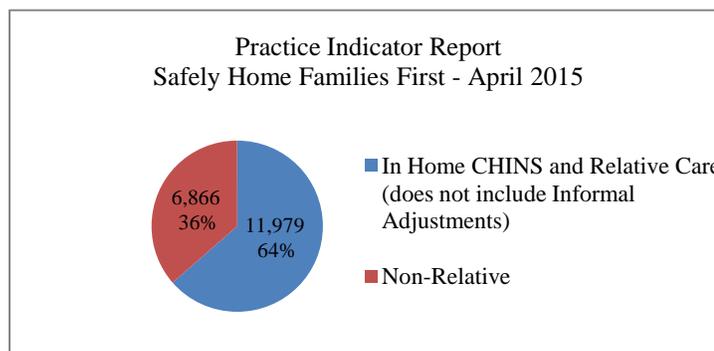
DCS, through implementation of its practice model, and emphasis on the Safely Home, Families First philosophy, has significantly increased the number of children remaining in-home or in relative placement. The “DCS CHINS Placement Type Breakdown” graph below has been updated to reflect data obtained since the CFSP in June of 2014. As can be seen in the chart, the children remaining in their own homes or being placed with relatives is increasing while foster care placements are declining.



The data included in the CHINS Placement Type Breakdown chart below includes results for residential and other placements (which are not included in the chart above).

CHINS Placement Type Data						
Measure	Sep-10	Sep-11	Sep-12	Sep-13	Sep-14	Apr-15
In-Home CHINS	28.25%	30.62%	31.35%	30.07%	28.76%	29.77%
Relative Care	25.60%	26.06%	26.62%	29.60%	32.03%	32.65%
Foster Care	37.11%	36.38%	35.21%	33.88%	33.18%	31.74%
Residential Treatment	7.41%	5.63%	5.51%	4.85%	4.79%	4.61%
Other	1.63%	1.31%	1.30%	1.60%	1.25%	1.23%

The updated Safely Home, Families First Practice Indicator Report below from April 2015, shows 64% of DCS involved children remained in their homes or are placed with relatives. This represents a 1.5% increase from October 2012, when DCS first implemented and started monitoring Safely Home, Families First data. The April, 2015 results are consistent with May of 2014 results which were also 64%.



3. Update on QSR (Case Record Review)

DCS uses an evidence-based case review method and practice appraisal process, known as Quality Service Reviews (QSR), to assess:

- 1) How children and their families are benefiting from services received, and
- 2) How well locally coordinated services are working for children and families.

DCS conducts a QSR in each region approximately every 18 months (one round). As of March 2015, DCS has completed 15 of 18 regions in the fourth round of QSR. For additional information on the DCS' QSR process, please refer to the Quality Assurance Systems section under Systemic Factors below in Section III C.

DCS will complete Round 4 in August 2015. The updated numbers below reflect preliminary result through the date of this report.

The Safety Indicator assesses to what degree:

- The child is safe from harm or abuse, neglect and exploitation by others in his/her place of residence and other daily settings,
- The child is free from injury caused by others in his /her daily home, school, and community, and
- Whether parents and caregivers provide the attention, actions, and supports necessary to protect the child from known risks of harm in the home.

The Behavioral Risk indicator assesses to what the degree the child /youth is consistently avoiding self-endangerment situations and refraining from using behaviors that may put them or others at risk of harm.

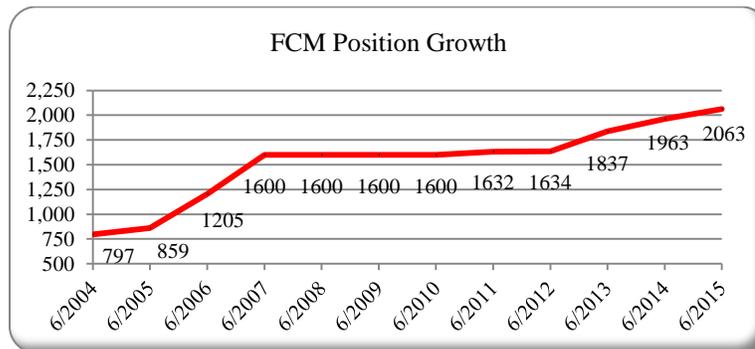
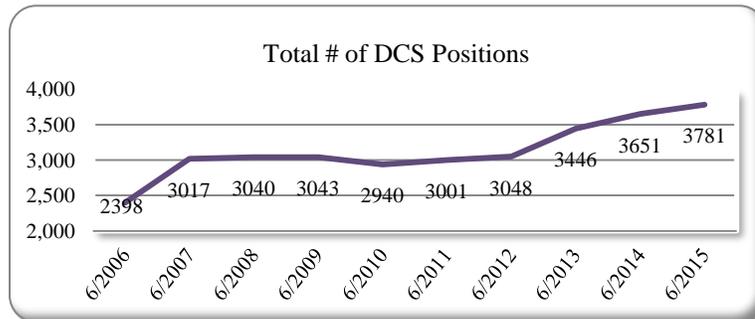
The table below provides the results for all eighteen (18) regions reviewed in the third round of the QSR compared to the same regions in the previous two rounds for the Safety and Behavioral Risk Indicators. This data represent the Refine/Maintain scores in each of the indicators for the Baseline, Second Round, Third Round, and most of the Fourth Round QSR across the regions. As of this point in Round 4, DCS showed a 2 percentage point improvement between the Baseline and Round 2, an additional 1 percentage point improvement between Rounds 2 and 3, and a 1 percentage point decrease between Round 3 and 4 in Safety. DCS showed an even greater increase in the Behavioral Risk indicator, which reflects an 8 percent increase between the Baseline and Round 2 and an additional 2 percentage point increase between Rounds 2 and 3. Behavioral Risk scores remained consistent between Round 3 and 4.

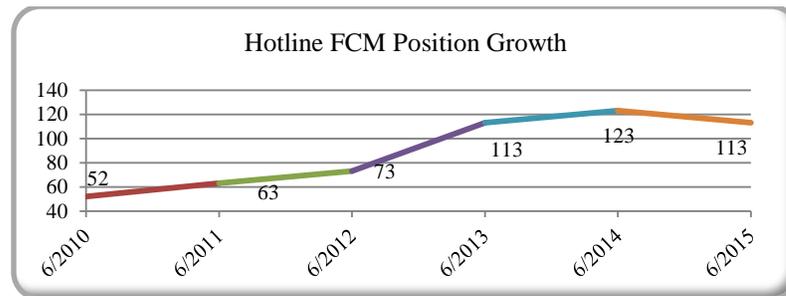
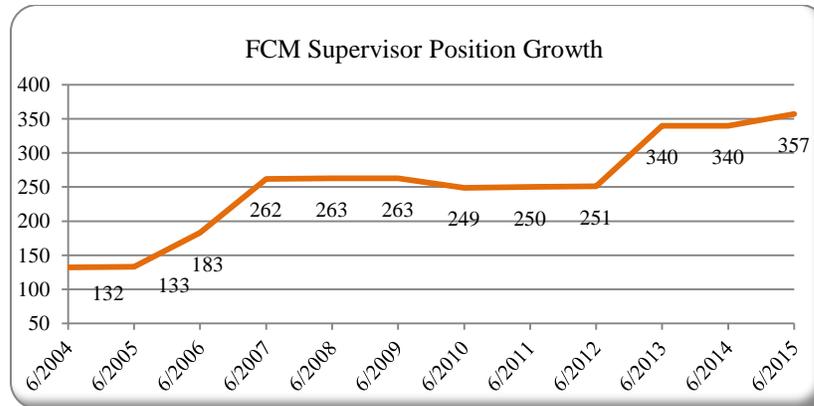
Quality Service Review Indicator	Baseline 4/2007 -6/2009	Round 2 8/2009 - 7/2011	Round 3 9/2011 – 8/2013	Round 4* 9/2013 – 3/2015
Safety	96%	98%	99%	98%
Behavioral Risk	78%	86%	88%	88%

4. Update on Additional Information on System Performance Related to Safety Outcomes

DCS Staffing Increase

DCS was very fortunate that the Indiana legislature authorized funding for DCS to hire an additional 100 FCMs and an additional 17 FCM supervisors. DCS also intends to hire additional attorneys and support staff in 2015. The increase in staff will assist FCMs in maintaining average caseloads consistent with the best practice standard of 12 new assessments or 17 on-going cases.



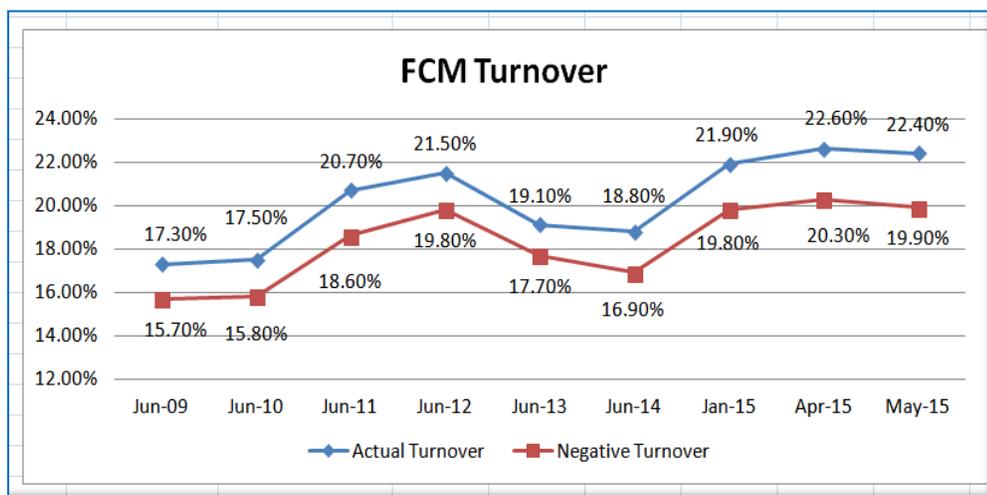


While the increase in staff strengthens the agency’s ability to achieve positive outcomes for children and families, DCS, like most child welfare organizations, must continue to monitor employee turnover.

DCS tracks two types of turnover—actual and negative.

Actual turnover includes all FCMs who left their position,

Negative turnover reflects only those FCMs who left DCS. Negative turnover excludes employees who were promoted or transferred to another position within DCS, and is determined to be a better measure of how the agency is doing with respect to retaining valuable staff.



As shown in the chart above, efforts at reducing turnover appeared to have been making an impact, when between

June of 2012 and June of 2014 negative turnover decreased from 19.80% in 2012 to 16.90%. However, the numbers are rising again and are back to 2012 levels. DCS is hopeful that addition of new position will lead to a reduction in negative turnover based on lower caseload levels.

DCS continues to review and employ strategies to attract and retain talented employees including a more robust recruitment strategy as well as programs which foster positive employee engagement and address employee well-being. DCS is undergoing efforts to develop a sustainable workforce planning and talent management strategy.

5. Summary of Additional Strengths and Concerns

SYSTEM STRENGTHS

DCS has implemented a number of strategies and programs designed to ensure the agency is successful in furthering its mission to protect children from abuse and neglect. An update on some of the system strengths previously included in the CFSP are outlined below.

Children's Mental Health Initiative (CMHI)

DCS continues its collaboration with the Indiana Division of Mental Health and Addiction (DMHA) and the Indiana Bureau of Developmental Disabilities Services (BDDS) on the Children's Mental Health Initiative and also the Family Evaluation process, which began in late 2012 and was released statewide in March 2014. Additional information about the CMHI can be found in Section V. A under Prevention Services.

Community Based Service Support

DCS has continued to build strength in its Community Based service array by expanding services such as:

- Adding Evidence Based Practices to the Home Based Array (see Comprehensive Home Based Services section).
- Increasing community based rates to equip agencies to attract and retain high quality staff.
- Home Based Therapy rates were increased by 25%, Home Based Casework by 17%, other services by 5%.
- Increasing oversight and monitoring by contracting with model developers to consult with agencies implementing EBPs
- Increasing support for substance abuse treatment providers through a consultant from Child and Family Futures.

SYSTEM CONCERNS

DCS continues to struggle with increasing drug use, especially heroin use in many communities. Data indicates that in some communities the incidence may be as high as 80-90% of cases. According to a recent report issued from Pew Charitable Trust, Indiana ranks the 4th worst in the nation with regard to the number of providers per

1,000 non-elderly adults with addictions.⁴ While the National average is 32 providers per 1000 adults with addictions, Indiana has only 18 providers. Further, Indiana has a higher prevalence of substance use disorder in the expanded Medicaid population. The National average is 14% of the population and Indiana has 21.1% of the expanded Medicaid population having a substance use disorder. This, coupled with increasing access to substance abuse services through the Healthy Indiana Plan and other private insurance, places a high level of stress on an already strained service delivery system.

DCS recognizes that this issue is not just isolated to the child welfare system, but has significant impact on other state systems as well. There are many task forces at the local and state level working to address substance abuse issues including access to services. DCS is increasing support to these providers by:

- Providing technical assistance through a consultant from Child and Family Futures
- Supporting Evidence Based Practices
- Contracting for Transitional Housing programs
- Expanding the Sobriety Treatment and Recovery Team model to additional communities

Child Fatality Review Process

DCS assesses all deaths of children under the age of 18 that are reported as suspicious for abuse or neglect, and are perpetrated by a parent, guardian or custodian. State child fatality teams are managed by the Indiana State Department of Health. There have been no changes in the process in the past year.

Institutional Child Protective Services Unit (ICPS)

The Institutional Assessment Unit (ICPS) continues to assess allegations of abuse or neglect occurring in day cares, schools, residential facilities, group homes, detention centers and other scenarios where child care staff are identified as alleged perpetrators.

PEDS Program

The PEDS Program (Pediatric Evaluations and Diagnostic Service), a cooperative partnership between DCS and Indiana University School of Medicine Child Protection Programs (IUCPP) continues to grow and thrive in spite of the substantial increase in the number of referrals received. Additional information regarding the PEDS Program can also be found in the Indiana Health Care Oversight and Coordination Plan.

The overall numbers of consultations provided to DCS by IUCPP is now well over four (4) times what was initially anticipated in 2008. This number is expected to rise in CY 2015 by 2,000 additional consultations.²

PEDS Referral Types	2008	2014
Mandatory PEDS Referrals	33	879

⁴ How Severe is the Shortage of Substance Abuse Specialists?, PEW Charitable Trust, April 2015, Christine Vestal , PEW Trusts How Severe is the Shortage of Substance Abuse Specialists?

Fracture		61
Head Trauma		760
Burn		58
Total	33	1758

Title IV-E Waiver

Indiana’s 2012 IV-E Waiver extension enables DCS to utilize a broadened service array and increase the target population to all children served by DCS.

CHALLENGES / OPPORTUNITIES FOR IMPROVEMENT

While DCS has made great strides in furthering its mission to protect children from abuse and neglect, there are always opportunities to further improve the ways in which the agency ensures child safety. Through the goals and objectives outlined in the Plan for Improvement in Section IV below, DCS hopes to address the system challenges outlined below.

Developmental and Intellectual Disability Service Array

DCS is more frequently interacting with and serving children with complex developmental, intellectual and mental health needs. This is due, in part, to the launch of the Children’s Mental Health Initiative, outlined in Services Section V below, aimed at keeping children out of the child welfare system through the provision of services to address the child’s complex needs. This program, along with a shortage of placement options due to the closure of a large residential facility in 2012, has magnified the service gaps for this population. DCS will identify strategies to address this system barrier through Objective 1.2 outlined in the Plan for Improvement Section (IV- A).

Domestic Violence Policy, Training and Stakeholder Collaboration

DCS implemented the Domestic Violence Policy and Service Standards as recommended by the National Resource Center for Child Protective Services (NRCCPS) in their Assessment Results (Results) received on November 4, 2013. However, DCS still needs to further evaluate opportunities to address other areas identified in the technical assistance results. DCS will continue to implement strategies to improve practice in this area as outlined in Objective 1.5 outlined in the Plan for Improvement Section (IV- A).

Family Case Manager Visits / Face to Face Contacts

The report below is designed to show a running total of federal standards for case manager contacts for the year-to-date months within the current federal fiscal year. This report is used to determine the progress of case manager contacts throughout the year. It provides a monthly breakdown of children with whom FCM’s have visited and with whom FCM’s have visited in the child’s home setting. Although DCS has seen improvements in family case manager visits for children in the child welfare system, the improvements are believed to be offset by difficulties with tracking of visits for probation youth placed in foster homes. DCS will address system deficiencies in this area through Objective 2.7 outlined in the Plan for Improvement Section (IV- B).

Monthly Family Case Manager Visits

Month	Children with Contacts				Children with Contacts in Home Setting		
	Contacted Children	Total Children	Percentage		Contacted Children	Total Children	Percentage
October 2013	9132	9903	92.21%		7449	9903	75.22%
November 2013	9274	10067	92.12%		7404	10067	73.55%
December 2013	9293	10010	92.84%		7428	10010	74.21%
January 2014	8985	9621	93.39%		7306	9621	75.94%
February 2014	9234	9847	93.77%		7281	9847	73.94%
March 2014	9554	10076	94.82%		7757	10076	76.98%
April 2014	9867	10410	94.78%		7788	10410	74.81%
May 2014	10437	10986	95.00%		8418	10437	80.66%
June 2014	10578	11078	95.49%		8984	10578	84.93%
July 2014	10576	11105	95.24%		8914	10576	84.29%
August 2014	10597	11134	95.18%		8612	10597	81.27%
September 2014	11034	11603	95.10%		8822	11034	79.95%

Substance Abuse Treatment Services

The Biennial Regional Services Strategic Plans (BRSSP) completed by Regional Service Councils (RSCs) throughout Indiana in 2014 identified substance abuse services as a significant gap in the DCS service array. Each region identified this service need in their BRSSP. DCS will address this service gap as outlined in Objective 1.4 outlined in the Plan for Improvement Section (IV- A).

B. PERMANENCY

Child and Family Outcomes - Permanency

1. Children have permanency and stability in their living situations.
2. The continuity of family relationships and connections is preserved for children.

1. Federal Safety Measures

Indiana's performance on federal permanency measures is shown in the charts below.

CFSR Data Profile	National Standard	Indiana Observed Performance 2014	Indiana Risk Standardized Performance 2014	Met/ Not Met/ No Diff
Permanency in 12 Months For Children Entering Foster Care in a 12 month period	40.4%	45%	42.7% (41.6–43.8)	Met
Permanency in 12 Months For Children in Care 12-23Months (as of 1 st day of a 12 mo period)	43.7%	43.6%	42.7	No Diff
Permanency in 12 Months For Children in Care 24 Months or Longer (as of 1 st day of a 12 mo period)	30.3%	33.1%	28.2%	Not Met
Re-entry to Foster Care in 12 Months	8.3%	4.4%	4.8%	Met
Placement Stability (<i>moves per 1,000 days in foster care</i>)	4.12	3.15	3.21	Met

2. Child Welfare Information System (MaGIK) Data

DCS has developed several reports to monitor factors known to have an impact on permanency for children and youth.

Permanency Outcomes for Children in Out of Home Placement

DCS selected ‘Permanency Outcomes for Children in Out of Home Placement’ as a key performance indicator for the agency in SFY 2014. DCS recognizes that permanency for a child means a safe, stable and secure home and family, love, unconditional commitment and lifelong support. The agency believes that every youth exiting foster care should have, at a minimum, a permanent connection with one caring, committed adult who will provide them with guidance and support as they make their way into adulthood. This key performance measure demonstrates whether DCS is achieving timely permanency either through reunification, adoption, guardianship or living with a relative within 24 months of case start date. DCS started utilizing this report in July 2013. This report is published quarterly on the Indiana Transparency Portal at: <http://www.in.gov/itp/> under Performance and Accountability, Performance Measure Dashboard, Child Services. An excerpt from this portal is included below which reflects the percentage of cases closing to permanency within 24 months.

Percentage of Permanency within 24 Months for Children in Out of Home Placements (Calendar Quarter)



- Q3 2013 = 78.54
- Q4 2013 = 77.67
- Q1 2014 = 81.98
- Q2 2014 = 80.10
- Q3 2014 = 79.98
- Q4 2014 = 76.19
- Q1 2015 = 81.72

Other key indicators included on the transparency portal include:

- Percentage of children in care who do not re-enter foster care within 12 months of case closure
- Percentage of children with no substantiated maltreatment after DCS involvement in last 12 months
- Percentage of children with trauma symptom or related needs and strengths improvement
- Percentage of current child support collected

Adoption Trending Report

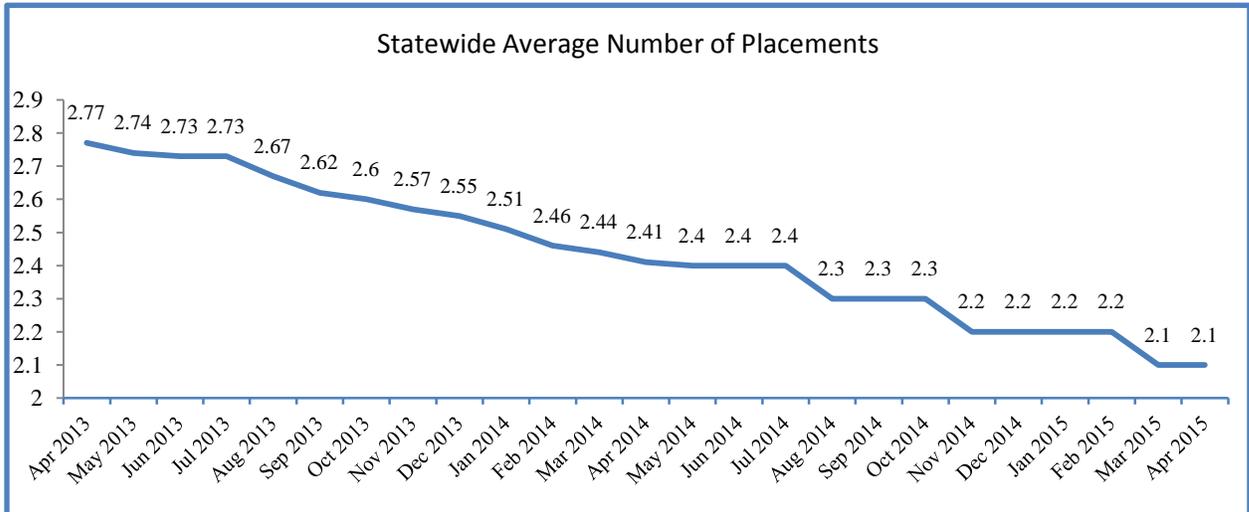
DCS monitors the number of completed adoptions through its adoption trending report. In 2012 and 2013, the number of completed adoptions decreased from prior years. It has started rise again. DCS is presently completing some additional data analysis to get a better understanding of the factors impacting this trend. Below please find a summary of adoptions completed by calendar year.

Calendar Year	Total # of Completed Adoptions
2009	1,226

2010	1,551
2011	1,790
2012	1,282
2013	1,033
2014	1,183

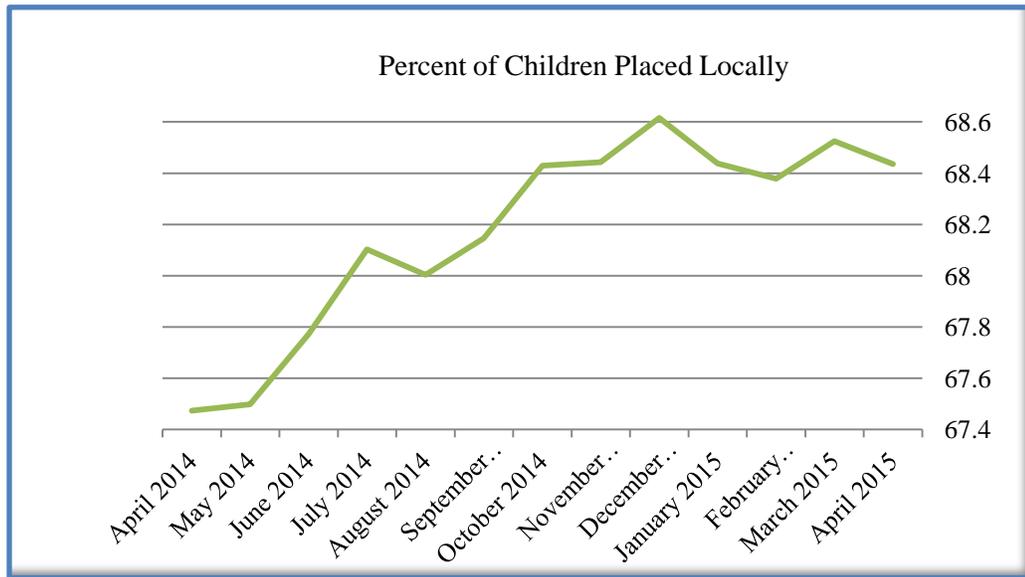
Placement Stability

DCS uses the Average Number of Placements per Child practice indicator report to monitor placement stability. The calculation is based on the total number of out-of-home placements for each CHINS child in placement on the last day of the report month and includes all placements during the current removal episode. This number is then divided by the total number of CHINS children who are in out of home placement on the last day of the report month to arrive at the average number of placements per child. As indicated in the chart below, the average number of placements has steadily decreased each year for the last 2 years.



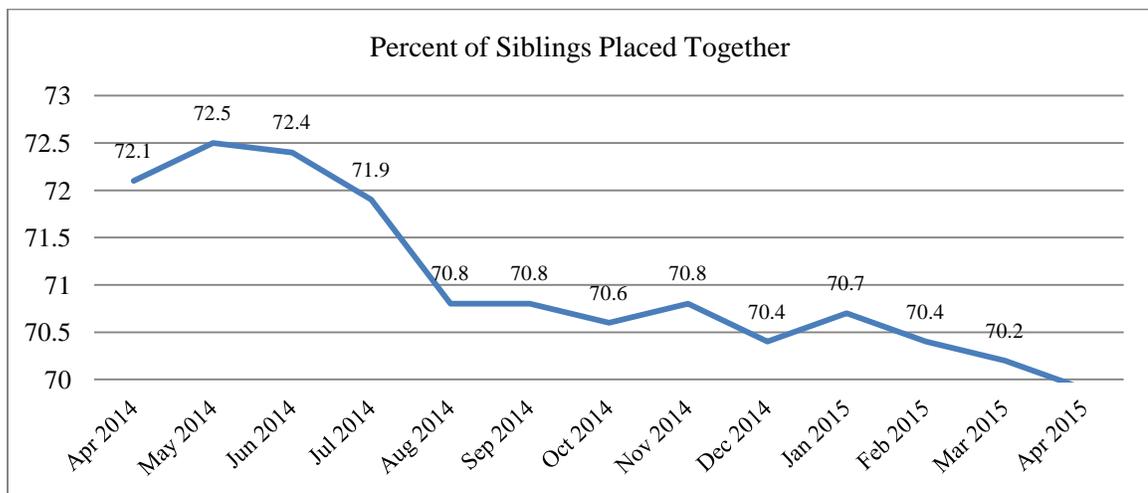
Children Placed Locally

DCS utilizes another practice indicator report to monitor the number of children in out-of-home placement who are placed locally within their communities. The report reflects the total number of children who are living in the same county as the court in which they were adjudicated as a CHINS. The percent of children locally placed is determined by dividing the number of children living in the same county by the total number of children with a CHINS case that are placed outside of their home. The percentage has increased 1% since April of 2014.



Sibling Placements

The chart below depicts information from a practice indicator report that shows the percentage of cases in which siblings are placed together. **In May 2014, siblings were placed in the same home in 72.5 % of DCS cases involving siblings. This represented a steady improvement in the number of cases involving siblings placed together. This percentage has decreased slightly in the last year, falling to 70.2% in April 2015.**



3. Case Record Review - QSR

Round 4 of the Quality Serve Review (QSR) will not be completed until August of 2015. Preliminary results ran for the purpose of this report include data from all regions except the 3 remaining regions, regions 1, 6, and 13. The two child status indicators related to permanency measured by the QSR are stability, and permanency.

Stability

The stability indicator evaluates to what degree:

- 1) The child’s daily living, learning, and work arrangements are stable and free from the risk of disruption,
- 2) The child’s daily settings, routines and relationships are consistent, and
- 3) Risks are being managed to achieve stability and reduce the probability of future disruption.

The stability indicator acknowledges that continuity in caring relationships and consistency of settings and routines are essential to a child’s sense of identity. This indicator looks retrospectively at the past 12 months and prospectively over the next 6 months to assess and project the relative stability of the child’s home setting and relationships. A 12 month “opportunity window” (consistent with CFSR timelines) is used to track recent life disruptions for the child to establish any movement pattern over that time period. Prognosis for future disruption in the next six months is based on the pattern observed over the past 12 months and on future events that would have a high probability of causing a disruption.

As shown in the chart below, QSR results for stability increased in Rounds 2 and 3 but have declined in Round 4. The preliminary QSR Round 4 results indicate that 60% of the cases reviewed resulted in scores of 4, 5, or 6 (Refine/Maintain), in stability, with 6 being optimal or the best possible result. This represents a 3% decrease in scores from Round 1.

QSR INDICATORS	Baseline 04/07 -06/09	Round 2 08/09 -07/11	Round 3 09/11 – 08/13	Round 4 * 9/2013 – 3/2015
Stability	63%	65%	65%	60%

* Round 4 has not been completed – Data represent all regions except Regions 6, 13, and 1

Permanency

The Permanency child status indicator assesses the degree to which the child/youth is living with parents or out-of-home caregivers that the child, parents or out-of-home caregivers believe will sustain until the child reaches adulthood and continue onward to provide family connections and supports. The Permanency Child Status Indicator shows the percentage of cases which were rated with a Refine/Maintain score (4, 5, 6) for the length of time taken to place the child in a home in which everyone believes the child will remain until adulthood.

Although the Round 3 QSR results indicated that significant progress had been made in this area, increasing from 49% in the first round to 60% in Round 3, preliminary results for Round 4 indicated a decline back to 49%.

QSR INDICATORS	Baseline 04/07 -06/09	Round 2 08/09 -07/11	Round 3 09/11 – 08/13	Round 4 * 9/2013 – 3/2015
Permanency Indicator	49%	56%	60%	49%

* Round 4 has not been completed – Data represent all regions except Regions 6, 13, and 1

Maintaining Relationships

The QSR also measures several caregiver indicators. One of the factors in a child’s stability and successful reunification is the ability to maintain relationships with parents, siblings and extended family while the child is in out-of-home care. The Maintaining Quality Family Relationships indicator looks at criteria that maintain and encourage the child’s connection to family members. Specifically, the indicator evaluates when children and

families are temporarily living away from one another:

How well are specifically planned strategies and supports working to build and sustain family connections through appropriate visits and other means, unless compelling reasons exist for keeping them apart, and

To what degree have strategies and efforts been put into place to support the following between the child and his/her parents for:

- Building and maintaining positive interactions,
- Creating and using opportunities for providing emotional support, and
- Using varied and creative opportunities for family members to nurture one another.

DCS showed improvement in all relationship categories between Rounds 1 and 3; however, this is an area in which DCS' QSR performance has shown some fluctuation.

QSR Maintaining Relationships Indicator	Baseline 04/07 - 06/09	Round 2 08/09 - 07/11	Round 3 09/11 - 08/13	Round 4 * 9/2013 - 3/2015
Mother	61%	76%	69%	59%
Father	40%	36%	48%	43%
Siblings	61%	70%	62%	69%
Extended Family	57%	61%	61%	63%

* Round 4 has not been completed – Data represent all regions except Regions 6, 13, and 1

Role and Voice of Family Members

The caregiver's level of investment in and commitment to taking an active role in making decisions about strategies, services and results for the child and family has a direct impact on permanency for children. The QSR Engaging Role and Voice of Family Members measure looks at the extent to which:

- Family members with whom the child is living and/or will be reunited with are active, ongoing participants in decisions made about child/family change strategies, services and results,
- Caregivers are active participants in the plans and services they identified, and
- Trust-based relationships exist between all team members.

The table below reflects the percentage of cases reviewed that scored a Refine/Maintain in engaging family members to actively participate in case decisions. DCS showed significant improvement in this measure in Round 3 compared to both Baseline and Round 2 scoring. This is an area in which DCS has remained focused on demonstrating continued improvement, particularly with regard to the role and voice of fathers. Fathers have consistently scored lower than mothers in this area.

Engaging Role and Voice	Baseline 04/07 - 06/09	Round 2 08/09 - 07/11	Round 3 09/11 - 08/13	Round 4* 9/2013 - 3/2015
Mother	44%	57%	63%	59%
Father	25%	29%	37%	32%

Child/Youth	50%	65%	68%	63%
-------------	-----	-----	-----	-----

* Round 4 has not been completed – Data represent all regions except Regions 6, 13, and 1

4. Summary of Additional System Strengths and Concerns

Expansion of Definition of Relative

Legislation passed by the 2014 General Assembly statutorily expanded the definition of relative to include those having an established and significant relationship with a child. As a result of this legislative change, DCS amended Policy 4.84, effective July 1, 2014, to add “any other adult with whom the child has an established and significant relationship,” to the list of available placement options. This expanded definition provides FCMs with an additional placement option when circumstances require removal.

Foster and Relative Care Specialist Positions

In recent years DCS established several specialist roles in an effort to support stable placement and permanency options for children in care. For additional information about these positions and the roles they play within the DCS system, please see Section III - G. Foster and Adoptive Parent Licensing, Recruitment, and Retention.

How to consistently educate substitute caregivers, particularly relatives, on the types of financial and other support resources available to them is one area DCS plans to address as a part of Objective 2.2 outlined in the Plan for Improvement Section (IV- B).

Permanency Roundtables

Since piloting PRTs in June 2011, DCS has completed 761 round tables. Of those 297 (28%) cases have been closed and 528 cases (69%) have improved permanency status.

Guardianship Assistance Program

DCS utilizes guardianship as a permanency option for children in care. DCS offers both the Title IV-E Guardianship Assistance Program (IV-E GAP) and a state funded Guardianship Assistance Program (State GAP). There are currently 53 participants receiving IV-E GAP funding and 28 participants in the State GAP. Participation in both of the guardianship programs is incredibly small. DCS has tasked a Permanency and Practice Support (PPS) staff member to provide education and guidance to the Field to improve and increase the use of this program. This individual makes regular visits to regional management meetings in the fields, answers questions and refers to eligibility or legal for some, and maintains a mailbox developed specifically for guardianship questions. In addition, the Assistant Deputy of Permanency and Practice Support is making a tour of the state visiting each local office and part of the presentation includes information about this program. Recent changes in the law to expand the definition of relative to include individuals with significant relationships with the child may result in an increase in the number of children achieving permanency through guardianship.

C. WELL-BEING

Child and Family Outcomes – Well-being

1. Families have enhanced capacity to provide for their children’s needs.

2. Children receive appropriate services to meet their educational needs.
3. Children receive adequate services to meet their physical and mental health needs.

While there are no federal outcome measures related to well-being, DCS is in the early stages of developing several MaGIK reports to help monitor how the agency is doing in terms of improving child well-being. In addition, through the QSR, DCS evaluates several indicators to determine well-being outcomes for children.

1. Child Welfare Information Systems (MaGIK) Data

Child and Adolescent Needs and Strengths (CANS) Reports

DCS utilizes the Child and Adolescent Needs and Strengths (CANS) assessment tool to identify the unique needs and strengths of children and families and to make appropriate service referrals based on the specific needs of each child. DCS implemented the CANS starting in 2009, and in recent years, has developed a series of reports to allow management to monitor how the assessment is being used. For example, DCS utilizes several compliance reports to determine whether CANS are being completed at the intervals required by policy, and to monitor whether staff are remaining up to date on training recertification, **as well as a report which focuses on trauma scores.**

In 2013, as a part of efforts to increase focus on trauma-informed care, DCS added the trauma module to the CANS. This series of questions included in the CANS are used to better identify children entering the system who have experienced adverse trauma due to abuse or neglect. One of the agency's goals in starting to complete this module of the CANS is to better identify those children who will more likely benefit from evidenced-based services, which focus on trauma (e.g., Child Parent Psychotherapy).

DCS clinical support specialists are assisting in agency efforts to improve child well-being by appropriately addressing trauma. When a child scores a three or above on the CANS adjustment to trauma indicator, the DCS clinician reviews the case to evaluate whether the services being provided are the right match to address the child's needs. DCS generates a monthly report from MaGIK that lists all cases in which the child scored a three or above for the clinicians to review. If a case appears on the report that the clinician is not already working with an FCM on, the clinician reaches out to the child's family case manager to offer assistance in reviewing the services in place. **Many times, the clinician finds that a referral has already been made for the children, a sign that the field is recognizing the need for assistance in these types of cases.**

One of DCS' goals in the 2015-19 CFSP is to ensure the well-being of Hoosier children by integrating a trauma-informed approach to its child welfare practice (See Section IV. Plan for Improvement, Goal #3). **In order to measure progress in this area, DCS developed a report to measure improvement in CANS adjustment to trauma scores over the life of a case. DCS has been utilizing this report for a little over a year now and has seen improvement in the field's recognition of trauma by the decrease in "zero" scorings on the CANS.**

Safely Home, Families First

One of DCS's values is that the most desirable place for children to grow up is in their own home - as long as the family is able to provide safety and security for the child. When a child cannot be safely maintained in the home, DCS is committed to finding absent parents and relatives. The agency looks for family members who know the child and who are familiar and comfortable to the child. These relatives have established relationships, and as such the trauma of removal is mitigated because the child is with people who know the child and who desire to help the child feel included in their family.

As indicated in Section II-A above, DCS is doing well with regard to maintaining children in the home and/or placing with relatives in an effort to minimize trauma and further child well-being. As of May 2014 and April 2015, 64% of children either remained in the home or with relatives. In addition, the agency has seen a steady increase in its use of relative placements in recent years.

2. Case Record Review System Data

The QSR measures several well-being indicators. These indicators are summarized below.

- **Learning and Development**
 - Age 0 – 5 – To what degree is 1) the young child’s development status commensurate with his/her age and developmental capacities, and 2) is the child’s developmental status in key domains consistent with age-appropriate expectations.
 - Age 5 and Older – Is the child 1) regularly attending school, in a grade level consistent with age, 3) actively engaged in instructional activities, 4) reading at grade level or IEP expectation, and 5) meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent.
- **Physical Health: To what degree:**
 - Is the child achieving and maintaining his/her optimum health status?
 - If the child has a serious or chronic physical illness, is the child receiving his/her best attainable health status given the disease diagnosis and prognosis?
- **Emotional Status: To what degree:**
 - Is the child presenting age appropriate emotional development, adjustment, attachment, coping skills and self-control?
 - Is the child achieving and maintaining an adequate level of behavioral functioning in daily settings and activities, consistent with age and ability?

Some of the QSR section results on well –being are summarized in the chart below. The statistics represent the Refine/Maintain scores in each of the indicators for the Baseline, Second Round, and Third Round QSRs.

Indicators	Baseline 4/2007 - 6/2009	Round 2 8/2009 – 7/2011	Round 3 9/2011 – 8/2013	Round 4* 9/2013 – 3/2015
Learning and Development Indicator	82%	89%	88%	91%
Physical Health - Child Indicator	95%	97%	97%	99%
Emotional Status Indicator: Child	76%	83%	86%	87%

* Round 4 has not been completed – Data represent all regions except Regions 6, 13, and 1

Parent/Caregiver Status Indicators

Parents should have knowledge of and the skills necessary to nurture, guide, supervise and provide age-appropriate discipline to care for, protect and provide for the normal development of their children. The Parenting

Capacities Indicator measures to what degree:

- The parent / caregiver demonstrates adequate parenting capacities on a reliable, daily basis commensurate with that required to provide the child with appropriate nurturance, guidance, protection, care, education and supervision, and
- If the child has special medical, emotional, behavioral and/or developmental needs, the caregiver has and uses any special knowledge, skills and supports that may be required to meet the needs of the child.

The following statistics represent the number of cases that received a 4, 5, or 6 (Refine/Maintain) score in the areas of Parenting Capacities and Informal Supports for the Baseline, Second Round, and Third Round QSRs. DCS showed a 12% increase in Round 3 from the Baseline review.

The following statistics represent the number of cases that received a 4, 5, or 6 (Refine/Maintain) score in the areas of Parenting Capacities and Informal Supports for the Baseline, Second Round, Third Round, and interim Fourth Round QSRs. DCS showed a 3 percentage point increase in Round 4 compared to the Baseline review.

Indicator	Baseline 04/07 - 06/09	Round 2 08/09 -07/11	Round 3 09/11 – 08/13	Round 4* 9/2013 – 3/2015
Parenting Capacities Indicator (Parents combined score)	48%	51%	60%	51%

* Round 4 has not been completed – Data represent all regions except Regions 6, 13, and 1

3. Additional System Strengths and Opportunities for Improvement

Permanency and Practice Support Specialists

In recent years, DCS created several specialized staff positions to provide additional support to family case managers in areas known to have a significant impact on child well-being. These employees provide subject matter expertise and serve as an invaluable resource to field staff in navigating challenging issues and barriers to child well-being and permanency in areas such as mental/behavioral health, physical health, education and parent locating. Below please find a summary of the Permanency and Practice Support Specialist Positions.

Clinical Support Services

DCS has long recognized that mental health issues, including substance abuse, mental illness, and domestic violence, can present unique challenges to case planning and service coordination efforts. In the fall of 2010, DCS leadership identified the need for internal clinical resources, and the Clinical Resource Team (CRT) was formally launched in the summer of 2011. The team consists of 12 licensed mental health clinicians – employed by DCS – based regionally throughout the state. In addition, the team includes two licensed clinicians who work closely with DCS Residential Licensing Staff to ensure compliance with DCS residential contract expectations. Supervision and program oversight for the CRT is provided by an HSPP psychologist.

The Clinical Resource Team provides the following services:

- Consultation regarding safety/risk concerns, needs for additional assessment, placement decisions, complex behavioral health issues, and service planning,
- Liaison between DCS and other human service systems, including mental health, juvenile justice, education and the provider community,

- Assistance with linkage and referral services (e.g., PRTF admission), and
- Education regarding complex mental health issues and best practice models.

In addition to the above duties, the Clinical Resource Team has been working on an initiative, in collaboration with FSSA, OMPP, DMHA and the Indiana University School of Medicine (IUSM) Department of Psychiatry, to provide oversight, monitoring, education and consultation for youth in DCS care who are prescribed psychotropic medications. This initiative aligns with the *Fostering Connection to Success and Increasing Adoption Act*, and includes the following components:

The Indiana Psychotropic Medication Advisory Committee (PMAC):

The Indiana Psychotropic Medication Advisory Committee (PMAC) is an oversight committee that meets quarterly to review the psychiatric treatment of DCS-involved youth, with a specific focus on psychotropic medication utilization patterns. This committee includes representatives from IUSM Department of Psychiatry, DCS, OMPP, FSSA, DMHA, pediatricians, social workers, psychologists, pharmacists, child advocates and other identified stakeholders. The PMAC monitors Federal legislation, reviews best-practice guidelines for psychotropic medication use, monitors Indiana prescription patterns, reviews formularies and makes policy recommendations to DCS and OMPP.

Psychotropic Medication Guidelines for Youth in Care with Indiana’s Department of Child Services (Guidelines):

This document was developed in 2014 by the Psychotropic Medication Subcommittee of the PMAC (Leslie Hulvershorn, MD, DMHA – Chair), with input and guidance from a wide variety of medical and behavioral health professionals across the state. The Guidelines provide “best practice” recommendations for the use of psychotropic medications in child and adolescent populations, including research-based dosage parameters, “red flag” indicators, etc. The Guidelines were recently approved by the Mental Health Quality Assurance Committee (FSSA) and are being considered for broader adoption with all Medicaid-eligible youth. DCS requires all contracted providers to adhere to the Guidelines when using psychotropic medications with our youth.

IU School of Medicine, Department of Psychiatry Physician-to-Physician Consultation Program:

DCS is finalizing a contract with the IUSM Department of Psychiatry to provide physician-to-physician consultation on any DCS case that meets one or more of the “red flag” indicators listed in the Guidelines. Examples would include youth on four or more psychotropic medications, youth on two or more atypical antipsychotics, etc. Given that most psychotropic medications in Indiana are prescribed by practitioners without Child/Adolescent Psychiatry Certification, this program will provide a much needed level of oversight and consultation by Board Certified Child/Adolescent psychiatrists at IU/Riley. Target date for implementation of this program is 7/1/15.

Monthly Psychotropic Medication Utilization Reports:

DCS has an MOU with FSSA to share Medicaid claims data, including psychotropic medication data. As part of the MOU, OMPP will produce monthly utilization reports for DCS wards on psychotropic medication(s) – target date 1/1/15. The Medicaid claims data base captures psychotropic medication

prescriptions on a “real time” basis, allowing for identification of cases that fall outside of best practice parameters. The monthly utilization reports will identify all “red flag” outliers listed in the Guidelines, including names of the prescribing providers. The utilization reports will also allow for comparison of Indiana psychotropic medication rates vs. other states.

Psychotropic Medication Statewide Education and Training Initiative:

The PMAC has developed a psychotropic medication training curriculum for DCS staff and other key stakeholder across the state. The schedule for 2015 includes trainings for DCS staff, residential, foster care and community-based providers, as well as parents and child advocates (e.g., CASA/GAL). The training curriculum includes information about best practice guidelines, current psychotropic utilization trends and issues unique to youth in the foster care system. Leslie Hulvershorn, MD and other psychiatrists from IU will be facilitating these trainings.

Provider/Consumer Information Portal:

DCS will develop a “psychotropic medication” information portal through the website. The information portal will include an overview of the DCS psychotropic medication initiative, contact information, summary performance data (e.g., quarterly utilization reports), and links to relevant research, resources and Federal legislation. The information portal will also include a list of answers to frequently asked questions for consumers. Target date for completion of the information portal is 10/1/15.

Education Services

DCS recognizes that children involved in the child welfare system experience multiple risk factors that may keep them from succeeding in school. Moreover, the education system is complex. Navigating through the system to resolve issues, overcome barriers, and address the many needs of DCS youth can be extremely challenging for individuals without a background in education. The education services team provides expertise to family case managers, families, students and schools to ensure the educational needs of youth under DCS care are met and to provide a seamless transition for students entering new and unfamiliar school environments. DCS employs 14 regional Education Liaisons and a state-wide manager to ensure foster children receive the educational opportunities they need to succeed in school, and in life. During the 2013-2014 school year, the Education Liaison team serviced 3,080 referrals state-wide. The Education Liaison team provides the following services:

- Serves as a subject matter expert and resource to DCS staff and external stakeholders, including school districts, biological parents, relatives, foster parents and service providers.
 - The education liaison team has extensive knowledge and skills related to navigating the complex network of education and special education related services.
- Provides guidance and recommendations to FCMs on how to work with parents/families/schools to navigate education issues and develop a sustainable plan for how to address such issues in the future.
- Emphasizes the importance of community collaboration by communicating and advocating to FCMs and school districts about the importance of working together to identify and address the educational needs, including determining if the need for special education services of youth in DCS care is present.
- Develops and presents trainings for parents, relatives, and foster parents, with the intent to help build their capacity to support the educational success of children in DCS care.

- Develops systems and processes to ensure timely transfer of information between DCS, school districts and the Department of Education, including timely transfer of education records, notice of medical needs, prompt schedule of move in and/or 504 conference, etc.
- Partners with and serves as a liaison between the Indiana Department of Education, school districts, and DCS to develop and implement strategies for addressing the educational needs of youth in care, improving educational outcomes for this population and ensuring a seamless transition for students transferring from residential placement and/or to a new school.
- Works with the Indiana Department of Education, school districts and DCS offices to develop processes and communication strategies to ensure individual children are quickly enrolled after moving to a new placement and that appropriate educational services are provided.
- Works closely Collaborative Care and Independent Living staff to ensure that older DCS youth are aware of opportunities of post-secondary education, financial aid, scholarships and other funding supporting their transition to post-secondary education.
- Develops and presents trainings to FCMs and school districts on the educational needs of children involved in the child welfare system and strategies for ensuring these needs are met.
- Prepares and disseminates local resources that can assist FCMs and schools in assessing and meeting the educational needs of youth in care.
- Identifies and/or builds capacity of educational services or community resources available in the Region(s) and educate FCMs about these programs and how to access them.
- Assists FCMs with how to develop plans to identify, address and resolve a child's unmet educational needs including participating in child and family team meetings, case staffing or planning sessions, and/or school conferences (IEP, discipline, etc) as appropriate.

Nursing Services

DCS Nursing Services staff provide consultation, assist with health and medical issues, and support FCMs in decisions that impact positive health outcomes, well-being, and safety for Indiana children and families served by DCS. The role of the DCS Nurse and their specific functions include:

- Assisting with CANS completion (Health / Medical),
- Assisting in cases with complex / multiple medical needs,
- Answering medical and health related questions
- Medical record review & Interpretation,
- Collaboration with PEDS and the Docs INCASE programs
- Participating in Home visits / Provider visits / Other visits,
- Attending CFTM's / Staffings / Various Committees & Taskforces
- Providing Resources, Education for families and Training for DCS staff / community, and
- Fostering the team concept in the framework of all the DCS divisions.

Parent/Relative Locate Investigators

To further strengthen the Department's efforts with regard to locating absent parents, DCS created investigator positions in July 2012. The investigators, all possessing law enforcement experience, have a unique skill set and knowledge of / access to a variety of locate resources not familiar or available to social work staff. They are experienced in utilizing a variety of mediums such as computer databases, social media, telephones, public records, court systems/records, the Internet, and knocking door to door in order to gather information. These

investigators not only exercise different means to locate and engage fathers and extended family on both sides, but are available to assist family case managers with challenging cases where the investigations require more extensive research and officer presence.

Through feedback from family case managers and some limited tracking of outcomes, these additional specialist positions are having a positive impact in improving child well-being for children in DCS care. In order to better track the impact these specialists have on child outcomes, DCS is in the process of developing a series of reports for each specialist function. Reports will look at the number and types of referrals received for each specialist unit, and will also look at the impact of specialist involvement in addressing the needs that resulted in the referral.

The function of the investigators is to assist local office staff with locating relatives, including absent father, and any other individual who is a possible connection for the child. Any time from the onset of the case as well as any time during the life of said case. To date there are 16 investigators and two supervisors in this unit.

The investigators utilize a variety of internet search tools, such as computer databases, Accurint, Federal Information Portal, Federal and State Department of Corrections, Federal and State Offender Registries, and the Indiana Bureau of Motor Vehicles. Social Media is utilized, including Facebook, Public Records, County Court Systems and records.

Other services which investigators may provide include, but, may not be limited to locating youth in runaway status in DCS care, providing service for summons and court appearances, collection of state and out of state criminal histories and verifying no contact orders for child safety.

During the course of a referral request the investigators not only exercise different methods to locate fathers and or extended relatives. Investigators are also available to assist family case managers with challenging cases that require more extensive research.

The services provided by the investigators assist the family case managers when only limited information about absent parents and family members is known. This information may in turn be utilized in making familial placement options and support systems for the child.

DCS is in the process of developing a report that will track the types of referrals and will also look what impact the investigators involvement in addressing the needs of field staff.

Home-based and Evidence-based Service Array

The DCS service array, as described in Section III - E, is a system strength with regard to supporting improved child well-being. The availability of home-based services allows more children to remain in-home safely, which in turn reduces the amount of trauma experienced by the child. In addition, the expanding evidence-based service array provides opportunities to utilize proven treatment interventions to address the individual needs of children and families with a focus on addressing underlying trauma.

While the availability of evidence-based services has increased significantly in recent years, DCS still has service gaps in some areas, particularly in addressing the needs of children with severe developmental or intellectual disabilities, or complex mental health needs. In addition, there are opportunities, through service mapping to ensure that children and families are referred to the right evidence-based services based on their individualized needs. These areas will be addressed as detailed in Objective 1.1 outlined in the Plan for Improvement Section (IV- A).

III. SYSTEMIC FACTORS

A. INFORMATION SYSTEM

How well is the statewide information system functioning statewide to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

DCS launched a new child welfare information system, the Management Gateway for Indiana's Kids (MaGIK) in July 2012. MaGIK is based on the core platform of Casebook, an emerging Commercial-Off-the-Shelf (COTS) solution developed by Case Commons, a non-profit private organization originally launched by the Annie E. Casey Foundation. In this public – private partnership between DCS and the Annie E. Casey Foundation, private funds are used for development of the core Casebook system, while DCS pays the costs of configuration and integration of this system in the DCS environment, which creates the MaGIK system. MaGIK includes functionality that allows DCS to readily identify the status, demographic characteristics, location, and goals for the placement of every child in foster care. In addition, the system does much more to support FCMs in making child safety decisions, identifying appropriate placement options and achieving timely permanency for children in care. Though a young system, MaGIK has already shown increasingly positive results in functionality and usability.

The MaGIK Dashboard feature (dashboard) has been particularly useful to family case managers. The dashboard displays useful and important reminders to provide FCMs with a visual picture of what's going on with a case and call attention to those things that research tells us impact child safety and permanency. For example, every FCM's dashboard displays the number of days since their last face to face contact with each child on their caseload. It also provides reminders of approaching deadlines and due dates. This feature is well-liked by family case managers because it provides them with real time updates and feedback on their cases.

MaGIK's embedded family and extended support network capabilities make seeing and utilizing family members for placement and support much easier for FCMs. The case history function provides FCMs with a greater understanding of a child's history with DCS. Resource directories within MaGIK provide a better view into foster family service coverage within a local area. MaGIK also provides FCMs with real-time access to the child protective history of the family, aides them in assessing the possibility of involving relatives and family friends as formal or informal supports, and supports the documentation of child and family team meetings.

MaGIK incorporates a comprehensive view of each child's family and support network that is both easy to update and easy to view. Historically, genograms had been captured in a separate tool or on paper and not consistently kept up to date. As a result, FCMs did not necessarily have reliable and current information on relatives available to them. MaGIK encourages FCMs to use the family network extensively, to capture contact information for each relative and support member and to track relationships. The networks have become a significant resource for FCMs looking to place children and support the goal of increased kinship placements.

Although MaGIK has been maturing in the past year and half since implementation, there are still several enhancements to be developed that will take into account the data that is being captured, validation of the data entered, and use of the data to allow rapid decisions to be made on behalf of the child for their safety, well-being, and permanency. Discussions with our vendor, Case Commons, occur on a regular basis with senior DCS management and with the DCS MaGIK development and maintenance team. In recognition of the need to continue identifying ways to further enhance the system to support improved outcomes for children and families, and improved access to reliable data for reporting purposes, DCS included a few interventions related to using technology to support the objectives and goals outlined in Objective 4.3 in the Plan for Improvement Section (IV-D).

DCS Reports produce a Child Data Summary which can display aggregate data for any region, county, etc, or individually by family case manager for cases on their caseload, which includes date of birth, removal data, placement date, resource type and resource name as well as primary and concurrent Case Plan goals for permanency. The accuracy and reliability of data in this report, as in all reports, is dependent upon the data entered by the user as recommended by policy and practice. However, placement agreements and subsequent per diem payments and fiscal records are managed within an integration system to MaGIK. Therefore claims for payment cannot be processed timely if the information in MaGIK is not accurate. This serves as an internal check and balance to ensure that information is accurate and is updated timely by the user and supervisory staff.

Modifications to the Reflective Practice Survey are being considered in order to measure the accuracy of common demographics and other information in MaGIK to also provide a better understanding of the accuracy of this data.

1. Status of the Child

The Case Page in MaGIK displays a variety of case information in distinct bands which includes the status of a child's involvement (in foster care or no longer in foster care) and the child's placements and locations. The Placements and Locations band identifies where the child is physically located at any time and will further segregates the placement as out of home or in an in home setting. The Out of Home locations can be expanded to show the type of resource for the Out of Home Placement, including Foster Care Resources. If additional information is needed regarding the child, users are also able to view the child's Location History which provides a chronology of the child's location history from removal to the current date.

2. Demographic Characteristics

Demographic characteristics include date of birth, sex, race, ethnicity, disability, medically diagnosed condition requiring special care; and ever been adopted. In MaGIK, each child has a person page to record demographic data. On each person card, data can be recorded for the child as it pertains to name, gender, DOB, race, and ethnicity. Beginning in 2014, medical conditions are limited to a configured list in order to provide better data quality on diagnosed medical conditions. MaGIK records information for children who have ever been adopted when completing the AFCARS questionnaire at the time of removal of the child.

3. Location (child's physical location)

In MaGIK, a child's physical location is visible at all times from the main case page. Locations are divided into 5 categories for description: Placement, Trial Home Visit, Temporary Absence, Runaway or Collaborative Care Placement. Further details can also be added to the category of location.

- **Placement:** Foster Family Home (including unlicensed relative), Residential Resource, Placement Provider (not licensed by DCS), Out of State Foster Family (including Relative Homes), Out of State Residential Resources and Non-Custodial Parents.
- **Trial Home Visit:** A trial home visit is utilized as a location when a child returns home for a period of time as a short-term option to prepare for reunification. This occurs during an open removal period.
- **Temporary Absence:** Hospital, Overnight camp, Respite Placement, Visit with siblings, Visit with other caregivers.
- **Runaway:** Self explanatory. Runaway can be added as a concurrent location to either At Home or Out of Home locations.

- Collaborative Care Placement: Apartment, College Dormitory, Host Home/Foster Family Home, Shared Housing, Residential Resource and Other Resource.

Once a user selects a Trial Home Visit as a location option, the location becomes reflected as an “At Home” location for the child with the banner of THV so staff reviewing the case are immediately aware of the status.

4. Goals for Permanency

Goals for permanency (reunification, adoption, guardianship, other planned permanent living arrangement, or not yet established) are recorded within the Case Plan feature in MaGIK. The goals available within MaGIK include Reunification, Adoption, Legal Guardianship, Emancipation as a Result of Planned, Permanent Living Arrangement and Placement with a Fit and Willing Relative. These goals are also displayed as aggregate data within the Child Data Summary report.

5. Identification of Every Child in Foster Care

DCS can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care. This information can be obtained for current status but based on descriptions above. The locations history page will display the complete history of a child since the time of removal.

B. CASE REVIEW SYSTEM

1. Written Case Plan

COMPLETION OF A CASE PLAN FOR ALL CHILDREN IN CARE

A case plan is required for each child in need of services who is under the supervision of DCS. The DCS Child Welfare Policy Manual Chapter 5: General Case Management, Section 8: Developing the Case Plan, included as Attachment 16d, instructs FCM’s on development of the case plan.

CASE PLAN INCLUDES REQUIRED ELEMENTS

The case plan includes all of the federally required elements as is reflected on the case plan itself, Case Plan – State Form 2956, included as Attachment 17a. The Case Plan – State Form 2956 and the policy, Chapter 5, Section 8 are in the process of being updated to reflect changes necessary due to the Preventing Sex Trafficking and Strengthening Families Act.

CASE PLANS ARE SUBMITTED TIMELY

Case plans are submitted timely. Although Indiana law requires that case plans be completed within 60 days under IC 31-34-15-2, DCS Policy (Chapter 5, Section 8 mentioned above) requires FCM’s to complete case plans within 45 days of initiation of the case. Because updates are required by most courts at all hearings, case plans should be prepared timely.

CASE PLANS ARE DEVELOPED JOINTLY WITH THE CHILD'S PARENTS

The DCS Child Welfare Policy Manual Chapter 5: General Case Management, Section 7: Child and Family Team Meetings, included as Attachment 16c, instructs FCM's to develop the Case Plans jointly with the child's parents and other team members in the Child and Family Team Meeting. The Child and Family Team Meeting (CFTM) section of the case plan includes a checkbox that indicates whether parents were involved in the CFTM. The parents are also encouraged to sign the case plan. Policy and practice are also being modified to include children age 14 and older and/or their representatives in the Child and Family Team Meetings and in development of the case plans in compliance with the Preventing Sex Trafficking and Strengthening Families Act.

STRENGTHS AND BARRIERS

The Child Data Summary Report includes the involvement date and the case plan start date. Supervisors review this report to monitor whether case plans are being completed timely and they can drill down and select individual cases. The report does not currently provide local, regional or state-wide data with regard to the number of case plans completed within 45 days.

Objective 2.5 in the Plan for Improvement includes plans to evaluate the structure of, and policy surrounding, the use of the case plan and transition plan to ensure they support development of goals that are in the best interests of children and families, and furthers timely permanency.

While DCS policy and the case plan itself include required provisions, DCS intends to identify ways to make the case plan more user-friendly. In order to assess concerns with the current structure and policy surrounding use of the case plan, DCS formed a committee of DCS staff and stakeholders to gather feedback on the effectiveness of DCS case plans. This committee noted the following concerns which will be addressed by the CQI committee assigned to goals involving case plans:

- Complexity: the committee had concerns that the Case Plan is too complex and is difficult for some family members to understand.
- Not User Friendly – the case plan committee requested that case plan completion in MaGIK be more user friendly, including capability to download other information into the case plan (like CFTM notes).
- Tracking – the committee identified ways in which we could better track case plan completion in MaGIK.
- Parent Involvement - We are not currently monitoring the participation of parents in the CFTM but rather are capturing parent involvement in the CFTM as a part of QSR sampling. We have the ability to run reports on this data point, but are not currently doing so.

As stated above, the CFTM should be used to develop the case plan. This engages families in the planning process which empowers them to make informed decisions about their own lives including setting goals and developing strategies to attain them.

There are a number of checks and balances to ensure the completion and quality of case plans, through internal supervisory review, case staffing reviews, Reflective Practice Surveys and externally through the Quality Services Review. MaGIK also ensures that written case plans are created and made a part of the file or case record. The MaGIK dashboard notifies FCM's when case plans are due and the Case Plan form (identified above) that the FCM's use to complete the plan covers the required criteria and provisions. More problematic, is measuring the engagement of parents and children in the case planning process. FCMs should be involving parents in the development of the case plan and children age 14 and older should be involved in the development of the case plan and the transition plan. Policy requires that the case plan be signed by the parent or include an

explanation as to why it is not signed by each parent (parent is missing, refused to attend the conference, etc.). The parent's signature on the case plan does not necessarily mean that they were actively engaged in the development of the plan but does indicate they were present. This measurement will require additional work by the CQI Group assigned to the Case Plan Objectives 2.5, 2.6, 3.2, 3.3, and 3.4.

2. Periodic Reviews

Each child's case must be reviewed at least once every six (6) months through a formal court hearing under IC 31-34-21-2. The first periodic case review must occur at least six (6) months after the date of the child's removal or at least six (6) months after the date of the dispositional decree, whichever is first.

This is an area of strength for DCS. The Child Data Summary report includes a field for the date of the last review and for the next scheduled periodic review. Dashboard ticklers in MaGIK alert FCMs of the date of the next periodic review hearings.

Information addressed in periodic review hearings include the child's safety, the continuing need for foster care, the extent of compliance with the case plan and progress made to alleviate or mitigate the causes necessitating placement in foster care, and a likely date for reunification or other permanency. This information is also included in the child's case plan and the Periodic Review Orders issued after the hearings. Local office attorneys also review this information with FCM's in preparation for the periodic review hearings and ask these questions during examination of the FCM. The FCM enters the results of the hearings in MaGIK and then uploads the order when it is received. DCS works with the Indiana Supreme Court to prepare benchbook forms for Judges to use in the periodic hearings to ensure that all of these issues are addressed in the periodic review hearing and are included in the periodic review court orders.

STRENGTHS AND BARRIERS

This is an area of strength for DCS. Many courts hold periodic reviews every three (3) months. More problematic is tracking, reporting and measurement of progress in this area. The inclusion of tracking and reporting periodic review hearings for probation cases is also an area being reviewed.

3. Permanency Hearings

Permanency hearings are tracked in MaGIK and through court orders. The Child Data Summary report includes a field for the date of the last permanency hearing and a field for the next scheduled hearing. Based on the court date of the last permanency hearing, MaGIK sends a notification to the FCM when it is time for the next hearing. Indiana statute requires courts to hold permanency hearings timely and Indiana courts and DCS local office attorneys monitor permanency hearings to ensure they are held timely. Indiana's law is more expansive than the Federal requirement in that it applies to all children under DCS care, whether in foster care placement or in home with parent. It also includes a provision that Permanency Hearings may be held more often if ordered by the court. DCS has a Memorandum of Understanding with the Indiana Judicial Center to exchange information and reports related to judicial cases and permanency.

Indiana code IC 31-34-21-7 requires a Permanency hearing not more than 30 days after a court finds that reasonable efforts to reunify or preserve a child's family are not required.

4. Termination of Parental Rights (TPR)

Historically, DCS ran a monthly report to track children out of home for 15 out of 22 months. This report was not created at the time of MaGIK implementation, and was not available when the CFSP was completed. This report has been re-created and is now available. DCS executives review the 15 of 22 report and other reports relating to children for whom parental rights have been terminated to continually monitor the length of time they are in care after termination. DCS is in the process of reviewing all reports related to permanency to determine relevant quantitative and qualitative data to measure performance and show that TPR proceedings are occurring in accordance with required provisions. Timely filing of TPR is also being reviewed as part of the Case Load Committee.

Improved tracking of timelines associated with TPR filings is incorporated in Objective 2.5 as outlined in Plan for Improvement Section IV – B.

5. Notice of Hearings and Reviews to Caregivers

DCS includes information about requirements for caregivers to receive notice of hearings and periodic reviews. Notice of Hearings and Reviews to Caregivers.

IC 31-34-21-4 requires DCS to provide notice of hearings at least seven (7) days prior to the hearing to the following individuals:

- the child's parent, guardian, or custodian;
- Any attorney that has filed an appearance on behalf of the child, parent or guardian;
- Any prospective adoptive parent named in a petition for adoption of the child;
- Tribal representatives;
- Foster parents;
- Any other person that DCS knows is providing care for the child; and
- Any other suitable relative or person whom the department knows has had a significant or caretaking relationship to the child.

Courts also include most of these individuals of their distribution list for court order and hearing notices. In addition to formal written notification, courts also require notice of service at some hearings and inquire as to the reason for non-attendance of parents or other key participants in the case as this information is included in hearing orders. This also includes tribal members. Courts also frequently set hearings during other hearings and notify everyone at the hearings of the next hearing date. FCM's also remind everyone involved of hearings during their conversations and hearings are discussed in Child and Family Team Meetings.

A form has also been developed for children to submit to the court if they are not able to attend the hearing to advise the judge of their wishes.

DCS is in the process of reviewing methods to improve data collection and tracking and to measure performance in this area.

To more effectively evaluate how the agency is performing with regard to this particular systemic factor, DCS is considering adding a question to the QSR related to whether caregivers were in fact timely notified of hearings and reviews and felt they had input. DCS is also considering adding questions to the Reflective Practice Survey (RPS) on this issue. Potential questions include the following:

- Did all individuals involved in the case, including the parent, foster parent, and/or caregiver receive a letter or document notifying them of hearings which occurred regarding the child?
- Were these individuals aware that they could attend the hearing.
- Did they attend the hearings? If so, did they feel they were provided an opportunity to provide input at the hearing?

Additional measures of performance need to be established and reviewed.

C. QUALITY ASSURANCE SYSTEM

1. Foundational Administrative Structure

The Indiana Quality Assurance System has evolved significantly since the agency's creation in 2005. Indiana now has well-defined policies and procedures in place to evaluate various areas of practice: Quality Service Reviews (QSR), Quality Assurance Reviews (QAR), Reflective Practice Surveys (RPS), Hotline Quality Review (HQR), and Institutional Child Protection Services (ICPS) Quality Review. These processes are managed by DCS and are applied consistently throughout the state. These processes are familiar to, and in the case of the QSR and Hotline Quality Reviews, include internal and external stakeholders in the evaluations who provide important feedback on the functioning of the child welfare system in Indiana.

Indiana has made a commitment to continuously evaluate its child welfare practice, and continues to revisit the practices and procedures in place to do so. The developing organizational structure and staff resources the agency has devoted to emphasizing quality improvement practices is one of the greatest strengths of the Indiana Quality Assurance System.

In recent years, Indiana has made several organizational changes to support development of a more robust, comprehensive continuous quality improvement structure. These changes include the creation of a Research and Evaluation team. This team evaluates the effectiveness of the service array and of providers to impact outcomes for children and families. In 2014, DCS modified the reporting structure of the Performance and Quality Improvement unit (PQI), Office of Data Management (ODM) and MaGIK IT teams and moved them under a newly created child welfare outcomes division that reports to the DCS Chief of Staff. This structure supports a more comprehensive continuum for gathering and analyzing both qualitative and quantitative data and the development of technology to further initiatives and support how the agency collects and reports data.

A description of the DCS units supporting quality improvement efforts is included below.

New Director of Child Welfare Outcomes

DCS developed a new position in 2015 for a Director of Data and Outcomes. The new director joined DCS on June 8, 2015. He will be responsible for the Quality Assurance Team and the Office of Data Management. The Director of Child Welfare Outcomes will work on reports needed to ensure that the CQI process is implemented through all areas of the agency. He will be integral to implementation of CQI and will be working on the DCS Child and Family Services Plan.

Research and Evaluation Unit

DCS developed the Research and Evaluation Unit within the Programs and Services Division (now Services and Outcomes Division) in November 2010. The Research and Evaluation Unit serves as the clearinghouse for DCS and provider data to generate constructive analyses on data trends, measurable and quantifiable outcomes, and

findings around the practice-model achievements. As of May 2014, there are five staff members in the Research and Evaluation Unit who work closely with DCS executive committee members, other Services and Outcomes staff, Information Technology staff, community providers, and research consultants. During the last year, this team has been tasked with looking primarily at the services provided by the DCS external partners. The Office of Data Management has focused on the practice model and analysis of internal DCS operations.

Staff in the Research and Evaluation Unit provide timely information on service utilization and service gaps within Indiana, create templates for community providers to report services received by DCS children and families, and conduct monthly and yearly reports on specific outcomes related to youth in institutional placements. Projects assigned to the Research and Evaluation staff by the Deputy Director of Services and Outcomes support service delivery throughout the state. As the Continuous Quality Improvement process at DCS expands, Research and Evaluation staff will continue to focus on measuring the impact of services that are delivered by community providers as they work in collaboration with DCS partners to achieve positive results for children and families in Indiana.

Performance and Quality Improvement (PQI) Team

The Performance and Quality Improvement (PQI) team has been restructured to be champions of the Continuous Quality Improvement (CQI) processes within the regions and across the state as the statewide CQI process is further developed. The team consists of nine team members. Eight team members focus on conducting Quality Service Reviews (QSR) and being CQI facilitators and liaisons to the 18 regions throughout Indiana. One team member is assigned primarily to serve in the same capacity for state-wide applications such as the Hotline, Quality Assurance Review (QAR) and Older Youth Services (OYS) Quality Service Review (QSR). Other responsibilities of PQI team members includes development and modification of training curriculum, scheduling and tracking of reviewer training, and management of QSR on-site reviews. They also provide CQI goal development, tracking, and monitoring assistance to regional management and they provide RPS data reports for assessment, ongoing, and ICPS cases. PQI works with the Office of Data Management on reports and tracking of data.

During the summer and fall of 2014, the PQI team, Research and Evaluation, Service Coordinators and some administrative staff attended a three day train the trainer instructional conference on how to facilitate CQI plans using Plan, Do, Study, Act (PDSA) Cycles. Currently, the PQI team is internally piloting a “Plan-Do-Study-Act (PDSA) cycle. In addition, DCS has employed outside contractors to assist in reviewing agency data regarding how children enter the system and the longitudinal data showing how children enter and exit the system.

Office of Data Management

The DCS Office of Data Management (ODM) develops all reports from the DCS child welfare information system, MaGIK, for a variety of audiences including various levels of DCS staff, legislative partners, the Governor’s office, Federal partners, and for the general public. ODM works closely with DCS executive staff to develop reports to help them monitor practice and to help answer operational questions from the various business areas. ODM works to ensure quality and consistency with the data DCS staff use to make business decisions. ODM also completes data analysis for the DCS executive staff. ODM uses live data from various source systems as well as an analytical data warehouse to produce reports and data. As of May 2014, 9 people comprise the ODM including the ODM manager, a business analyst, a federal reports analyst, 5 report developers / programmers, and a data architect.

Child Welfare Information Systems Division

The DCS Child Welfare Information System team (MaGIK staff) also reports to the DCS Chief of Staff. The team includes 51 staff with responsibilities for Project Management, Business Systems Analysis, Software Development, Quality Assurance Testing, and End User Support. In addition to the DCS state staff and contractors, the MaGIK team works with peers employed by Case Commons to further develop the Casebook components of the MaGIK child welfare information system.

While existing quality assurance policies and practices, along with the staff resources devoted to managing quality improvement initiatives within the organization are great strengths for the agency, Indiana lacks a comprehensive policy that ties all of these things together and provides a context for how the Department will utilize CQI to make decisions about how to further improve practice. To address this gap in the Indiana quality assurance system, Indiana has identified a specific goal and a number of objectives to further evolve its quality improvement system. See Section IV –Goal 4 for additional information about CQI related goals and objectives.

2. Quality Data Collection

Child welfare data collection is managed through several different vehicles. Qualitative data is gathered through the QSR and RPS practices, which allow DCS to get a picture and understanding of trends, contributing factors, and practices in Indiana's child welfare system. Quantitative data, such as monthly practice indicators, compliance related reports and federal data points are gathered primarily from the State's child welfare information system, MaGIK. The agency also uses information gathered through its service database, KidTraks.

While DCS management staff is used to managing by data and familiar with how to access and analyze the data and reports available to them, the agency had some initial delays in being able to provide access to the same level of detailed reporting with the implementation of the state child welfare system, Management Gateway for Indiana's Kids (MaGIK), in 2012. At this time, many standardized reports are available to staff from the DCS Home Page and through MaGIK. Reports include data at a statewide level as well as more granular regional, county, or FCM level drill down for more detailed information and analysis.

The avenues available to DCS staff to gather information about system functioning are a strength for the agency. However, DCS has not historically done a good job of linking and analyzing qualitative data gathered from QSRs, alongside the quantitative data that is maintained in MaGIK. Indiana plans to address this gap through the objectives outlined within Goal 4, further detailed in Section IV.

Quality Service Review (QSR)

The DCS Quality Service Review (QSR) is a thorough case review and practice appraisal process which assess how children and their families benefit from services received and how well locally coordinated services are working for children and families.

DCS conducts a QSR in each region (including all DCS local offices in the region) approximately every 18 months. This is referred to as a Round. A random sample of cases are pulled for review. The number of cases pulled is based on the size of the counties in the region but normally includes 4 assessment cases and 20 ongoing cases, with more cases being reviewed in larger counties. The cases are reviewed to determine child and parent/caregiver interactions with the child and DCS, progression of the case through the Courts and DCS, related system practice, and performance results. Cases being reviewed are assigned to a team of reviewers, which is usually two but sometimes up to three (if reviewers in training observe). Cases are reviewed during a 2-day period. On the afternoon of the second day, the review teams provide feedback (i.e., debrief session) to the assigned FCM and/or Supervisor on the case they have reviewed. The reviewers then participate in mini-round

conferences led by PQI team members, where each team presents information on their case and scoring results are discussed. The PQI team reviews the results of the case reviews as a group to identify regional and statewide trends, as well as to evaluate scoring reliability among qualified reviewers.

They present an analysis of the data collected and Data Indicator Reports for the region to the Regional Management staff. The central purpose of the QSR is to encourage and support a successful process of change for families leading to safety, permanency, and well-being for children.

Qualitative data is gathered through the QSR and RPS practices, which allows DCS to get a picture and understanding of trends, contributing factors, and practices in Indiana’s child welfare system. Quantitative data, such as monthly practice indicators, compliance related reports and federal data points are gathered primarily from the State’s child welfare information system, MaGIK. The agency also uses information gathered through its service database, KidTraks.

While DCS management staff is used to managing by data and familiar with how to access and analyze the data available to them, the agency had some delays in being able to provide access to the same level of detailed reporting with the implementation of MaGIK. This delay was to be expected with the implementation of a brand new system; and while data collection and reporting has improved significantly since implementation of MaGIK in July 2012, DCS must continue to prioritize further development of user-friendly reports and data analysis to allow continued evaluation of child welfare practice.

Indiana is expanding QSR Indicators to align them with the Child and Family Service Review (CFSR) Onsite Review Instrument (OSRI). This includes expanding the following indicators:

- Team Formation,
- Team Functioning,
- Assessing and Understanding the Child,
- Assessing and Understanding the Family,
- Intervention Adequacy.

These indicators will measure current practice over the past 90 days, as well as over the past 12 months. Further, mother, father, child, and resource parents will be rated individually during both time frames.

The Office of Data Management (ODM) is developing DCS reports from MaGIK and data validation questions which have been added to the RPS tool in order to measure federal requirements before, during and after the federal review scheduled in Indiana in 2016. These qualitative and quantitative data reports in conjunction with other DCS reports will assess practice and monitor progress toward improvements.

Quality of Services

The most up-to-date statewide data for the QSR, demonstrates Intervention Adequacy remains an area for improvement despite the availability of resources.

Quality Service Review Indicator	Baseline 4/2007 -6/2009	Round 2 8/2009 - 7/2011	Round 3 9/2011 – 8/2013	Round 4* 9/2013 – 3/2015
Intervention Adequacy	50%	63%	69%	59%

Resource Availability	75%	88%	93%	94%
-----------------------	-----	-----	-----	-----

Trends in this area reveal that services implemented are insufficient or underpowered to meet identified and underlying needs of children/youth and/or families.

Lack of engagement by parents hindered progress on the identification of underlying needs and individual treatment goals. Reviewers also noted assessments were either not completed or not taken into consideration when determining appropriate service needs. Analysis conducted through Indiana University on QSR data supports through assessments as a basis for better outcomes for children and families. In response, DCS developed the service mapping program to match the model and intensity of services to individual’s needs.

The avenues available to DCS staff to gather information about system functioning are a strength for the agency; however, DCS has not historically done a good job of linking up and analyzing qualitative data gathered from QSRs, alongside quantitative gathered through MaGIK. Indiana plans to address this gap through the objectives outlined within Goal 4, further detailed in Section IV.

Indiana University School of Social Work Support

The PQI team continues to partner with Indiana University (IU) to reconstruct the PQI roll-up sheets (data intake sheet for reviewers) and the PQI data base. The purpose is to standardize data collection to ensure data can be integrated and compatible with quantitative data from other DCS data resources. Additionally, the PQI team and IU staff are still in the process of converting existing QSR data starting with the baseline reviews (April 2007 – June 2009), QSR Round 2 (August 2009- July 2011) and QSR Round 3 (September 2011- August 2013) data into the new existing data base format. Once the data is converted approximately fall 2015, PQI will begin working with the Office of Data Management and Research and Development staffs to conduct a further analysis of QSR data, as well as QSR data combined with MaGIK data to provide more in-depth information and recommendations for CQI based on qualitative and quantitative data findings.

As part of the Title IV-E Waiver Demonstration Project, IU utilized data from the first three rounds of the QSR to analyze correlations in the data. Specifically, they wanted to explore and identify how child welfare practice performance indicators influence national child welfare domains of safety, permanency, and well-being. Results from this analysis showed understanding the needs of a child and family plus having a strong plan in place contributes to children/youths’ safety, permanency, and well-being. Further, planning is essential to permanency. Though teaming is an ideal way of developing such plans, the analysis showed that teaming presents complexities and at times may hinder permanency and well-being goals. Further additional exploration of the state’s teaming practices is necessary in order to determine what could improve the teaming process (See CQI).

Well-being			
Practice performance indicator	Under 5yrs N=634	5 -9 years N=408	10+ years N=570
Engaging	-.037	-.142	.067
Teaming	-.020	-.103	-.081
Assessing	.382***	.363***	.262**
Planning	.003	.106	.067
Intervening	.025	.262*	.149
Maintaining family relationships	.144**	.117	.121
Overall system performance	.098	-.142	.028
Gender (male)	-.074	-.128*	.027
Race (white)	-.015	-.029	.121*
Case length (greater than 19 months)	-.073	-.083	.010
Adjusted R ²	.227	.234	.246

Quality Assurance Review (QAR)

Automated QAR began for assessments March 2014. The QAR has the ability to capture all of the 2013 data and is currently being revised to reflect 2012 data. The quarterly report is available to all staff and staff may review data daily to ensure standards are being met. Staff can review data reports on a statewide, regional, county or at a Family Case Manager (FCM) level in order to validate and use the data for FCMs' skill set enhancements, training and staff development plans, and compliance to state and federal statutes.

The automation of ongoing cases and Older Youth Services cases for QAR reports remain under construction in MaGIK. The real time and quarterly reports will be available in MaGIK in Fall 2015. The reports will enable supervisors to monitor cases and make changes to them on an ongoing basis. The reports will enable FCM Supervisors to engage in ongoing conversations with FCMs regarding areas of strength and those needing improvement. The statewide data will be used to track progress and make adjustments to current strategies.

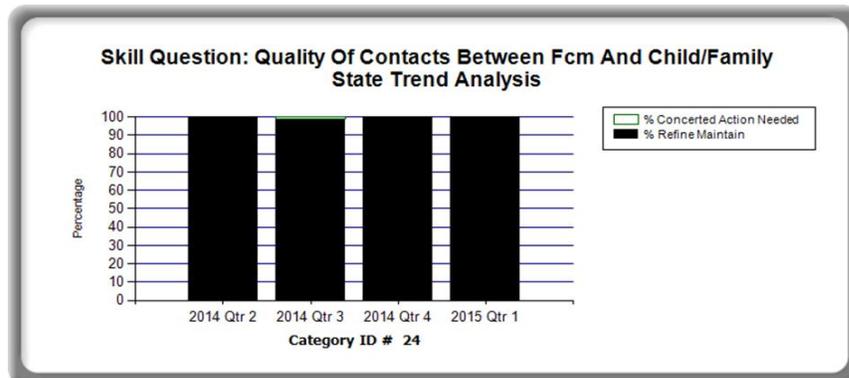
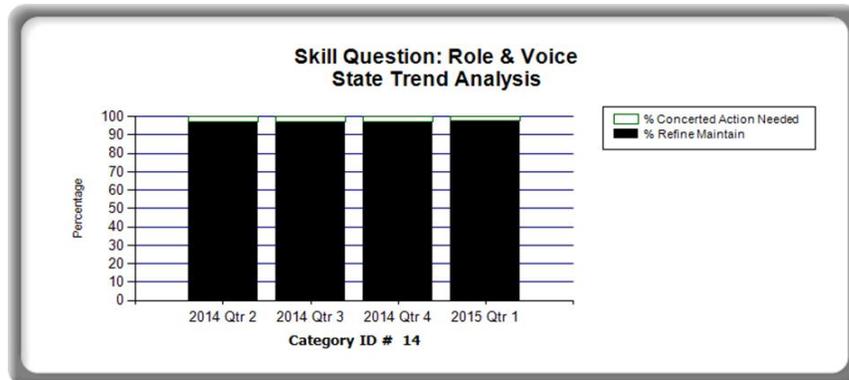
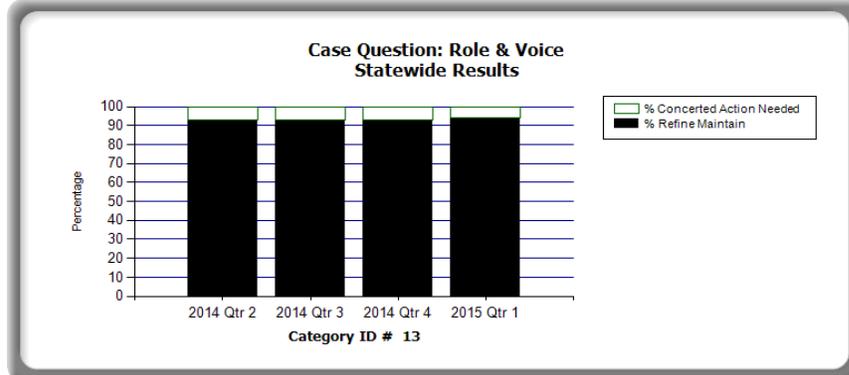
Both automated assessment and ongoing data reports are in the initial phases of development with the most critical QAR questions measured in developed reports. As these reports rollout and are refined, additional questions will be added in MaGIK.

Reflective Practice Survey (RPS)

Role & Voice

Case Observations

Skill Observations

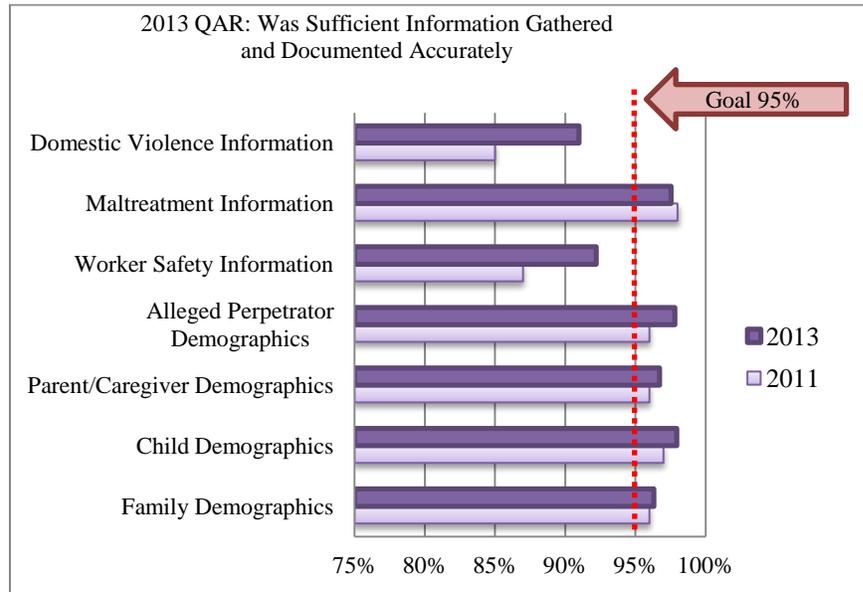


RPS data currently remains unreliable. In order to identify reasons, focus groups were conducted with Supervisor and Local Office Directors. Results from these groups further support the need for the agencies' goal of promoting a culture of learning. A comparable survey conducted by Staff Development produced similar results. See CQI section.

In addition, data validation questions are in the process of being added to the RPS tool. Supervisors will verify demographic data in MaGIK data by querying parents and children/youth. Supervisors will validate the data accuracy ensure any inaccurate or inconsistent data is corrected in the system.

Hotline OAR - Was Sufficient Information Gathered From Caller and Documented Accurately

QAR reviews are conducted quarterly by reviewing calls recorded by the hotline. QAR reviewers listen to calls and score the call based on whether hotline staff followed recommended policy and practice when asking questions. They review information gathered by Hotline staff and the information documented in the Child Abuse and Neglect Report. They look at the sufficiency and the accuracy of the information gathered by the Hotline staff. The chart below compares the results of 2011 and 2013 QAR Reports. Information is reported based on the topic. Domestic violence information and information obtained that ensures the FCM's safety are still below the Hotline goal of 95%.



Reporter Survey Data

In addition to the Hotline QAR, the PQI team also continues to conduct an annual Hotline Reporter Survey. Callers are asked if they wish to participate in a brief survey immediately following their report. If they agree to participate, they are transferred to a summer intern who asks the caller specific questions and documents their responses. The chart below reflects the questions asked and answers provided in the Fall of 2013.

Hotline Reporter Survey – Fall 2013					
<p>Q3: In regards to your current reporting experience reporting child abuse or neglect, please indicate the degree to which you agree or disagree with the following questions. I will read you a question and you will need to indicate if you: strongly agree, agree, are neutral (you neither agree nor disagree), disagree, or strongly disagree.</p>					
Answer Options	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
You were able to find the Hotline phone number easily	487 59%	310 38%	13 2%	12 <1%	3 <1%

Your call was answered in a reasonable amount of time	477 58%	321 39%	12 <1%	12 <1%	3 <1%
The Hotline staff listened to what you had to say	615 75%	208 25%	0 0%	2 <1%	0 0%
The Hotline staff was thorough in probing for additional information	572 69%	246 30%	5 <1%	2 <1%	0 0%
The Hotline staff was courteous and professional in receiving your report	640 78%	185 22%	0 0%	0 0%	0 0%

In 2014, the Hotline QAR process was reviewed to ensure that it was measuring the correct information based on what the Hotline requested. It was subsequently updated to include additional questions in QAR and the Hotline reporting period was changed to state fiscal year in order to align with other DCS reports. Hotline management staff utilize qualitative data collected from their call recording system along with the quantitative data from this report and other data sources to continuously improve their practices.

3. Method for Conducting Ongoing Case Review

The Region V Administration of Family and Children (ACF) office provided Indiana with an assessment of its current quality assurance system(s) in January 2014. This letter identified several system strengths with regard to Indiana methods for conducting ongoing case reviews.

- Indiana’s case record review instrument is utilized statewide and collects case level data, provides context, and addresses quality standards for best practice, Indiana’s Practice Model (TEAPI), safety, permanency, and well-being of children.
- Indiana has a process in place to conduct ad hoc reviews (Mini Reviews) to assess a specific area of practice.
- Indiana uses random sampling to select cases for review, and includes foster care and in-home services cases.
- Indiana’s QSR process includes case specific interviews with the child, parent, both formal and informal child/family supports, and key stakeholders in the case.
- Indiana’s QSR reviewers are required to complete New Reviewer Training, Mentor Training, and are mentored through a Shadow, two Lead, and a Mentor case review experience by a Mentor Qualified Reviewer prior to becoming Qualified Reviewers.
- Indiana has a formal process in place to ensure inter-rater reliability is achieved.
- Indiana has written policy that constitutes a conflict of interest for internal and external case reviewers.
- Indiana’s DCS Website posts the QSR Review Schedule to ensure awareness of the on-going case review schedule through Round 5, which includes representation of populations served, including the largest metropolitan areas. Updates to the DCS Website will reflect future QSR Rounds’ schedules as needed.
- Indiana implemented an additional level of IRR, which includes PQI staff serving as Site Leaders for discussion of indicators and justifications with individual review teams prior to mini-rounds.

- DCS developed an improved Advanced Reviewer Training for qualified reviewers; training will start in summer of 2015.
- DCS is expanding current processes to create supplementary data reports in order to measure and track similar data points before, during, and after the CFSR review. Various system indicators in the QSR will capture a 12-month timeframe to ensure consistency and quality of practice during the Period Under Review (PUR). Additional questions will be incorporated into the RPS to validate data captured for systemic factors. The Hotline QAR added questions that specifically reflect Hotline practice. DCS is currently in the process of developing a standardized pull from MaGIK reports in order to measure CFSR outcomes. DCS is now utilizing electronic binders for QSRs and OYS reviews. The electronic binders contain information completed by FCMs or Collaborative Care FCMs (3CMs) and reviewers access the remaining information through MaGIK.
- DCS is in the process of creating a Reviewer File that is auto-populated with data/information from MaGIK. This electronic Reviewer File will reduce preparation time for FCMs and 3CMs prior to the QSR and OYS. This will enable DCS to build capacity for an increase in OYS case review. This procedure will allow 3CMs to have multiple cases pulled during the review and will enable a statistically valid sample for OYS case review.
- DCS is in the process of relocating the QSR data and workbooks in MaGIK in order to integrate it with other DCS data.
- DCS is in the process of updating the QSR Protocol with CFSR related changes. Reviewers will receive information and training on updates to the QSR Protocol.
- DCS made modifications to the OYS Protocol and rollup sheet in order to improve data collection and trends identification.
- DCS is updating QSR trainings to reflect changes made to the QSR and OYS Protocols for the CFSR.
- Discussions regarding review of Juvenile Probation cases during the QSR have begun between DCS and Juvenile Probation representatives.
- DCS is currently adding an IRR process specifically for OYS Reviewers. OYS mentor reviewers are sent OYS indicators to rate quarterly. Data is collected on the accuracy of their rating of the indicator.
- DCS updated the QSR Database to contain the results of the quarterly Inter-rater Reliability Survey (IRRS). DCS will update the QSR Database to contain the results of the quarterly OYS IRS when implemented.

ACF also identified several opportunities for improvement as listed below. DCS will continue to evaluate opportunities to incorporate these ideas into its quality assurance system.

- Define in written policy what constitutes a conflict of interest for internal and external case reviewers.
- Consider developing ongoing training opportunities for provider reviewers, similar to current DCS reviewer practice (Advanced QSR reviewer training) and including this standard in future RFPs.
- Develop and share an on-going case review schedule which includes representation of populations served, including the largest metropolitan areas.

4. Analysis and Dissemination of Data

DCS has several methods for disseminating data to external audiences for a variety of purposes. A few of these methods are outlined below.

- Monthly Practice Indicator reports are published on the DCS website.

- Information is shared with several legislative study committees and associated task forces via quarterly data reports and in an Annual Report to the Legislative Budget Committee.
- Information about the DCS system, data summaries and ad hoc data reports are released to external stakeholders through media and public information requests.
- DCS supports Citizen Review Panel projects by providing data related to their project goals.
- Regional and local practice and financial data is provided to RSCs to allow assessment of regional trends and development of strategic plans to address local service needs. See Section I- C for additional detail.

To ensure data quality, DCS developed a Data Governance Committee which includes internal stakeholders from ODM, Research and Evaluation, PQI, Field Operations, Services, Placement, Practice Support, Finance, Communications, MaGIK, Constituent Services, and Legal to make sure data is consistent with existing data reports, to develop data reports which are easily understood, and provide clarity for data points in reports.

Data needs identified through implementation of a statewide CQI policy, should drive the collection methods and prioritization of report development. As outlined in Objective 4.1, DCS intends to develop regional CQI teams to support data driven decision-making and practice improvement at the local level. The agency does not currently have a consistent process for combining stakeholder feedback (providers, families, youth, courts, etc.) and connecting that information with quantitative data to get a comprehensive picture of trends and the functioning of DCS’s child welfare practice, which will be addressed as part of Objective 4.3.

In addition to developing regional CQI teams and identifying mechanisms for incorporating stakeholder feedback into the agency’s CQI policy, DCS needs to formalize a process for using information gathered and analyzed by local/regional teams to inform state-wide data analysis and decisions to pursue implementation of state-wide initiatives. Evaluating what this process will look like will be one aspect of Objectives 4.1 and 4.3.

Develop an ongoing case review for Juvenile Probation cases through the QSR process.

5. Feedback to Stakeholders and Decision-makers

DCS gathers feedback from stakeholders in a number of different ways. For example, DCS utilizes both internal and external stakeholders as qualified reviewers in the QSR process. To incorporate stakeholder feedback into the QSR process, DCS recently added a requirement to contracts that comprehensive home-based service providers have at least one qualified QSR Reviewer for each organization. There has been an overwhelmingly positive response from service providers. Many providers have sent several staff members to QSR training and they have participated in multiple regional QSRs across the state. The providers shadow QSRs in the region(s) they serve. Providers attend and give their feedback at the Regional Service Council (RSC) meeting where the QSR results are presented. DCS also gathers feedback from stakeholders as outlined in the Collaboration section I-C.

DCS makes concerted efforts to gather feedback from a variety of stakeholders. The QSR has a definitive process to communicate back to stakeholders, which includes presenting QSR data at the Regional Service Council meetings. External stakeholders are present at these meetings and are able to ask questions and provide feedback. In addition, Regional Service Coordinators are in attendance at RSCs and are able to provide feedback to Service & Outcomes. DCS has been developing a standardized procedure for including and incorporating stakeholders in the broader CQI process along with more formal mechanisms for communicating the results of decisions back to stakeholders. See CQI section.

D. STAFF TRAINING

The training opportunities available to DCS staff and the commitment of the Staff Development Division to continually evaluating employee professional development and training needs is an incredible strength for DCS. The DCS Staff Development Division and the training curriculum offered for all levels of DCS staff has evolved significantly since the agency's creation in 2005.

In order to support training for hundreds of new employees each year, in addition to over 3,400 current staff, DCS maintains a Staff Development Department with 75 employees. The Staff Development Department works in conjunction with Indiana University (IU) to develop and deliver high quality, relevant training content. Currently, the Department offers 103 classroom and 67 computer-assisted trainings, in addition to the twelve (12) week new FCM training.

There are two primary tools used to assess performance of DCS training initiatives.

The Child Welfare Education and Training Partnership (CWETP), a partnership between DCS and Indiana University, utilizes a formal training evaluation. DCS staff complete an evaluation of training which is compiled and analyzed by Indiana University. IU provides quarterly and annual reports to DCS. Pre and post testing of new FCMs is also included in the CWETP. All Providers complete evaluations of trainings offered by DCS. DCS is working on incorporating an evaluation process for providers. This formal evaluation was incorporated into Foster and Adoptive Parent Training effective June 1, 2014.

The Indiana Training Needs Assessment (ITNA) report identifies training needs as reported by Family Case Managers and Family Case Manager Supervisors. Outcomes from these evaluations are included in the sections below.

1. Initial Staff Training

DCS created a comprehensive new FCM training program in 2006. All new FCMs complete twelve (12) weeks of training prior to taking on a case. Over time, DCS' new FCM training has been updated to reflect feedback of graduates and practice improvements. The formal training evaluation for the 2014 first quarter indicated that initial staff improved 96 % from pre to post testing. The areas of improvement that were identified by participants were in training regarding sexual abuse cases and initial staff case closures. The ITNA was used with Family Case Managers in 2012 and with Family Case Manager Supervisors in 2013. Veteran staff identified domestic violence, child development and substance abuse as training needs.

During most of fiscal year 2006, new FCMs participated in twelve (12) weeks of classroom training, four (4) of which took place in Indianapolis, with the other eight (8) taking place in one of the DCS regional training centers. The training was updated in 2006, 2009, and 2011 to reduce the number of days in the classroom and increase the days of on-the-job training. The current new FCM training, implemented on July 1, 2011, consists of twenty nine (29) classroom days, twenty one (21) local office based transfer of learning days and ten (10) local office based on the job reinforcement days.

To better support staff transitioning into the challenging work of case management, a Field Mentor Program was implemented in 2007. This program matches a trainee with an experienced, trained, Family Case Manager in the local office to provide one-on-one support. When challenges are noted, training can be adjusted to better facilitate the transfer of learning from classroom to the actual practice of child welfare. In collaboration with Dr. Anita Barbee from the University of Kentucky, a comprehensive Skill Assessment Scales tool was developed to assist the Field Mentor with providing feedback to the trainee based on established, research-based competencies. Feedback from this process is used as a framework for developing additional training assistance if needed, as well

as to provide necessary modifications to the new FCM curriculum. This project is on the cutting edge of national best practices in training and supervision of frontline child welfare FCMs.

During 2014 a total of 431 new workers completed new worker training, completing both a pre-test prior to the onset of classes and a post-test administered upon completion of all classes. The pre-test score was an average of 54.8 and the post-test score was an average of 73.4, resulting in an 18.6 percent improvement on average. All but one of the 431 new workers trained during 2014 showed an improvement from their pre-test to their post-test. Additionally, evaluations for each class were completed by participants subsequent to every class. These evaluations had twenty questions that were each rated from a low of one to a high of five. The class evaluations completed during 2014 were given a mean overall rating of 4.32, indicating that new workers rated the training that they received as “exceeds” expectations.

The new worker training program was redesigned during 2014, with the onset of the pilot in January, 2015. Most of the training content was retained in the redesign since the new worker training received high scores, as measured by both the comparison of pre-test and post-test scores administered to all new workers to measure knowledge acquisition, as well as the evaluations completed subsequent to each class. Both of these were cited in the prior paragraph. Most of the redesign changes were made in the training delivery replacing much of the classroom lecture with the use of computer assisted trainings to provide the foundational knowledge on each of the training topics. The classroom delivery moved to facilitated discussion and small group activities, using more actual real case examples, to develop critical thinking skills at a higher level. First quarter pre-test scores were 53.6, and post-test scores were 72.6, resulting in a 19 percent improvement. DCS is currently working to determine how to correlate classroom learning with improved outcomes for children based on our permanency outcomes and practice indicators.

With the new cohort redesign new workers receive 1-2 cases during their last weeks of the training for the purpose of applying what they have learned. Casework is completed working closely with the assigned mentor and the assigned supervisor. Each new cohort member must complete all of the work assignments of the initial training and graduate from the cohort prior to being assigned a caseload in MaGIK. All new workers in child protection services and in on-going services are DCS employees who begin the new worker training curricula on the first day of employment as a family case manager.

Additional information is provided in the 2015 DCS Training Plan.

2. Experienced Employee Training

Ongoing training of staff was identified as an area needing improvement in DCS’ Round 2 CFSR. Throughout the course of the 2010-2014 CFSP plan period, DCS invested significant resources to develop a robust training plan for all levels of staff. DCS recognizes that staff expertise is a critical component of achieving positive outcomes for children and families and to that end, has established an expectation that staff professional development remain a priority. DCS memorialized this expectation in Policies GA 10 and GA 11 (available at <http://www.in.gov/dcs/2516.htm>), which requires all levels of staff to satisfy certain annual training requirements. These hours can be a combination of classroom and computer assisted trainings.

The training curriculum now available to staff includes more than 109 different types of training courses and provides staff ample opportunity to satisfy the annual training requirements. It also supports continued professional development for all staff. Additional detail about the training program and course offerings, including the extensive array of leadership trainings offered, is included in Section XI -D.

In addition to the expansive training curriculum available for experienced FCMs and other staff within the Department, Staff Development also offers initial Family Case Manager Supervisor training for all new supervisors. Supervisors identified judgment and critical thinking, case work supervision and public community relations as areas in need of improvement.

Staff Development also provides the Leadership Academy for Supervisors, which is inclusive of the National Child Welfare Workforce Institute model. Local Office Directors and Central Office Middle Managers continue to be trained in the Leadership From Within training. This training focuses on leadership styles and leadership concepts. DCS also provides leadership training for middle management staff aspiring to promote into executive level positions. This comprehensive, intensive 6 month training program is known as the Child Welfare Management Innovations Institute. Participants are trained on various aspects of leadership and complete a change management project during the course of the training. The second CWMII class graduated in May 2014.

Experienced workers participating in classes complete a training evaluation at the end of the day for each class. The Yearend Training Evaluation Report for 2014 indicates a mean score average of 4.12 for all classes, on a one to five scale, where five is a perfect score. This indicates the training provided to experienced workers exceeded expectations. There were a total of thirteen different classroom training courses repeated in locations throughout the state during 2014. During the first quarter of 2015 experienced workers completed the course evaluations which resulted in a mean of 4.2 for all classes, which is slightly higher than the 2014 mean, indicating that training continues to exceed the expectations of experienced workers.

The Experienced Worker Classroom and Computer Assisted Trainings are registered for in Peoplesoft ELM. For classroom trainings an attendance sheet is maintained for each class and completion is recorded into the ELM system. The CATs are accessed through ELM and completion is tracked within the system. Supervisors have access to each team member's training list in order to ensure that each employee completes the required number of annual training hours.

3. Foster and Adoptive Parent Training

Training for current and prospective foster and adoptive parents was also identified in CFSR Round 2 as an area requiring improvement. To address this issue during SFY 2011, DCS assumed responsibility for foster parent training for DCS direct managed homes, a service previously contracted to a private provider. By directly providing foster parent training, DCS was able to expand the number and types of course offerings, and ensure improved consistency in the course curriculum / content. This change allows the agency to further its goal of reducing barriers to becoming a licensed foster parent. Now prospective foster parents can take classes at night or on the weekends when the training fits into their schedules, while obtaining the skills and knowledge they need to provide quality care for DCS wards.

DCS is collaborating with Licensed Child Placement Agency (LCPA) Providers to develop trainings for their foster parents. DCS also meets with LCPA representatives quarterly to identify their training needs. In the most recent meeting, the workgroup identified four trainings as a need. They include: Behavioral Interventions, Trauma Informed Care, Substance Abuse and Cultural Competence. DCS is also currently collaborating with LCPA agencies to provide and share training for LCPA supervisors on these and other topics.

During the second quarter of 2014 class evaluations for the Resource and Adoptive Parent training was added to the Partnership Training Evaluation System. Results from the second quarter through the end of 2014 indicate that a total of 18 different classes were provided throughout the 18 regions to a total of 5,625 foster parents during the three quarters evaluated. The mean score on the evaluations, using a scale of 1-5 where 5 is a perfect score,

was 4.52. This indicates that the training “highly exceeds” the expectations of the foster and adoptive parents. During the first quarter of 2015 the mean score for all trainings was 4.5. Although this first quarter is slightly below the 2014 mean it is still within the “exceeds” ranking.

DCS in partnership with the Licensed Child Placing Agencies has now completed the development of the additional therapeutic curricula for foster parent pre-service. These courses include Trauma Informed Care, Sexual Abuse, Managing Challenging Behaviors and Cultural Competencies. This uniform curriculum was provided to the LCPAs by a series of “train the trainer” classes that occurred from December 2014 through March 2015, with the goal that the LCPAs would begin to use the new curricula subsequent to training the trainers, and no later than July 1, 2015.

Each foster parent is required to complete 15 hours of in-service training annually. Upon completion of each training class the foster parent is provided with a certificate of completion which is given to their licensing specialist. The licensing specialists maintain a record of the training hours to ensure that the annual requirement is met.

E. SERVICE ARRAY

There are three core objectives for services paid by DCS.

1. To ensure a safe home environment,
2. To create permanency for children and youth, and
3. To maintain/develop a strong level of well-being for children and youth.

The DCS service array supports a safe home environment by providing the following services throughout the state. Home-based services including case management and therapy; Homebuilders; mental health services in collaboration with the Community Mental Health Centers including Medicaid Assessment to connect to the state-wide program 1915i to prevent residential placement for mental health needs, Medicaid Rehabilitation Option (MRO) services, and the prevention program, Children’s Mental Health Initiative (CMHI); substance abuse assessment and treatment including the Sobriety Treatment and Recovery Team (START) model; other prevention programs including Healthy Families Indiana, Community Partners for Child Safety, and collaboration with Prevent Child Abuse Indiana across the state; and general products and services.

In addition to the above listed services, DCS expanded the service array in 2014 to include comprehensive home-based services that include many evidence-based practices such as Family Centered Treatment, Trauma-Focused Cognitive Behavioral Therapy, Motivational Interviewing, Cognitive Behavioral Therapy, Alternatives for Family Cognitive Behavioral Therapy, Child Parent Psychotherapy, and Intercept through Youth Villages. These evidence-based programs are designed to not only address the home environment, but also to address child well-being.

The breadth of evidence-based, trauma-informed services now available to help children and families is a system strength; however, there is concern that the service array is too complex for case managers to know every service that exists. To help address this concern, DCS is using scores from the Risk and CANS assessment tools to map to services most likely to meet a family’s unique needs. See Objective 1.1 . The goal is that service mapping will help to address the complexity of the added Comprehensive Home Based Services in 2014 and beyond. Service mapping is currently being piloted by selected teams throughout the state. Statewide implementation is expected July 1st. (See Service Mapping section for more information.)

The service array for achieving permanency for foster and adoptive children include the above mentioned service

array (when appropriate) in addition to: Older Youth Services including Collaborative Care, Youth Connections, Connected by 25 utilizing Education and Training Vouchers (ETV) funds, Permanency Roundtables, Special Needs Adoption Program specialists (SNAPs), Regional Foster Care Specialists, and Relative Specialists. Having all of these comprehensive services across the state is also a strength of the DCS service array. An additional strength is that because many of the services are home-based, client transportation to receive the services is less of an issue.

1. Statewide Data Presentation and the Biennial Regional Strategic Services Plan

DCS collaborates with community stakeholders involved in child welfare through multi-disciplinary teams in each of DCS' 18 regions, known as Regional Service Councils (RSC). The RSC's complete biennial plans, which include service arrays for the regions. All DCS regions conduct the Biennial Regional Strategic Services Plan (BRSSP) process (See Section I-C, Collaboration section, for a complete description of this process).

The Regional Management Team and Regional Service Council, in conjunction with regional service coordinators and performance quality improvement team staff, developed the BRSSP for July 1, 2014 – June 30, 2016. These plans incorporated CQI plans developed through the QSR and RPS processes, the child protection plan and the early intervention plan. The biennial plans also identified gaps in services and strategies to improve the quality of services and available service array in a region. State-wide quantitative and qualitative data, ad hoc reviews, and improvement planning outcomes were used to assess regional progress on their plans. Prevention data were part of the data used to develop the BRSSP, as well as regional reports on contracted community-based services by county and their utilization in SFY 2013 (whether or not the service provider had a payment in SFY 2013). These data were used by the regions to develop both service strengths and gaps that could be addressed by DCS and the local communities. The Regional teams continue to utilize their plans to develop services within their regions and address service gaps that exist.

The Regional Management Team and Regional Service Council, in conjunction with regional service coordinators and performance quality improvement team staff will begin development of the BRSSP for July 2016 – June 2018 in the fall of 2015. As in past years, these plans will be developed using a collaborative approach which includes representation of stakeholders from the provider community, foster parents, youth, clients, probation, courts, CASA/GAL and prosecutors. The plans will identify gaps in services and strategies to improve the quality of services and available service array in a region. Regional Action Plans will include the specific steps each region will take to improve in the following areas:

- Increase permanency in 12 months for children in foster care 24 months or more by 2%
- Reduce maltreatment in foster care by 6%
- Reduce recurrence of maltreatment by 2%

As DCS prepares to begin the Biennial Regional Strategic Planning process during the fall of 2015, data points similar to those used in 2014, are being prepared for the regional teams. In recognition of the increase in cases where substance use is a contributing factor, a main area of focus will be on improving the service array and capacity within each of the regions. The BRSSP will serve as the roadmap for CQI efforts within each region. In addition, each plan will include a measurable goal related to improving access to or retention in substance use disorder treatment.

2. Safety and Risk Assessment Data

There is no change in the information provided in the CFSP for this section.

3. Child and Adolescent Needs and Strengths Assessment

DCS utilizes the Child and Adolescent Needs and Strengths assessment tool to aide family case managers in identifying the individualized strengths and needs of a child and his/her family. Each month, the MaGIK system provides reports for field staff to review the Child and Adolescent Needs and Strengths (CANS) tools completed the prior month for that region. Within the region's report, viewers of the report can drill down to county and case level information. This detailed report provides information to the regional managers and local office directors on those cases that could be referred for Medicaid services (if the child's behavioral health CANS recommendation is 3 or higher) as well as other diagnostic and evaluation services.

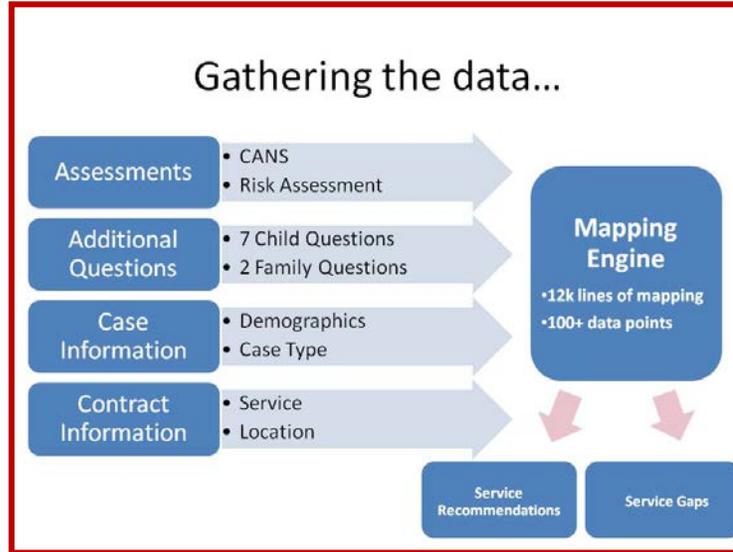
A score of 3 or higher on the CANS behavioral health recommendation indicates supportive community-based services, intensive community home-based services, or high intensity services are needed to address concerns around mental health issues in the child/youth. It is also important to connect the child and family to the local community health center to ensure continuity of care after DCS involvement ends. DCS utilizes the CANS extensively as part of the Service Mapping project to ensure services are provided that are individualized to the child and family's needs.

The CANS report also indicates the placement CANS recommendations that are used to identify the level of care as well as services, and funding for contracted placements/foster care if the child requires placement outside of the home. These CANS reports can also be used during case supervision with the case managers to ensure the child and family are being connected to appropriate services.

4. Service Mapping and Continuous Quality Improvement

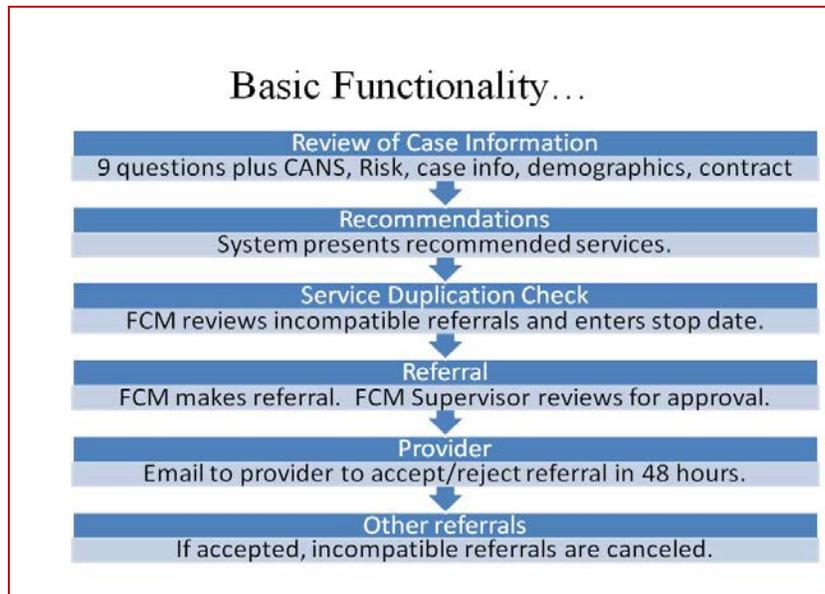
One of the most important products that has been developed as a result of the Title IV-E Waiver is Service Mapping. DCS is in the fortunate position, as a result of the Title IV-E Waiver, of being able to greatly enhance its community based service array. DCS has chosen to do this by enhancing the service array with multiple evidence-based practice models. With this expansion, and each EBP having a specific target population, the service array has become too complex to utilize traditional service referral methods, thus necessitating a more complex system of making referrals. Service mapping provides an electronic service consultant, allowing even inexperienced Family Case Managers to make quality service decisions. The system reduces the use of cookie cutter services, by utilizing assessment and other information to recommend services for families based on their individual circumstances, improving the chances for positive outcomes.

FIGURE 1. GATHERING THE DATA



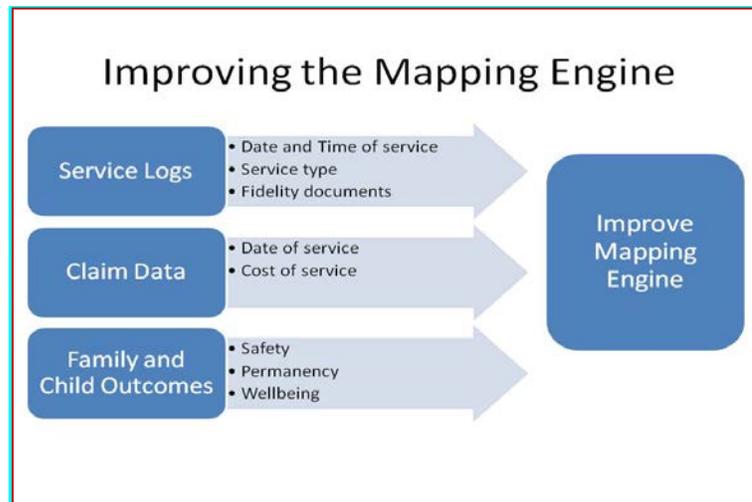
The system utilizes information from the Child and Adolescent Needs and Strengths assessment as well as the Structured Decision Making tool for Risk Assessment. In addition the Family Case Manager is asked seven questions about each child and 2 questions about the family. This information is paired with the case information (demographics, case type, other information) and contract information to produce service recommendations for the family. The Mapping Engine utilizes more than 100 data points in order to determine individualized services for families. There are more than 12,000 different ways for a family to map to a service. In addition to Service Recommendations, the Mapping Engine provides information about service gaps. Essentially summarizing what services would have been mapped had they been available in the community.

FIGURE 2. BASIC FUNCTIONALITY



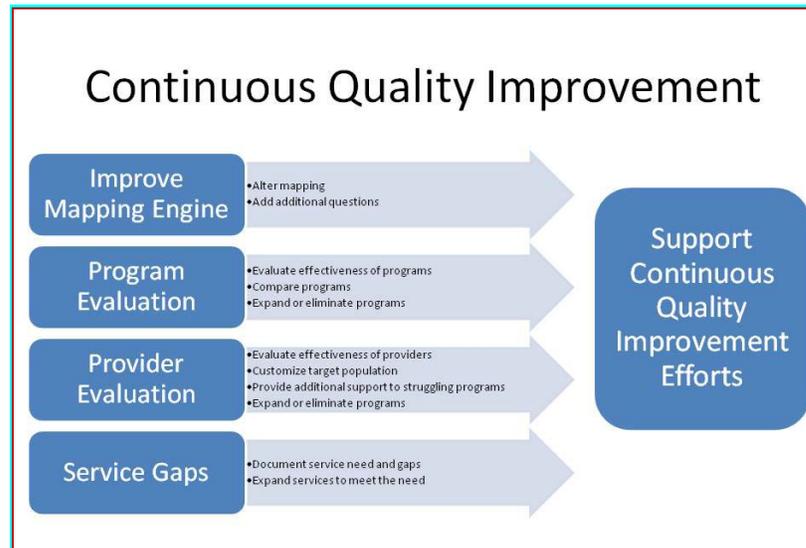
The basic functionality includes gathering information and providing a recommendation. Also, to ensure service duplication is minimized, the system checks to see what other services are being provided at the time a new referral is initiated. These duplicative referrals are cancelled in the system if the provider accepts the referral in the system within 48 hours. Providers, Family Case Managers, and Supervisors are notified via email of the referral progress as it moves through the system (e.g., when the referral is sent to the provider via email, when the provider accepts or rejects the referral, when the duplicative referrals are cancelled).

FIGURE 3. IMPROVING THE MAPPING ENGINE



Several other systems work in conjunction with the Mapping Engine. Service Logs were developed to provide detail data on the actual service provision, including the date and time of service, the type or category of service being provided as well as any fidelity documents or milestones that pertain to the model. Claim data will also be utilized to show the cost of the service provision. Family and child outcomes in the areas of safety, permanency, and wellbeing will be utilized as well to improve the mapping engine and ensure the families are matched to the most appropriate services.

FIGURE 4. CQI AND SERVICE MAPPING



Service Mapping is a critical part of the Continuous Quality Improvement of services. As DCS looks to make improvements, the focus will be on the outcomes of children, youth, and families. The Service Mapping engine will be altered as more information becomes available as to the success of the families involved in the various services. The mapping may be altered to provide alternative recommendations for families who are not successful in the recommended services. Additional questions may be added to determine more information about families to improve service recommendations.

Programs will be evaluated to determine the effectiveness of programs with specific target populations. The Family Centered Treatment Sub-study is one example of how program evaluation is tied to service mapping. Results from this study may expand or eliminate programs or alter the target population served by specific EBPs. In addition to evaluating at the program level, DCS will evaluate at the provider level. This information will allow for comparison between providers. This could lead to further refinement of the target population by service provider, further support and training of the provider, or elimination or expansion of some service provider services.

Service gaps will be identified and closely monitored. This information will assist DCS as regional needs assessments are completed to develop the Biennial Regional Services Strategic Plans. The plan could lead to an expansion or elimination of services in a particular county or region.

DCS has a vast array of services available to meet the needs of families and children. The service availability for each region is attached to the CFSP. **It should be noted that** contracts are in place statewide for Family Centered Treatment, Motivational Interviewing and Trauma Focused Cognitive Behavioral Therapy. Other programs are offered in selected communities.

F. AGENCY RESPONSIVENESS TO THE COMMUNITY

The Collaboration section under General Information includes a complete description of the methods by which DCS is responsive to the community.

DCS continues to look for opportunities to work with stakeholders to review and provide feedback on the goals and objectives outlined in the CFSP. To date, the agency has reviewed the goals and objectives outlined in the CFSP with two provider groups – the Community Mental Health Centers (CMHC) and the Community-Based

Providers. Feedback from these two organizations was incorporated into the goals. As an example, DCS added an objective and modified several interventions under its safety goal as a result of feedback from the CMHC workgroup.

In the coming months, DCS intends to review the agency's CFSP goals, objectives and interventions with other stakeholder groups, and will incorporate feedback and revise the plan as appropriate. As an example, DCS plans to schedule a meeting with tribal representatives from the Pokagon Band of Potawatomi Indians, Indiana's only recognized tribe. DCS also intends to review the plan with several work groups representing Licensed Child Placing Agency and Residential Treatment Facility Providers during an upcoming meeting.

Collaboration on Prevention Efforts

DCS has built a strong network of partnerships with other state departments and councils that also lead a variety of related prevention efforts. DCS works closely with the Indiana State Department of Health and their prevention efforts to ensure children arrive at school healthy and ready to learn which includes Early Childhood Comprehensive Systems (ECCS), Project LAUNCH, Maternal Infant Early Childhood home Visiting (MIECHV) and Safe Sleep Projects. DCS also works closely with the Family and Social Services Administration (FSSA) and their prevention efforts to meet the mental health needs of children as well as support and preserve families through their Child Care Development Fund (CCDF), Temporary Assistance to Needy Families (TANF) and Head Start Collaboration Office (IHSCO).

Collaboration for Older Youth Services

Service providers and case managers continue to ensure that youth are referred to Work One, through the Indiana Department of Workforce Development (DWD) for employment related coaching, TASC (Test Assessing Secondary Completion) classes, and testing. Specifically, DCS partners with the Department of Workforce Development (DWD) JAG (Jobs for American Graduates) program to identify foster youth in their junior and senior year in high school. Foster Youth continue to be prioritized for local Work One initiatives. More specifically, foster youth have been prioritized to participate in the Indiana Lt. Governor's State Fair Summer Employment Opportunity program.

Enhanced Multidisciplinary Team (EMDT)

The DCS hosts the EMDT which includes leaders from other state agencies including the Family and Social Services Administration (Division of Mental Health and Addictions, Bureau of Developmental Disabilities Services, Office of Medicaid Planning and Policy, Division of Aging) and the Department of Corrections. This group exists to ensure systems are cooperating to provide a full continuum of services to children and families.

G. FOSTER AND ADOPTIVE PARENT LICENSING, RECRUITMENT, AND RETENTION

As reported in the CFSP, licensing of foster homes and residential facilities remains vitally important for DCS. First, DCS strives to license relatives to provide needed financial support to the relative and children. Second, DCS will always need quality, unrelated foster homes when a relative cannot be located to care for a child. Third, residential treatment will be needed at times for children with serious behavioral health needs in order to stabilize and return them to the community. Thus, DCS must continue to work to ensure that quality foster care and residential programs are available to children and families in Indiana.

With regard to foster family homes, DCS licenses these homes through DCS local offices and through licensed child placing agencies (LCPAs). LCPAs are private agencies that are licensed by DCS and in turn license foster

homes on behalf of DCS. For foster homes licensed through DCS local offices, DCS has 98 Regional Foster Care Specialists (RFCS), who are dedicated to recruiting, licensing and supporting/retaining foster homes. LCPA staff and RFCS staff are provided consistent guidance and information through collaboration between the LCPA Licensing Unit and the DCS Central Office Foster Care Unit staff. This information is provided through monthly calls for the LCPAs and monthly meetings with the supervisors for the RFCS staff.

DCS also has 31 Relative Support Specialists (RSS), who provide critical support to a relative in the first 30 days of placement. This includes explaining all of the financial options available to the relative, including licensure. DCS has 21 Supervisors who manage the RFCS and RSS staff.

During the past year, DCS has seen an increase in children being placed into out of home care. Due to the growing number of reports to the Hotline that require removal on assessment, the number of children in out of home care in April 2015 was 12, 831, with 5,799 (45.1%) residing in non-related foster homes and 5,965 (46.5%) residing in relative caregiver homes. While the number of children placed with relative caregivers continues to increase and is desired when removal must occur, the current increase of 2,427 children residing in out of home care settings (834 more in foster care) has certainly maximized usage of available placement resources within Indiana. The availability of the 98 Regional Foster Care Specialists (RFCS) has been even more important under these circumstances, as they are able to employ increased knowledge and placement networking to find available matches for children in a climate of more limited availability. They are also a valuable resource in advocating and facilitating appropriate supportive services to foster homes if they are called upon to stretch their capacities to accommodate the needs of children.

DCS continues to contract with the Children's Bureau, Inc. (CB) for adoption recruitment services. CB collaborates with local diverse neighborhoods, faith-based organizations, and minority leaders to recruit appropriate families that reflect the diversity of children in the state for whom adoptive homes are needed. CB handles local recruitment through Adoption Champions (people who have a personal tie to adoption and can answer the public's questions at various events), prepares the monthly "Opening Hearts, Changing Lives" adoption picture book, and assists in the coordination & hosting of matching events.

DCS has also contracted with Transform Consulting Group for The Heart Gallery since December 1, 2012. The Heart Gallery is a program that has been implemented in almost every state. The program expands the exposure of children eligible for adoptive homes to a wide range of individuals beyond the DCS website and the "Opening Heart, Changing Lives" adoption book publication. The gallery pictures are professionally done and capture the child's unique personality. The Indiana Heart Gallery exhibits travel to different events, including two major heart galleries, and many minor galleries. These galleries are placed across the state in churches, libraries, and businesses. The travelling Indiana Heart Gallery collaborates with CB to on educational and public relation events about adoption.

In addition to efforts of CB & Transform Consulting Group, Special Needs Adoption Program (SNAP) Specialists continue to walk potential adoptive parents through the adoption process and to serve as a liaison for post-adoption service referrals. SNAP Specialists work on behalf of potential adoptive families and children waiting to be adopted by assisting local offices with the matching process.

1. DCS Licensed Foster Homes

The DCS Central Office Foster Care Unit has continued to work with Office of Data Management staff and foster care field staff on the development of reports to assist in determining the effectiveness of the foster care program at ensuring consistent quality and standards for foster home licensure. The development of these reports is a

standing agenda item for monthly meetings with foster care supervisors and managers. Some progress has been made in report development within the last year. Reports providing data on the timeliness of licensure, and regional and state-wide summary numbers of licensed foster homes are completed and available for use by staff, as described in more detail below. A report addressing factors important to recruitment of foster parents (relating to statistics of children placed in homes out of county or region) is the current focus. An early version of this report was determined to need further manipulation, in order to add other necessary data points to enable the report to be utilized to improve services.

Several other reports related to reasons for foster parent withdrawal, homes approved with waivers or exceptions, and foster home utilization and available capacity, are all in continued development. Because of the concurrent ongoing development of Management Gateway for Indiana’s Kids (MaGIK- Indiana’s enhanced SACWIS system), certain reports have been delayed because the required data points have not yet been refined within MaGIK to allow for a meaningful extraction of data. However, the development of a full array of data and reports remains a goal.

Employee Performance Metrics

The following reports, in addition to those on the five year plan for development, will help in the quantitative measurement of staff performance. The following report metrics will also be analyzed in order to relate their impact on the qualitative outcomes measured during each region’s yearly review. The reports that are currently available include the following data related to employee performance:

Timeliness of Licensing.

This report measures the average time (in days) for FCMs to complete licensing. This report provides data by region and the total, and can be viewed at a granular level by name of RFCS. In April 2015, 51 non-relative homes and 30 relative homes were licensed. The average time to complete licensing for the non-relative homes was 118.4 days, and for relative homes was 107.6 days. Further state wide data can be seen in the charts below.

TIMELINESS OF LICENSING License Approved in Last Month 4/1/2015 - 4/30/2015				
	No Relative Restriction	Avg Days	Relative Only	Avg Days
Statewide Total	51	118.4	30	107.6

TIMELINESS OF LICENSING License Approved in 2-6 Months 11/1/2014 - 3/31/2015				
	No Relative Restriction	Avg Days	Relative Only	Avg Days
Statewide Total	259	127.2	184	108

TIMELINESS OF LICENSING License Approved in Last 7-12 Months 5/1/2014 - 10/31/2014				
	No Relative Restriction	Avg Days	Relative Only	Avg Days
Statewide Total	367	119.7	239	93.1

TIMELINESS OF LICENSING License Approved in Last 13-24 Months 5/1/2013 - 4/30/2014				
	No Relative Restriction	Avg Days	Relative Only	Avg Days
Statewide Total	645	119.1	460	90.2

Caseload information regarding the number of licensed homes and homes licensed in the last month by FCMs appears on the Timeliness of Licensing report listed above. This is a good tool for supervisors to assist FCMs in staffing barriers that arise due to timeliness of licensure and identification of any issue areas or personnel.

Summary data for the state, including a break down by region and by county, is available for the following data points:

Total licensed homes; broken down by DCS or LCPA; non-relative or relative. This information is available state wide, and by region. As of May 15, 2015, the report provides the following state wide data:

	DCS Licensed			LCPA Licensed			DCS & LCPA Total
	Relative Only	Non Relative	Total	Relative Only	Non Relative	Total	
Final Totals	988	2464	3452	18	1917	1935	5387

An example of the data report for Region 9 is included below, as of May 15, 2015.

Reg	County Name	DCS Licensed			LCPA Licensed			DCS & LCPA Total
		Relative Only	Non Relative	Total	Relative Only	Non Relative	Total	
9	Boone	3	17	20	0	5	5	25
	Hendricks	19	61	80	1	31	32	112
	Montgomery	7	17	24	0	5	5	29
	Morgan	12	31	43	0	17	17	60
	Putnam	1	10	11	0	6	6	17
	Region	42	136	178	1	64	65	243

	Total:							
--	---------------	--	--	--	--	--	--	--

Total applications pending for initial application, annual review, and re-licensure. This information can be pulled through inquiries in the system but a standardized report providing this information is in continued development.

Program Metrics

The DCS FCU will utilize the report above and additional reports identified in the five year plan once they have been finalized for an annual review of each Region’s foster care program. We continue to work toward finalizing the necessary reports in order to establish baseline information from which to conduct such an analysis and set quantitative benchmarks related to the goals identified for Objective 2.4 The Regional Managers and the DCS FCU continue to meet and discuss appropriate ways to reach the goals; their efforts are described more fully in Section IV, Plan for Improvement & Progress Made to Improve Outcomes related to Objective 2.4.

Licensing and Practice Review

The Central Office Foster Care Unit has developed a compliance review tool and process, fashioned after the existing tool/process utilized for LCPA reviews, and plans to pilot file reviews in two DCS regions in the months of May and June. Based on those experiences, a finalized plan and policy will be implemented for the completion of these reviews annually in each region. With regard to the QSR data to support foster care program evaluation and development, there have been preliminary discussions and agreement regarding this need. Meetings to actively plan for this are expected to occur in upcoming months.

Once the data has been compiled from the Quality Service Review and Licensing Compliance Review (LCR) the Foster Care Consultant will create a comprehensive data report to regional and program management. This report will consist not only of QSR and LCR data, but also summary data from the RPS, performance and program metric reports. From the comprehensive report, regional management and the Foster Care Consultant will identify goals and program enhancements to help ensure success in reaching the goals. At the region’s subsequent review, prior scores will be compared to current scores as well as evaluating the region’s progress in achieving goals outlined.

2. Licensed Child Placing Agencies

There are 36 LCPAs that provide foster care services licensed by DCS. The DCS Residential Licensing and Contract Compliance Unit (RLCCU) licenses these LCPAs, and then DCS contracts with these agencies to provide foster care services, including recruitment, licensing and support/retention. As of May, 2015, there were 1,935 foster homes licensed through LCPAs as compared to a total of 5,387 licensed foster homes in Indiana.

When the DCS RLCCU licenses an LCPA, DCS ensures that the LCPA and the foster homes managed by the

LCPA meet Indiana statutes, rules, and policies. While LCPA licenses are valid for 4 years, DCS RLCCU conducts annual licensing reviews of LCPAs to ensure that Indiana statutes, rules and policies continue to be met. DCS plans to make revisions to the Indiana Administrative Code within the next five years related to LCPA regulations.

DCS RLCCU implemented a revised licensing audit tool for foster care LCPAs beginning in March of 2014. Three LCPAs were selected as pilot sites for implementation of the revised tool. A team of consultants from the RLCCU, each including at least three licensing consultants, conducted each review that was a part of the pilot. After the completion of the pilot audits, feedback regarding the review process was solicited from LCPAs as well as the licensing consultants who conducted the reviews. Persons from RLCCU met with the foster care committee of the state organization of facilities following the pilot and received feedback and input from that organization. Changes were made to the tool accordingly prior to the state-wide roll out of reviews using the new tool. Licensing consultants participated in four of hours of training regarding the new tool prior to the pilot and have continued to receive training following implementation to ensure continuity.

When an LCPA is not meeting licensing and/or contract standards, DCS RLU utilizes a Plan of Correction. Depending on the nature of the non-compliances, DCS RLU may also institute a placement hold and/or a probationary status on the license. Additionally, if an individual foster home is not meeting standards, the same actions can be taken.

Consistency in Application of Licensing Standards

The Central Office Foster Care Unit has 3 consultants who provide guidance and oversight to DCS and LCPA staff regarding the licensure and monitoring of foster homes. Two of the consultants work with DCS licensing staff, and one consultant works primarily with LCPA licensing staff. Their duties are largely to ensure consistency in the standards that are being applied state wide. Their activities include consultation and training to DCS and LCPA staff regarding foster care policies and practices, as well as approval of certain licensing activities. The staff work closely together to monitor complaints or concerns regarding foster homes, utilizing a Licensing Complaint Response Form, for communication about plans for development or intervention to resolve issues.

Waivers

Additionally, licensing staff are required to submit any licensure requests with associated waivers to these consultants for evaluation of appropriateness and approval. Waiver requests must meet two criteria:

- 1) that meeting the requirement places an undue hardship on the applicant; and
- 2) that waiving the requirement will not compromise the health, safety and welfare of children.

Data indicates that 1538 non-relative foster homes were licensed within the past year, with 254 (16.5%) of them receiving an approved waiver. Additionally, 501 relative foster homes became licensed within the past year, with 167 (33.3%) of those homes being approved with a waiver. The most common reasons for waivers include: exceeding capacity regulations (generally to accommodate sibling groups), having a bedroom located in a basement, and physical environment accommodations such as having less bedroom square footage per child (most commonly for relative homes).

LCPA Licensing Reviews

The LCPA licensing review is composed of three components,

- 1) an administrative review of the LCPA;

- 2) a review of a sample of foster home/parent files and
- 3) a review of a sample of children's files.

The sample size varies depending on the number of homes licensed by the LCPA and the number of children in placement in those homes. For facilities with more than 50 licensed homes and more than 50 children in placement, the sample size is 20%. For homes with fewer than 50 homes and children, the sample size is 33%.

At this point, all LCPAs that license foster homes have been reviewed at least once using the new tool. The practice of involving multiple licensing consultants in each review, which began with the implementation of the new review format, has been continued as this practice was determined to be positive during the pilot. Results of the reviews and a copy of the exit report are provided to LCPA staff during an exit meeting at the end of the review. A copy of the exit report is also provided to the individual on the DCS Foster Care Licensing (FCL) team that has responsibility for monitoring the licensure of LCPA foster homes.

LCPA Contract and Licensing Audits

Those LCPAs that provide foster care services and admit children referred by DCS must enter into a contract with the State of Indiana. The contract contains requirements regarding service delivery that are more rigorous than the requirements of the Indiana Administrative Code (IAC) that governs LCPAs. The RLCCU has doubled in size and now includes 10 consultants and two supervisors to provide adequate manpower to conduct contract and licensing audits of residential facilities and foster care LCPAs. During the first months of 2014, DCS worked with the Foster Care Licensing Unit to develop an instrument and process by which LCPA's compliance with the DCS LCPA Master Contract is assessed. Licensed LCPAs and the organization of providers were given the opportunity to review and make comments and suggestions regarding the proposed instrument. This information was integrated and the instrument was completed in May of 2014. The tool consists of 62 compliance points.

The Contract Compliance instrument was piloted with selected LCPAs beginning in June of 2014 and the instrument was finalized by the end of June. All LCPAs that provide foster care have received an initial contract review. There were no LCPAs that were determined to be in compliance with 100% of the compliance points. As this was the initial year that compliance with the contract was assessed, reviews were considered to be training oriented and consultative in nature. Primary areas in which non-compliance was identified are:

- (1) provision of services to children related independent living;
- (2) documentation of children's involvement in leisure activities.

When it is determined that an LCPA is not in compliance with licensing and or contract standards, the DCS RLCCU requires that each facility develop a Plan of Correction (POC) in which the agency specifies what action will be taken for the LCPA to come into compliance. The POC must specify how the corrective action can be accomplished (i.e. what processes and/or systems will be changed or implemented to correct the deficiency); who will be responsible for implementing each component; how will adherence be monitored, sustained and evaluated to ensure new practice(s) remain in place; the timeline for implementation; and how staff will be trained in any of the new processes/systems identified.

Depending on the nature of the non-compliances, the DCS RLCCU may also institute a placement hold and/or probationary status on the license. Additionally, if an individual foster home is not meeting standards, the same actions can be taken. The DCS consultant from the Foster Care Unit (FCU) that is assigned to work with LCPAs continues to provide consultation to foster care homes to guarantee consistency between county operated foster care homes and LCPA managed foster care homes. Additionally, this consultant has begun to work very closely with consultants from the DCS RLCCU as issues with LCPA foster homes are identified. The consultant has

participated in reviews of LCPA licensed foster care homes and participates in the training process for new LCPAs.

Reasonable and Prudent Standard

DCS plans to use the Residential and LCPA contracts to ensure compliance of LCPAs and residential facilities with requirements of the Reasonable and Prudent Parent Standard. Compliance with this requirement will be assessed through the LCPA and residential services contract compliance process.

3. Residential Treatment Facilities

The DCS RLCCU also licenses residential facilities which include private secure facilities, child caring institutions and group homes. There are currently 132 residential facilities licensed by DCS. Residential facilities are licensed for a four year period and must submit a new application for license renewal at the end of the four year period. To assess the compliance of residential facilities with Indiana Administrative Code (IAC), the DCS RLCCU conducts annual licensing reviews of each licensed facility. DCS is able to take action against a license for non-compliance, including requiring licensed agencies to submit plans of correction, limiting the licensed facilities ability to admit children and placing the agency on probationary status.

Licensed residential facilities that serve children referred by DCS must enter into a contract with DCS and the State of Indiana. DCS began to audit residential facilities as to their compliance with the residential contract in 2013. Therefore, DCS is in year three of completion of these audits. Residential contract audits consist of program, clinical and fiscal components. DCS RLCCU staff conducts the programmatic audit, DCS residential clinical services specialists conduct the clinical audit and DCS fiscal staff conducts the fiscal audit. The residential contract contains requirements related to quality of services provided, which are reflective of voluntary accreditation organizations such as the Council on Accreditation. Examples include:

- All programs must utilize trauma focused CBT as a base competency;
- Other evidence-based practices should be utilized that are specific to the population being served; and
- Independent living skills must be provided to all children 16 years and older for a minimum of 3 hours per week.
- Specialized service standards have been developed for the following programs: developmental and/or intellectual disabilities, sexually maladaptive, short term diagnostic and evaluation, and substance abuse treatment.

In order to clarify findings and to make results more meaningful, significant changes were made in the method of rating facilities' compliance with contract compliance points effective in January of 2015. The following rating scale is being used to document compliance with each item:

0 Noncompliance

Required practice standards are not implemented, or are implemented in a cursory or haphazard manner such that program processes and/or outcomes are compromised. Significant omissions or exceptions to required practices are observed. Exceptions occur routinely, involvement of required individuals is not valued and/or policies and procedures are not developed. Health, safety and/or wellbeing of residents may be compromised.

1 Partial Compliance

Significant aspects of the program's observed service delivery practices deviate from written policies or protocols. Omissions or exceptions to recommended practices occur regularly, involvement of required individuals is limited or lacking, procedures are superficial or personnel are poorly informed about procedures. Required practices are implemented in an inconsistent, cursory or haphazard manner, to an extent that the program processes and outcomes may be compromised. Health, safety and/or wellbeing of residents may be compromised.

2 Acceptable Level of Compliance

The program meets a majority of the standard's requirements; service delivery is purposeful and goal-oriented. Appropriate policies and procedures are in place. Minor inconsistencies and not yet fully developed practices may be noted; however, these do not prevent demonstration of how services make a difference/achieve their intended purpose, and do not hamper service delivery or significantly diminish program quality.

3 Outstanding Performance

All elements or requirements of the standard are evident with rare or no exceptions. The program's service delivery practices and policies fully meet the standard and reflect "best practice" in the identified area.

In addition to being rated via the rating scale, each item on the contract audit tool is also categorized based on each item's potential impact on the health, safety and well being of children in placement. Impact categories are defined as follows:

Immediate Threat: While not linked to any specific Clinical Compliance item, immediate threats are identified during Clinical Compliance Audits and represent an *immediate threat* to the health or safety of residents.

Potential Risk: This category is used to designate those items that directly impact the health, safety or wellbeing of residents (noncompliance presents a *potential risk* to residents).

Direct Impact: This category is used to designate those items that *directly impact* the quality of care, treatment and services, but not necessarily health, safety or wellbeing.

Indirect Impact: This category is used to designate those items that *indirectly impact* the quality of care, treatment and services.

The impact ratings are intended to identify critical issues and focus on child safety and outcomes. As the use of these impact ratings was implemented in early 2015, the RLCCU continues to develop required follow up protocols based on these ratings. In addition to the changes to the scale, the RLCCU has added a mechanism to record whether the noncompliance was cited in a previous year.

In the coming 5 years, DCS plans to further review and improve the contract compliance assessment process for residential providers. The recent changes in the rating scale are part of the DCS plan to move toward an assessment that yields results that can be used to improve the quality of care provided, and that can be more consistently applied across facilities. DCS also has identified the need to increase the accessibility of the results of reviews to consumers and the general public.

DCS plans to use the Residential contract to assure compliance of residential facilities with requirements of the Reasonable and Prudent Parent Standard. Compliance with this requirement will be assessed through the LCPA

and residential services contract compliance process.

4. Stakeholder Feedback

The Deputy Director of Placement Support and Compliance continues to host monthly conference calls with residential providers. There has been significant participation by providers in these calls and provider's response to these calls has been extremely positive. The purpose of these conference calls is to discuss hot topics, trends, policy, needed areas of training, and other relevant issues. Representatives from fiscal and other areas of DCS regularly are part of the calls. Onsite licensing and contract visits as well as these calls are major sources of information gathering for DCS to ensure that input from stakeholders is obtained.

LCPA and residential services contracts expired at the end of 2014 and an amendment to the 2013 master contract was put into place effective January 1, 2015. DCS engaged in an extensive process to gather information to guide changes to the master contract, including soliciting information from individual providers; from the organization that represents providers in Indiana and through a public hearing. A draft of the addendum with proposed revisions was given to providers for review before the final amendment was issued and DCS RLCCU and clinical consultants provided training for providers regarding changes through a four hour training session offered three times at various places in the state. Following are examples of items that were a part of the amendment:

- A copy of an up to date Medical Passport is provided to the child/placing agency when the child is discharged.
- If the facility determines that the child's needs cannot be met by the facility, the facility gives 30 days notice (whenever possible) of the facility's intent to discharge the child to allow the Placing Agency adequate time to find an appropriate placement.
- The Contractor reports to the Placing Agency within 24 hours any issue concerning a child placed with the Contractor that impacts the child's health, case or permanency plan progression, welfare, or general well-being.
- A requirement for each agency to develop policy and procedure regarding searches of children placed in residential facilities.

5. Background Checks and Case Planning

DCS has statutory requirements for background checks for foster and adoptive families that exceed the federal standards for such checks (see IC 31-19-9 and 31-27-4). DCS also has extensive policy explaining the requirements for background checks as well as the procedures to be followed (see DCS Policy Chapter 13). Effective July 1, 2015, Indiana's statutory scheme also requires that staff for LCPAs, residential providers, and service providers submit to national name based sex offender registry checks, and local law enforcement criminal history checks. The DCS Residential Licensing and Contract Compliance Unit (RLCCU) audits residential programs, foster care homes and LCPAs for compliance with background check statutes. Indiana also statutorily requires background checks of employees and volunteers of LCPAs and residential facilities (see IC 31-27-3, 5 and 6).

During the annual review of both residential facilities and LCPAs, the RLCCU confirms, via direct record review, that background checks consisting of a fingerprint based national criminal history; local law enforcement; sex offender registry and child protective services checks have been acquired in a timely manner for 100% of employees who were hired since the last review. The reviews conducted by RLCCU staff are reviewed by management to ensure consistent standards are applied. These programs must be relicensed every four years.

Indiana Code requires that all employees whose backgrounds have not been checked within 365 days of the expiration date of the license undergo background check when the facility/agency is relicensed. The RLCCU also confirms that these checks were acquired in a timely manner via record review during the re-licensure review.

A Licensing Compliance Review process for DCS foster family homes is in the final stages of development. This process will allow for review of DCS licensing files to ensure that required background check documentation is present and confirms the completion of required checks at all necessary intervals, consistent with the requirements above. This will further verify information documented within MaGIK regarding background checks for foster home licensure.

As to a case planning process that includes provisions for addressing safety of foster care and adoptive placements for children, DCS currently uses child and family team (CFT) meetings for case planning. During the CFT meeting, a Safety Plan is created/updated, which includes the child's current level of safety in placement, visitation, school, etc.

6. Interstate Compact on the Placement of Children

DCS participates in the Interstate Compact on the Placement of Children (ICPC). The DCS ICPC unit produces a monthly 60 day overdue report to ensure DCS is doing everything that it can to provide information to other states to move ICPC cases through the process as quickly as possible. ICPC home studies must be completed within 60 days. Any home study not completed within 60 days appears on the overdue report. Field management utilizes these reports to manage the timeliness of DCS responses to other states.

The DCS ICPC unit produces a report of Indiana CHINS cases in which children are placed outside of Indiana. The DCS ICPC unit follows up with other states on these cases if requested by the family case manager (FCM). Management utilizes this report to monitor these placements to ensure that they receive timely permanency for these children.

DCS is participating in the federal ICPC pilot, NEICE. NEICE is an electronic web-based system designed to shorten the processing time of ICPC cases. NEICE, if implemented nationally, should significantly reduce administrative costs. During the pilot phase, Indiana worked with five other states to test the system and collect data to be analyzed at the Federal level. The pilot is administered by APHSA and AAICPC with support from ACF, ACYF and the Children's Bureau. During the next phase, the production phase, DCS created 846 new cases in NEICE from August 26, 2014 through April 30, 2015. Preliminary findings show a decrease in overall processing time for ICPC referrals during this time period. If implemented nationwide, the NEICE system will provide invaluable assistance to States for monitoring the timeliness of home studies – both incoming and outgoing.

DCS is also working with Michigan on an ICPC Border Agreement. This would allow for expedited placement of children in five (5) Indiana counties and five (5) Michigan counties that border each other. This agreement will establish a process to access the safety and suitability of caregivers who have an existing relationship with a child, but live across the state border. A more comprehensive evaluation of the caregivers and their home would follow the initial, expedited assessment. Completion of this border agreement has been delayed due to changes in Michigan ICPC administration but finalization in 2015 or early 2016 is anticipated.

IV. UPDATE TO THE PLAN FOR IMPROVEMENT AND PROGRESS MADE TO IMPROVE OUTCOMES

A. SAFETY GOALS, OBJECTIVES AND INTERVENTIONS

Goal 1: Ensure the safety of Hoosier children through informed decision-making beginning from initial assessment.

DCS core mission is to protect children from abuse and neglect. In order to ensure the Department is successful in fulfilling that mission, DCS used information from a variety of resources to evaluate its strengths and opportunities for improvement in the policies, processes, training, services and other resources the agency uses to ensure child safety.

The Biennial Regional Services Strategic Planning process is one example of the ways in which DCS identified areas of focus for the goals and objectives outlined below. Data evaluated by DCS regions as a part of the Biennial Regional Services Strategic Plan (BRSSP) process, and discussions with local stakeholders in reviewing this data, helped to identify service gaps, not only in individual regions, but allowed agency leadership to identify those gaps that existed throughout the State. See pages 9-10 and 58-61 for information on the BRSSP.

A few examples of data and information used to develop the objectives outlined in this section include:

- Results from the Indiana University Needs Assessment Survey for both FCMs and community members compiled as a part of Indiana's Title IV-E Waiver Evaluation.
- Standardized Decision Making (SDM) Safety and Risk Assessment data, which identified a high frequency of substance abuse being identified as a risk factor in substantiated cases of abuse and neglect, consistent with information gathered through the BRSSP process, which supported service gaps in substance abuse assessment and treatment services.
- Review of Children's Mental Health Initiative (CMHI) cases and discussions with the Multi-Disciplinary Team about service gaps for children who have very complex mental health, physical health and/or developmental delays / intellectual disabilities.
- Information from the Individual Training Needs Assessment (ITNA) Survey, as well as the FCM Field Mentors and FCM Supervisor Training Skills Assessment Scales on the effectiveness of new FCM training and ongoing training needs for experienced staff.
- Assessment results from the National Resource Center for Child Protective Services (NRCCPS) on DCS domestic violence policy, training and stakeholder collaboration.

OBJECTIVE 1.1 EXPAND UTILIZATION OF EFFECTIVE, PROVEN HOME-BASED SERVICES IN ORDER TO INCREASE THE NUMBER OF CHILDREN WHO CAN REMAIN SAFELY IN THEIR OWN HOMES AND TO REDUCE THE INCIDENCE OF MALTREATMENT FOR CHILDREN INVOLVED IN THE CHILD WELFARE SYSTEM.

- a) Identify ways to monitor the utilization and effectiveness of services employed during the assessment phase.

This project has not yet been initiated

- b) Train service providers on Trauma-Focused Cognitive Behavioral Therapy, Motivational Interviewing and Family Centered Treatment.

During 2014, DCS trained service providers in TF-CBT, MI and Family Centered Treatment. These programs were implemented as part of the Comprehensive Home Based Service array. DCS has tracked referrals to these program from inception to date. See table below for the number of referrals to each service.

- c) Complete service mapping to ensure that children at high risk of maltreatment are recommended for the appropriate evidence-based service(s) based on the individually identified needs of the child and family.

Service mapping is completed and is being piloted with a selected team in each of the 18 regions. It is anticipated that service mapping will be available statewide by July 1, 2015. See Service Mapping section of this report for a full description. In addition, DCS Clinicians are providing consultation where there are questions or concerns regarding clinical risk factors.

- d) Educate field staff on the availability and appropriateness of evidence-based services.

Field staff are being educated on these services through service mapping.

Number of Cases Referred as of 4/27/15	
Children’s Mental Health Initiative	842 Assessment referrals made 590 cases referred for wrap facilitator and services
Comprehensive Home-based Services	
Cognitive Behavioral Therapy	29
Child-Parent Psychotherapy	1
Family Centered Treatment	566
Intercept	362
Motivational Interviewing	77
Trauma Focused Cognitive Behavioral Therapy	103
Alternatives for Families Cognitive Behavioral Therapy	7

OBJECTIVE 1.2 EXPAND DCS SERVICE CAPACITY TO MEET THE NEEDS OF DCS INVOLVED CHILDREN WITH DEVELOPMENTAL AND INTELLECTUAL DISABILITIES, AS WELL AS THOSE WITH SIGNIFICANT MENTAL HEALTH ISSUES.

- a) Collaborate with the Bureau of Development Disabilities Services to maximize access to available services and identify gaps that exist for children both within the child welfare and probation systems, as well as those outside of the systems in an effort to prevent their entry into foster care.

DCS developed an Enhanced Multi-Disciplinary Team (EMDT) which consists of representatives from multiple Indiana agencies including DCS, Division of Mental Health and Addictions, Medicaid, Bureau of Developmental

Disability Services, Division of Aging, and Department of Corrections. This group has been researching best practices related to serving this population effectively in the community. DCS issued a Request for Proposals for a pilot project to provide Care Coordination and Behavioral Intervention Services to 20 children who are at high risk of residential placement. The EMDT is in the process of selecting a provider. It is expected that if this service is effective, a 1915i State Plan Amendment may be completed through the Medicaid Plan, reviewing what next steps might be for that population

- b) Collaborate with the Bureau of Development Disabilities Services (BDDS) and the Division of Mental Health and Addictions (DMHA) services to ensure children who are dually diagnosed have appropriate service access.

The EMDT continues to research best practices and anticipates the pilot project will be helpful in determining appropriate services.

The Multidisciplinary Team meets every two weeks to staff complex cases which require a multiagency response to best meet the needs of the child and family. This team was developed to ensure state agencies are coordinating services and children are not falling through cracks in service systems.

- c) Develop capacity within the Community Mental Health Center (CMHC) service system to provide high fidelity wraparound services to manage care and service access for children with mental health issues to prevent their entry into foster care.

DCS continues to work with the DMHA and the CMHCs to implement high fidelity wraparound services. These services are currently available statewide. Some areas of the state need to increase staff in order to ensure timely access to services for children. DCS and DMHA continue to work on this issue. DCS has issued a Request for Proposals to secure additional wraparound providers outside of the CMHC system. These providers will begin in July 2015.

- d) Collaborate with DCS providers to develop interest in serving this population.

See a. for a description of the pilot program being planned for Central Indiana.

- e) Develop additional residential, group home, foster care and community-based service and treatment capacity.

See a. for a description of the pilot program being planned for Central Indiana.

- f) Ensure youth aging out of care have access to appropriate transition services for emerging adults.

The Collaborative Care program ensures there is specialized case management of older youth cases. Processes and procedures are in place to transition youth into adult services provided by the Bureau of Developmental Disabilities Services. There is still a need to address youth transitioning from children's mental health services into adult mental health services. DCS is currently working with the Managed Care Entities (MCE) to determine what role they may play in assisting with this transition and also with monitoring health services. The MCE's are developing incentive programs to encourage youth to become more engaged in their health care and more consistent in their utilization of preventive services.

- g) Expand expertise in infant mental health by supporting efforts to increase the number of professionals and paraprofessionals in the state that are endorsed by the Indiana Association for Infant and Toddler Mental Health (IAITMH) to ensure that all Indiana families with very young children have access to well-trained providers in their home communities.

In FY2014, the number of Healthy Families Indiana (HFI) staff in Indiana that achieved the endorsement more than doubled, largely in-part due to efforts to coordinate stakeholders and leverage multiple funding opportunities including a grant from the Indiana State Department of Health. By coordinating efforts between state and community stakeholders, the DCS Prevention unit significantly contributed to existing efforts to expand the availability of competent individuals by supporting efforts of DCS HFI providers to complete the endorsement.

OBJECTIVE 1.3 RE-EVALUATE AND UPDATE TRAINING CURRICULUM FOR NEW FAMILY CASE MANAGERS TO ENSURE NEW FCMS HAVE THE BASIC SKILLS AND KNOWLEDGE TO ENSURE CHILD SAFETY AND SUPPORT POSITIVE OUTCOMES FOR CHILDREN AND FAMILIES.

- a) Evaluate the role of peer coaches and field consultants in supporting new FCMs and helping to facilitate their skill development.

Effective with the new Pre-service training design (January 2015), Peer Coach Consultants provide a 1 day training on Child and Family Teaming in Unit 2. The Peer Coach Consultants then provide oversight within the regions for the Peer Coaches as they train new cohort members as facilitators of Child and Family Team Meetings. This is now completed within pre-service training so that cohort members are trained facilitators prior to graduation from pre-service, instead of receiving their facilitator certification subsequent to pre-service training. Cohort members are then able to conduct CFTMs immediately upon being assigned a caseload.

- b) Identify opportunities to maximize knowledge-based learning through online training.

Effective with the new Pre-service training design (January 2015), there are 28 computer assisted trainings (CATs) for cohort members to complete throughout their 58 days of pre-service training. The CATs are completed at the base office of each participant and reviewed with their supervisor and mentor as part of the TOL Activities Checklist. Specific CATs are to be completed prior to specific classroom training units so that the learning achieved through completion of the CATs, discussions with the Supervisor and Mentor, and field observations can become a basis of discussion for the classroom activities that take place in each of the curricula areas. These various activities reinforce the various learning styles of adult learners.

- c) incorporate training on the safety and risk assessments into new FCM training to ensure that new FCMS have the skills they need to evaluate risk and ensure child safety.

During Unit 1 - Activities at the base office, new FCMS observe an experienced FCM completing an assessment including a Safety, Risk and Family Strengths and Needs assessment in MaGIK. New FCMS will discuss their responses with the experienced FCM and the Field Mentor as part of the TOL Activities. This learning is reinforced during classroom activities using real case scenarios and facilitated classroom discussions.

- d) Incorporate training on the Child and Adolescent Needs and Strengths (CANS) assessment tool to ensure new FCMS have the skills to appropriately address child trauma and service needs particularly for targeted populations (children age 0-5).

Prior to graduation, each cohort is required to complete the Child and Adolescent Needs and Strengths Assessment (CANS) Certification. This is completed as part of the TOL Activities, with oversight provided by the Supervisor and the Field Mentor. Once they are certified, new FCMS assist their Field Mentor, or an experienced FCM, complete a Comprehensive CANS and case plan for a family. New FCMS are assigned a couple of cases prior to graduation so they can apply what they have learned to actual cases under the guidance of their Supervisor and Field Mentor.

OBJECTIVE 1.4 IMPROVE ACCESSIBILITY AND EFFECTIVENESS OF SUBSTANCE USE DISORDER TREATMENT.

- a) Document available evidence-based practices for the treatment of substance use disorders and determine service gaps, including services available for older youth.

DCS surveyed all Substance Use treatment providers and learned about the evidenced-based practices being utilized. The next step is to determine which communities are able to access these services.

- b) Collaborate with Community Mental Health Centers, with assistance from the National Resource Center for Child Welfare and Substance Abuse Treatment, to educate DCS and CMHC staff on the effects of substance use disorders on children, best practices in substance abuse disorder treatment, and to develop local initiatives to address service gaps and improve outcomes for families.

Completed during the annual meeting with the Community Mental Health Centers in July 2014.

- c) Continue collaboration with the Commission on Improving the Status of Children Substance Abuse and Child Safety Task Force to (1) evaluate the availability of services; 2) determine the best evidence-based treatment programs, and 3) determine the best evidence-based prevention programs.

DCS continues to participate with other stakeholders on this committee. The SFY 2015 accomplishments and SFY 2016 Action Plan of the Task Force are as follows:

Accomplishments:

- Took testimony from subject matter experts from rural and urban backgrounds.
- Establishment of a mission statement: “Explore best practices and evidenced-based research to create positive, lasting outcomes for children who abuse drugs, live in households where drug abuse exists, or who are in need of mental health treatment. To that end, our aim is to craft effective ways to address gaps in mental health and substance abuse services between urban and rural communities, the lack of long-term solutions for children with mental health and substance abuse problems in and out of the juvenile justice system, and financial barriers to receiving mental health and substance abuse treatment regardless of where families live.”
- Focused conversation on identifying specific issues and finding solutions by looking at evidence based practices, treatment programs, and prevention programs.
- Examined Youth First, an Indiana organization aimed at strengthening youth and families through evidence-based programs that prevent substance abuse, promote healthy behaviors, and maximize student success.
- Identified Morgan County as jurisdiction to study due to its high drug abuse rate, high opiate prescription rate, high on expulsion/suspension rate due to drugs, and had a high rate for children visiting the emergency room due to drug use.
- Identified and removed barriers to LCSW students giving needed services to students in DOC programs. As a result, Chairman Head, IDOC Commissioner Lemmon, and IPLA Executive Director Nick Rhoad



sent a letter to Indiana colleges welcoming them to enroll LSCW students in DOC youth service programs.

- Recommendation of the following Action Plan.

Action Plan:

- Continue to have subcommittees meet, discuss issues, and report to the Task Force with recommendations on how to address those issues/barriers.
 - Explore how the Task Force can help in expanding access to Tele Health for substance abuse treatment for adolescents. Expand the use of Skype and FaceTime for mental health services in rural areas especially.
 - Explore ways to duplicate the successes of Youth First and other similar prevention programs.
 - Create a plan to encourage parents to lock up their medications; encourage pharmacies to install prescription drop boxes in their stores.
 - Increase early childhood education about the effects of drugs.
 - Target services where they are needed, and have a plan to train and put services where there are none.
 - Look closely at teen suicide rates and how to educate children, parents, and teachers about suicide awareness and prevention.
 - Work with higher education officials and the legislature to examine the possibility of reimbursing tuition and other incentives for professional education/training in child psychiatry, psychiatric nurse practitioners and for Licensed Clinical Social Workers (LCSWs).
 - Study areas with greatest youth drug abuse rate, identify factors that contribute to abuse, and how to combat these factors. Continue the study of Morgan County and other counties that are in need of task force services and programs.
 - Look at increasing community transition programs for youth to transition back into the community.
- d) Develop an annual, mandatory staff training on substance abuse disorder and the impact on children, particularly drug-exposed infants and young children (ages 0-5).

Not yet initiated

- e) Implement the Sobriety Treatment and Recovery Teams (START) program in appropriate communities.

The START program has been operating as a pilot program in Monroe County and is currently in the start-up phase in Vigo County. In addition to the START local committees which meet monthly, DCS implemented a START Central Steering committee to assist with the rollout and plan for additional communities. This committee focuses on statewide data as well as what is happening in the pilot communities, The committee is responsible for ensuring that the program is adequately supported from a central administration viewpoint. Also, through support from Casey Family Programs, DCS now has the support of a consultant from Child and Family Futures to assist substance use disorder providers to develop their services to meet the needs of child welfare involved families.

- f) Consider service mapping to available evidence-based practices to ensure that families are referred to appropriate services based on their individually identified needs.

Service mapping is currently being piloted, but does not yet include substance use disorder services.

- g) Review and realign new employee competencies and learning objectives to identify ways to streamline training content and ensure consistency with policy and practice.

Not yet initiated

OBJECTIVE 1.5 BUILD STAFF COMPETENCY IN ENGAGING, ASSESSING AND WORKING WITH DOMESTIC VIOLENCE (DV) OFFENDERS TO APPROPRIATELY EVALUATE RISK AND PROMOTE SAFETY.

- a) Review and revise existing policy, practice guidance and training to more clearly align with best practice standards and eliminate inconsistent or confusing language.

During the redesign of pre-service training in 2014 the review process for all curricula included a step for the Policy Unit to review the curricula, as well as included the opportunity for the design workgroup to review and include best practice and ask questions regarding policy areas that were unclear. This process served both to ensure that the curricula was consistent with policy and practice and also provided an opportunity for the Policy Unit to re-write those areas that might be unclear to end users. This process continues during 2015 as we form workgroups for curricula writing for experienced FCM curricula, Resource and Adoptive Parent curricula and supervisor and management curricula.

- b) Expand DCS policy, practice and training to include an emphasis on working with DV offenders.

DCS currently has a one day training entitled “Domestic Violence: Holding a CFTM when DV is identified in the Family”, which includes working with the alleged DV offender within the framework of a CFTM. During 2015 this curricula is being enhanced with additional information about working with the DV offender/batterer. This training is available to the field upon request from regional management. DCS will also be exploring additional ways to include more training on working with DV offenders.

- c) Strengthen local / regional collaborations with DV victim advocacy programs to improve DCS practice consistency and to enhance safety for families.

This is a work effort planned for the future.

OBJECTIVE 1.6 EVALUATE THE DCS SERVICE ARRAY AND MECHANISMS FOR PROVIDING QUICK ACCESS TO SERVICES DURING THE ASSESSMENT PHASE.

- a) Evaluate the availability, utilization and effectiveness of crisis services to ensure children can be safely maintained at home.

Not yet initiated

- b) Improve monitoring of service provider response times.

Not yet initiated

OBJECTIVE 1.7 IMPROVE COMMUNICATIONS WITH SERVICE PROVIDERS TO BETTER ENSURE CHILD SAFETY.

- a) Ensure appropriate information is provided when a family is referred to a provider.

Not yet initiated on a statewide scale. Some Regional Child Welfare Service Coordinators are providing training to field staff on appropriate information to include on a referral.

- b) Ensure appropriate communication occurs between all service providers, formal and informal supports to collaborate for consistency and improved outcomes.

Not yet initiated

SAFETY MEASURES OF PROGRESS

Through implementation of the Goals, Objectives and Interventions outlined in this section of the CFSP, DCS will monitor, and anticipates improved outcomes related to the current and/or revised federal CFSR permanency outcomes:

- Absence of Recurrence of Maltreatment.
- Maltreatment in Foster Care.

DCS will also monitor and anticipates improved outcomes related key performance and practice indicator reports generated from MaGIK.

- Absence of Maltreatment after Involvement.
- Family Case Manager Visits.
- CHINS Placement.
- Safely Home, Families First.
- Re-Report of Maltreatment.

DCS will also monitor the impact of implementation of these goals, objectives and interventions on Safety and Behavioral Risk Quality Service Review Child Status Indicators. DCS also intends to develop additional reports and identify ways that technology can further support improved outcomes for children and families. As an example, DCS plans to identify strategies to better capture child visits completed by service providers. In addition, DCS plans to identify ways to measure utilization and effectiveness of proven, home-based services.

B. PERMANENCY GOALS, OBJECTIVES AND INTERVENTIONS

Goal 2: Promote safe, timely and stable permanency options for children.

DCS believes that every child has a right to appropriate care, a permanent home and lifelong connections. The objectives outlined below include a number of strategies to strengthen the types of placement and permanency options available for children requiring out of home care, and putting systems and monitoring mechanisms in place to improve permanency outcomes and time to permanency measures.

DCS decided to focus on these objectives following an analysis of CFSR permanency related outcomes, QSR permanency data and in evaluating the status of the foster care and adoption programs during development of the Foster and Adoptive Parent Diligent Recruitment Plan. While in recent years, DCS has either met or exceeded the national standard in CFSR permanency composites, in the FFY 2013 AFCARS submissions, DCS permanency composite scores for composites 1, 2 and 3 fell slightly. These decreases, combined with a decrease in the number of completed adoptions in 2013, prompted the agency to look more closely at data impacting permanency outcomes for children in care.

DCS is in the early stages of this analysis, and intends to use CQI methods to evaluate the data and identify solutions to improve outcomes. Because the agency is still in the information gathering phase of analyzing outcomes in this area, many of the objectives below are written very broadly and will likely be revised once DCS

has a better understanding as to the reasons behind the changes in permanency outcomes. In addition, to allow for improved monitoring and analysis in this area going forward, many of these objectives include interventions related to data tracking or analysis.

OBJECTIVE 2.1 EXPAND PLACEMENT AND PERMANENCY OPTIONS, AND IMPROVE PLACEMENT STABILITY FOR CHILDREN IN KINSHIP PLACEMENTS.

- a) Develop policy and procedures for the expansion of Indiana's definition of relative to include those with an established and significant relationship with the child.

In response to the new sibling requirement in the Preventing Sex Trafficking and Strengthening Families Act, Indiana Law was modified effective July 1, 2015. More specifically, IC 31-9-2-107 was revised to add “any other individual with whom a child has an established and significant relationship” to the definition of relative. DCS Policy 8.48, Relative Placement, was revised to include this new law and requirement.

- b) Evaluate system and fiscal application changes necessary to track and monitor use of the expanded definition of kinship care.

As discussed above, Policy 8.48 Relative Placement was revised to include the new sibling definition required by the Preventing Sex Trafficking and Strengthening Families Act. In response to the goal, the Safely Home Family First report has been identified as a potential way to track these placements by adding an “other relative” section. Fiscal is also reviewing fiscal reports as a potential source for tracking relative and kinship expenses. Further analysis of this goal continues.

- c) Review and revise, as necessary, policies and procedures related to the Guardianship Assistance Program to include the expanded definition of kinship care.

Policy 14.1 Guardianship Assistance Program (GAP) states: DCS will provide the Guardianship Assistance Program (GAP) to eligible relatives as define in 8.48 Relative Placement for whom the permanency option of guardianship is in the best interest of the child and reunification and adoption are not feasible.

- d) Evaluate resources available to kinship caregivers and revise policies, procedures and information systems to ensure these caregivers are well supported.

Kinship is included in the definition of relative and all services and programs for relatives are also available to kinship caregivers.

- e) Expand the use of resources (staff, financial and service) to provide support to and ongoing assessment of the needs of kinship caregivers.

Analysis of this goal has not yet been completed.

- f) Improve utilization of the CANS to ensure children are placed and provided services according to their individualized needs.

DCS implemented CANS in 2008-2009. To ensure sustainability, adequate and ongoing organizational supports were put in place through the development of CANS Consultants. Three CANS Consultants are assigned to various parts of the state, the North, Central, and Southern Regions. The CANS Consultants along with the Program Manager received certification to train the CANS from Dr. Lyons. This certification assisted the CANS Team in development of a series of internal trainings to Field Staff (CANS Education and Support). The first series was called CANS 101. The objective was to educate the field on how the CANS can be integrated into

DCS practice (TEAPI) and supervision with discussion of the CANS Decision Models (algorithms) and finally where staff can go to help with CANS via the CANS Mailbox which is manned by the CANS Consultants. CANS 101 was completed with all field staff in September of 2014. The second series of CANS Education and Support was CANS 102. CANS 102 discussed the use of CANS to assess trauma related needs, identified and scoring behavioural and emotional symptoms of trauma, and service planning for trauma needs. CANS 102 was completed in February 2015. Currently, in development is CANS 201 which will focus primarily on DCS Supervisors as to not only their understanding of the CANS from a trauma perspective but also to their role and responsibility as a CANS Super User/Implementation Coach for their staff as it relates to CANS. As discussed in the Collaboration section, DCS meets monthly with DMHA to continue dialogue and efforts to improve the CANS.

OBJECTIVE 2.2 EXPAND PLACEMENT AND PERMANENCY OPTIONS, AND IMPROVE PLACEMENT STABILITY FOR CHILDREN IN FOSTER CARE PLACEMENTS.

- a) Implement the Structured Analysis Family Evaluation (SAFE) to evaluate families for adoption, foster care licensure, relative placement and reunification readiness.

DCS hosted trainings, conducted by the Consortium for Children, for all DCS foster care staff in August and November of 2014. All DCS foster home applications after November 10, 2014 have been implemented utilizing the SAFE home study protocols and procedures. Feedback from the DCS Foster Care Supervisors has indicated that the process is more thorough and leaves them with fewer unanswered questions or concerns upon approval. Other feedback suggests that the tools and procedures promote discussion around issues that likely would not have been revealed without the enhanced structure of the SAFE home study. The first annual SAFE training for new foster care staff was held June 8-11, 2015. Refresher training for all previously trained staff was also held on June 11.

Because of the largely positive feedback from staff, DCS communicated to LCPA's the expectation that they become certified to implement the SAFE home study process and utilize it exclusively by January 1, 2017. This expectation will be added to their contracts to coincide with this date. DCS is working with the Consortium for Children to coordinate an orientation for LCPA administrators.

All DCS regions have been trained in SAFE; therefore, any DCS foster parents (including those pursuing adoption) will have their home study completed in the SAFE format.

LCPAs are not required to use the SAFE home study format with the families they license as foster parents. Therefore, any adoptive family who is licensed as an LCPA foster parent will not have a SAFE home study.

All Family Prep agencies are required by contract to become certified in the SAFE home study process, and begin utilizing the process with all DCS adopt-only families referred to them, no later than July 1, 2016 (a year after the start of their contract). Therefore, after 7/1/2016, all adopt-only families (those not licensed for foster care but who wish to adopt from DCS) will have a SAFE home study.

- b) Expand use of resources (staff, financial and service) to provide support to and ongoing assessment of needs of foster parents.

DCS has begun monthly in-service meetings with foster care Supervisors, Managers and Regional Managers in hopes of providing current information regarding available resources, as well as to problem solve and develop plans around any barriers to the provision of support and resources to foster parents. DCS continues to educate staff about referral procedures for supportive services for foster parents and situations in which these would be

appropriate. DCS also recently obtained a new foster parent liability insurance policy, which is providing a more comprehensive coverage to foster parents than had been previously available. Every foster parent is automatically enrolled into this coverage when a placement occurs. This can be a meaningful support to foster parents if they incur costs and damages associated with their fostering experience. Educational issues and fees can also be challenging for foster parents to navigate. Foster parents often don't understand whether a school fee should be assessed for the children in their care, and who should be responsible for paying such fees. To assist in this regard, DCS has recently created new protocols for the Educational Liaisons to assist foster parents in handling issues related to school fees and equipment.

- c) Improve utilization of the Child and Adolescent Needs and Strengths (CANS) assessment to ensure children are placed and provided services according to their individualized needs.

DCS implemented CANS in 2008-2009. To ensure sustainability, adequate and ongoing organizational supports were put in place through the development of CANS Consultants. Three CANS Consultants are assigned to various parts of the state, the North, Central, and Southern Regions. The CANS Consultants along with the Program Manager received certification to train the CANS from Dr. Lyons. This certification assisted the CANS Team to develop a series of internal trainings to Field Staff (CANS Education and Support). The first series was called CANS 101. The objective was to educate the field on how the CANS can be integrated into DCS practice (TEAPI) and supervision with discussion of the CANS Decision Models (algorithms) and finally where staff can go to help with CANS via the CANS Mailbox which is manned by the CANS Consultants. CANS 101 was completed with all field staff in September of 2014. The second series of CANS Education and Support was CANS 102. CANS 102 discussed the use of CANS to assess trauma related needs, identified and scoring behavioural and emotional symptoms of trauma, and service planning for trauma needs. CANS 102 was completed in February 2015. Currently, in development is CANS 201 which will focus primarily on DCS Supervisors as to not only their understanding of the CANS from a trauma perspective but also to their role and responsibility as a CANS Super User/Implementation Coach for their staff as it relates to CANS.

Policy 5.19 Child and Adolescent Needs and Strengths (CANS) Assessment states: The Indiana Department of Child Services (DCS) utilizes a comprehensive Child and Adolescent Needs and Strengths (CANS) assessment to document and communicate the strengths and needs of the child and to assist in determining the appropriate level of behavioral health services for the child. The CANS will be the basis for planning individualized services for children based on their identified strengths and needs. The CANS will also play a critical role in informed decision making regarding the category of placement recommended for a child when a decision to place has been made. The CANS policy further states: DCS will complete an initial CANS Assessment for each child in the home when: 1. A substantiated Child Abuse or Neglect (CA/N) assessment will be closed without opening a case; 2. A program of Informal Adjustment (IA) has been initiated; 3. An in-home Child in Need of Services (CHINS) has been initiated; 4. The child is placed in out-of-home care during a CA/N assessment; and/or 5. The child is adjudicated a CHINS and placed by DCS in out-of-home care during a Mental Health or Developmental Disability Family Evaluation.

OBJECTIVE 2.3 IMPROVE PLACEMENT STABILITY OF ADOPTED CHILDREN THROUGH PROPER IDENTIFICATION OF PLACEMENT OPTIONS BASED ON THE CHILD'S INDIVIDUALIZED NEEDS, AND BY PROVIDING SUPPORT FOR THAT PLACEMENT TO AVOID DISRUPTION.

- a) Expand use of resources (staff, financial and service) to provide ongoing support to pre-adoptive parents.

Family case managers utilize case resources and referrals to ensure that services are available to children and families preparing for adoption. SNAP specialist also provide ongoing support to pre—adoptive parents. Additional resource needs have not yet been determined.

- b) Promote availability of post adoption services to increase the numbers of families engaged in post-adoption services, including trauma-informed trainings, to prevent adoption disruptions and dissolutions.

A list of post adoption service representatives and post adoption services brochures are available at all adoption events. DCS has provided training on post adoption services to DCS probation staff who have also been provided a supply of brochures. In addition, SNAPS and/or PAS providers present to local offices and/or attend CFTMs to discuss the availability of post adoption services. The 2014 RAPT Conference was themed around trauma-informed (Building a Healing Home) care and both keynote & breakout sessions presented by state-wide and national trainers were held over 3 days. A trauma training focusing on practical skill building for caregivers is being piloted in Region 15. RAPT Staff offers a 3 part series (4 hours each) training on Trauma for all resource families. Also, all three PAS providers have held trauma-informed trainings in various regions throughout the state for families – most of these have been open to families not currently receiving PAS services in addition to their current PAS families.

- b) Develop mechanisms to track and evaluate the post adoption service array to assess its overall utilization and effectiveness, including its interaction with the Children's Mental Health Initiative.

In addition to monthly reports on each individual family receiving post adoption services, the three post adoption service providers also send quarterly reports which provide a summary of the number of new and renewed referrals, quarterly achievements and challenges, including systemic issues (navigating Medicaid issues, etc.). DCS has recently added the number of post adoption service cases which also have Child Mental Health Initiative (CMHI) involvement. Statewide, for calendar year 2014, 39 youth were referred to the CMHI, of which approximately 51% were accepted. DCS tracks post adoption services by family, not by child, so it is difficult to compare the number of children served

OBJECTIVE 2.4 INCREASE THE EFFECTIVENESS OF FOSTER AND ADOPTIVE PLACEMENTS.

- a) Expand resources available to foster and pre-adoptive parents.

DCS has begun monthly in-service meetings with foster care supervisors, managers and regional managers in hopes of providing current information regarding available resources. The meetings also allow them to problem solve and develop plans around any barriers to the provision of support and resources to foster parents. DCS continues to educate staff about referral procedures for supportive services for foster parents and situations in which these would be appropriate.

DCS also recently obtained a new foster parent liability insurance policy, which is providing more comprehensive coverage to foster parents than previously available. Every foster parent is automatically enrolled into this coverage when a placement occurs. This can be a meaningful support to foster parents if they incur costs and damages associated with their fostering experience.

Educational issues and fees can also be challenging for foster parents to navigate. Foster parents often don't understand whether a school fee should be assessed for children in their care, and who should be responsible for paying the fee. To assist in this regard, DCS has recently created new protocols for the Educational Liaisons to assist foster parents in handling issues related to school fees and equipment.

- b) Increase the effectiveness of matching foster children to resource homes.

DCS has multiple resources and tools to assist in this regard. First, specialized staff members who work with families have a better knowledge of families' strengths and needs and can make placement matches more effectively. Additionally, MaGIK has a placement matching feature that allows for the filtering of foster homes with available capacity by various characteristics, such as age and gender preferences, special needs they can or are willing to accommodate, and location (down to school district). This feature can be very useful at quickly narrowing a potential list of options. DCS will continue to educate staff on the need to enter this data in foster parent resource profiles so that this feature can be maximally effective.

Speaking only as to pre-adoptive matches, DCS uses the SNAP process of sharing SNAP recommended homestudies with FCMs and Child Social Summaries with SNAP recommended families helps to gauge interest. A team approach was established to interview and select the most appropriate family to ensure that various professionals provide input on the match.

- c) Minimize the number of disrupted placements.

While DCS has matching capabilities to maximize the appropriateness of placements and supportive services to support placement challenges, there is currently limited information that can be extracted on the rate of placement disruption. This is a target area for report development, as listed in an alternate section of this report. Once meaningful data is available to track disruption episodes in aggregate form, DCS will be able to determine if efforts to better match children and foster parents and support placements are effective in reducing disruptions. In addition, the efforts to expand resources available to foster and pre-adoptive parents could prove beneficial in minimizing disrupted placements.

- d) Maximize retention of resource families.

In recognition that foster parents' satisfaction with fostering often relates to their interactions with agency staff, DCS is planning a practice in-service for all Family Case Managers in the last quarter of 2015 on the topic of engaging foster parents. The in-service will focus on reinforcing to staff their role in the foster parents' experience and provide information on utilizing practice skills when working with foster parents. As mentioned previously, the availability of RFCS as a liaison to necessary resources and supports should bolster DCS's efforts to retain resource families and successful placements.

OBJECTIVE 2.5 EVALUATE THE STRUCTURE OF AND POLICY SURROUNDING THE USE OF THE CASE PLAN AND TRANSITION PLAN TO ENSURE IT SUPPORTS DEVELOPMENT OF GOALS THAT ARE IN THE BEST INTERESTS OF CHILDREN AND FAMILIES, AND FURTHERS TIMELY PERMANENCY.

- a) Determine methods to ensure permanency goals are appropriate to the child's needs and the circumstances to the case and that the goals are with input from the youth and parent.

Both the Developing a Case Plan policy 5.8 and the Transition Plan policy 11.6, communicate the importance of utilizing the Child and Family Team (CFT) meeting process to create plans for assessment, safety, service delivery, and permanency. A CFTM fulfils the requirement to hold a Case Plan Conference, if all required parties are present. If a family chooses not to participate in the CFT Meeting process, a Case Plan Conference is held to develop the Case Plan. The Case Plan policy states: DCS will work with the parent, guardian, or custodian, extended family, child (if age and developmentally appropriate), and the CFT, if applicable, in developing the Case Plan. Policy goes on to states that when developing a Case Plan the Family Case Manager (FCM) will

“Determine the Permanency and Concurrent Plans that are in the best interest of the child and ensure that the goals, objectives, and activities outlined in the Case Plan support the Permanency Plan”. For older youth the Transition Plan policy states: The plan shall be:

1. Youth-focused and developed with the assistance of the Family Case Manager (FCM) or Collaborative Care Case Manager (3CM) and members of the youth’s Child and Family Team (CFT);
 2. As detailed as the youth elects;
 3. An outline of the Older Youth Services the youth will receive;
 4. Focused on short-term and long-term achievable and measureable goals;
 5. Updated every six (6) months until the youth’s case is closed; and 6. Given to the youth at each update.
- b) Determine methods to ensure case plans are completed timely and consistent with the court orders for permanency goals (no later than 60 days from the date the child entered foster care).

To ensure that case plans are completed timely DCS requests that case plans be completed within 45 days of removal or disposition. The Developing a Case Plan policy 5.8 states: The Indiana Department of Child Services (DCS) will have a Management Gateway for Indiana’s Kids (MaGIK) approved Case Plan within 45 days of removal or disposition, whichever comes first for:

1. Every child who has been adjudicated a Child in Need of Services (CHINS);
 2. All children with an open case type;
 3. Children who are at imminent risk of removal; or
 4. A Juvenile Delinquent or Juvenile Status (JD/JS) for whom DCS has been ordered to pay for the placement and the child is IV-E eligible.
- c) Evaluate the existing case plan and transition plan to gather feedback on its current functionality and determine what information and or questions need to be revised or added to the Case Plan to ensure better outcomes for children.

Both the Case Plan and Transition Plan are currently being revised. Currently the transition plan is not programmed in the Management Gateway for Indiana’s Kids (MaGIK) so it must be completed on paper then uploaded into MaGIK. A majority of the current case plan is completed in MaGIK but there are still a few sections that must be completed by hand and then uploaded into MaGIK. Programming for both plans in MaGIK continues and is an ongoing project. Due to the extensive nature of MaGIK programming, needed revisions to the Case Plan and Transition Plan are made to the forms to ensure compliance with Federal and State requirements. Current revisions include legislative changes that are pursuant to the Preventing Sex Trafficking and Strengthening Families Act.

- d) Determine methods to ensure case plan goals are updated in a timely manner (e.g., when changing a goal from reunification to adoption). Consider system monitoring efforts.

The Developing a Case Plan policy 5.8 states “DCS will ensure that the Case Plan is updated at least every 180 days from the effective date of the previous plan and anytime there is a significant change (e.g., change in placement, identified needs, change in permanency plan, parents failure to participate in services, parents cannot be located, changes with parent’s income and employment, child’s income and resources, etc.)”.

OBJECTIVE 2.6 IMPROVE ENGAGEMENT AND PARTICIPATION OF FATHERS AND PATERNAL RELATIVES.

- a) Increase efforts to find fathers by utilizing available search tools and through referrals to the investigation unit.

The investigators utilize a variety of internet search tools, such as computer databases, Accurint, Federal Information Portal, Federal and State Department of Corrections, Federal and State Offender Registries, and the Indiana Bureau of Motor Vehicles. Social Media is utilized, including Facebook, Public Records, County Court Systems and records. FCMs make referrals to the Investigator unit through the KidTraks program when a need is recognized.

- b) Increase utilization and effectiveness of father engagement services.

Analysis of this goal has not yet been completed.

- c) Increase engagement of fathers in child and family team processes, case planning activities, visitation and service provision.

Analysis of this goal has not yet been completed.

- d) Engage paternal relatives as informal supports and placement and permanency options.

Analysis of this goal has not yet been completed.

OBJECTIVE 2.7 IDENTIFY AND IMPLEMENT STRATEGIES TO BETTER TRACK AND MONITOR CHILD / PARENT VISITS.

- a) Evaluate strategies for capturing parent / child visits supervised by either DCS or provider staff for both CHINS and Juvenile Delinquency cases.

Analysis of this goal has not yet been completed.

- b) Implement technology solutions to support consistent monitoring of visits.

Analysis of this goal has not yet been completed.

PERMANENCY MEASURES OF PROGRESS

Through implementation of the Goals, Objectives and Interventions outlined in this section of the CFSP, DCS will monitor, and anticipates improved outcomes related to the current and/or revised federal CFRS permanency outcomes:

- Improved Placement Stability and/or Reduction in the number of placement and adoption disruptions.
- Decrease in the length of time to permanency for all permanency options.
- Permanency in 12 months for children entering foster care
- Permanency in 12 months for children in foster care for 2 years or more
- Re-Entry into Foster Care

Since 2001, DCS has held 857 Permanency Roundtables (PRT's). 165 of those have been from July 1, 2015- May 5, 2015. Of those 65 received the Gold Standard of Permanency which includes reunification, adoption, or guardianship. The total number of cases closed between July 1- April 30th has been 101.

DCS will also monitor and anticipates improved outcomes related to the following Quality Service Review Indicators.

- Placement Stability and Permanency Child Status Indicators,
- Parent / Caregiver Status Indicators,
- Role and Voice of Family Members,
- Long Term View and Intervention Adequacy Planning Indicators.

DCS also intends to monitor the utilization of kinship placement options, as well as post adoption services and consistent with its goals related to continuous quality improvement, will identify and implement strategies to further improve outcomes based on data trends.

C. WELL-BEING GOALS, OBJECTIVES AND INTERVENTIONS

Goal # 3: Ensure the well-being of Indiana children by integrating a trauma-informed care approach to our child welfare practice.

During the 2010-2014 CFSP, DCS implemented a number of new services and created several specialized staff functions all designed to further well-being for children involved with the child welfare system. Many of the objectives outlined in this goal are designed to continue moving forward with strategies put in place during the prior CFSP. These objectives focus on improving and/or evaluating how we are using the services and staff resources we put in place in 2012 and 2013, as opposed to implementing new strategies to improve child well-being. Many of the programs and services identified in the objectives below are very new for the agency, and as a result, DCS needs to devote resources during the early years of the 2015-2019 CFSP towards identifying ways to track and evaluate the effectiveness of these programs in improving outcomes for children and families, and identify additional ways to measure child well-being.

OBJECTIVE 3.1 CONTINUE EXPANDING THE AVAILABILITY AND USE OF EVIDENCE-BASED AND EVIDENCE-INFORMED PRACTICES TO ENSURE CHILD AND FAMILY NEEDS ARE BEING MET.

- a) Document and train staff, CASAs, Judges and Probation on available evidence-based programs and target populations for these services.

Presentations have been provided to judges, probation and CASAs regarding the evidence based programs that are being supported by DCS. Additional training will be provided regarding how Service Mapping will assist in the selection of services.

- b) Improve the effectiveness of residential programs by requiring all residential programs to utilize an evidence-based program and auditing provider compliance with the program model.

The Residential Liaison (RL), in the Permanency and Practice Support Division, works closely with DCS Residential Licensing/Contract staff. The RL is responsible for assessing, reviewing, and monitoring the quality of programming and clinical services provided to DCS children and adolescents in residential care. The RL conducts residential program reviews for assigned facilities using the Residential Programs Clinical/Quality Indicators Checklist. A quarterly review schedule was developed in collaboration with providers to ensure that all facilities receive a review. Visits are scheduled on an "as needed" basis, in response to feedback from Clinical Services Specialists, Residential Licensure/Contract Staff and/or Field Staff. Residential Liaisons coordinate residential reviews, summaries of findings, recommendations for improvement and other survey activities with DCS Residential Licensing/Contract Staff. Any concerns, findings and/or recommendations for improvement are

integrated with information from the Contract/License Audit Tool.

RLs provide consultation to residential providers regarding trauma-informed, evidence-based practices and provide guidance, as necessary, to assist providers in meeting the expectations outlined on the Residential Programs Clinical/Quality Indicators Checklist. The RLs also work closely with members of the Clinical Resource Team to resolve identified concerns regarding specific DCS youth in placement and keep members of the Clinical Resource Team apprised of any concerns or trends involving specific residential providers. The RLs also assess provider capacity regarding evidence-based services for DCS youth on an ongoing basis and provide input to the Clinical Services Manager, the Deputy Director of Placement Support and Compliance and/or the Deputy Director of Programs and Services regarding needed services. On a quarterly basis, the RLs meet with the Clinical Services Manager to discuss residential providers' progress in implementing evidence-based programming (e.g., TF-CBT).

- c) Improve the effectiveness of community-based programs by contracting for services that utilize an evidence-based program and auditing provider compliance with program model.

DCS has provided the following EBP training and technical support to community based providers:

- Trauma Focused Cognitive Behavioral Therapy
- Family Centered Treatment
- Motivational Interviewing
- Child Parent Psychotherapy
- Homebuilders

- d) Collaborate with stakeholders to address unmet service and placement needs through provider engagement.

Not yet initiated. This will be included as part of the Biennial Regional Services Strategic Planning process conducted in the fall of 2015.

- e) DCS-involved youth who are identified as having significant needs associated with trauma (i.e., CANS “adjustment to trauma” item score = 3) will receive evidence-based, trauma-informed services to enhance their well being.

Service Mapping, which is currently being piloted, provides service recommendations. Children who have experienced trauma as documented by the CANS are provided service recommendations to EBPs which can address trauma. In addition, consultation is provided by the clinical team for these cases to ensure the child's needs are being met.

OBJECTIVE 3.2 ENHANCE STAFF CAPACITY TO UTILIZE SAFETY, RISK AND CANS ASSESSMENTS IN CONJUNCTION WITH ONE ANOTHER TO IDENTIFY UNDERLYING NEEDS OF CHILDREN AND FAMILIES, ENSURE APPROPRIATE CASE PLANS ARE ESTABLISHED, AND TAILORED SERVICES ARE PROVIDED.

- a) Improve staff capacity to effectively assess trauma and the behavioral health and placement needs of children and youth to identify appropriate services through use of the Child and Adolescent Needs and Strengths (CANS) assessment tool.

Certified and Trained CANS Consultants developed and implemented CANS 102. CANS 102 discussed the use

of CANS to assess trauma related needs, identified and scoring behavioural and emotional symptoms of trauma, and service planning for trauma needs. CANS 102 was completed in February 2015. Currently, in development is CANS 201 which will focus primarily on DCS Supervisors as to not only their understanding of the CANS from a trauma perspective but also to their role and responsibility as a CANS Super User/Implementation Coach for their staff as it relates to CANS.

- b) Improve assessment of the child and family's needs through utilization of the Safety and Risk Assessments and ensure results are being used to guide development of the case plan.

Analysis of this goal has not yet been completed.

- c) Utilize the assessment tools to map to appropriate services to meet the individual needs of the family and child.

Analysis of this goal has not yet been completed.

- d) Explore methods to improve participation and engagement of service providers in child and family teams and case planning activities.

Analysis of this goal has not yet been completed.

- e) Consider training and appropriate use of case plan goals associated with building social capacities, self esteem, coping skills and re-establishing and maintaining relationships.

Analysis of this goal has not yet been completed.

- f) Improve the utilization of contracted providers to offer more in-depth assessments for trauma, bonding and attachment, psychological evaluations, and independent living skills.

Analysis of this goal has not yet been completed.

OBJECTIVE 3.3 IMPROVE PARTICIPATION AND ENGAGEMENT OF CHILDREN AND CAREGIVERS IN CHILD AND FAMILY TEAMS, CASE PLANNING ACTIVITIES AND SERVICE PROVISION.

- a) Explore methods to engage children and youth in child and family teams, case planning activities, and service provision.

Analysis of this goal has not yet been completed.

- b) Explore methods to engage noncustodial parents, kinship caregivers, foster parents, and pre-adoptive parents in child and family teams, case planning activities, and service provision.

Analysis of this goal has not yet been completed.

OBJECTIVE 3.4 EVALUATE THE IMPACT OF TRAINING AND APPROPRIATE USE OF CASE PLAN GOALS ASSOCIATED WITH BUILDING SOCIAL CAPACITIES, SELF ESTEEM, COPING SKILLS AND RE-ESTABLISHING AND MAINTAINING RELATIONSHIPS.

- a) Identify ways to track whether nursing services staff are improving timely access to medical and dental care for children in care.

Analysis of this goal has not yet been completed.

- b) DCS Clinical Services Specialists will provide clinical consultation, as requested by the FCM, for any youth rated a 3 on the CANS “adjustment to trauma” item.

All youth are screened for trauma using the CANS. DCS is working on the development of a monthly report to identify those youth rated a “3” on the CANS “adjustment to trauma” item. The report will identify the following: “For the reporting period, X% of youth who were identified as having significant needs associated with trauma received consultation from a Clinical Services Specialist.”

- c) Evaluate the impact of the education liaisons with regard to school attendance and graduation rates, incidence of suspension and expulsion and attendance in post-secondary education.

The Education Liaison (EL) Director has been actively working with DCS legal, the Practice and Policy Support Deputy Director, and the Department of Education legal department to establish a MOU to obtain access to the Student Testing Number (STN) database with intent to use EL referred youth’s STN to track academic progress, enrolment, and graduation status.

The Education Liaison team is working with the KidTraks team to begin implementation of measurable outcomes based on the referral reasons for each child referred to the EL team. This will allow a data driven report to be cultivated identifying the impact the EL involvement has on the child’s education and DCS’ case plan.

- d) Evaluate frequency with which investigators are locating additional family members, which result in additional family supports and / or permanency options for children in care.

DCS does not currently have a way to measure how often investigators locate a person who ultimately becomes a placement or an informal support for a child/family. The Permanency & Practice Support Division’s CY 2015 Plan is to determine what needs to be measured and how it should be measured. We are hopeful that we will have data to report in the APSR due June 30, 2016.

WELL-BEING MEASURES OF PROGRESS

Through implementation of the goals, objectives and interventions outlined above, DCS will the monitor the measures outlined below to determine well-being outcomes for children and youth.

- Permanency and Practice Support reports related to the number and impact of referrals to nurses, clinical services specialists, investigators and education liaisons.
- CANS outcomes and compliance reports.
- Well-being Quality Service Review Child Status Indicators,
- Appropriate living arrangement,
- Physical Health,
- Emotional Status,
- Learning and Development,
- Pathway to Independence.

D. CONTINUOUS QUALITY IMPROVEMENT (CQI) GOALS, OBJECTIVES AND INTERVENTIONS

Goal #4: Promote a culture of learning whereby staff at all levels of the agency consider ways to improve

practice, programs and policy.

OBJECTIVE 4.1 DEVELOP A POLICY AND ORGANIZATIONAL STRUCTURE TO BUILD SYSTEM CAPACITY TO BEGIN USING CQI AS THE METHOD FOR EVALUATING AND IMPROVING CHILD WELFARE PRACTICE.

DCS is approaching CQI as a philosophy to support policies, programs, and practices that drive continued efforts to support and maintain quality practices on behalf of children and families in Indiana.

At the core of the CQI approach is the development of an organizational culture that supports continuous learning. DCS recognizes the need and value of integrating qualitative and quantitative data to provide a more comprehensive view of the agency's strengths and areas for improvement.

Data gathered, analyzed, and shared for the Title IV-E Waiver evaluation support CQI efforts and permit DCS to make necessary changes to policy, programs, and practice through data-informed decision-making. The Title IV-E Waiver serves as a tool for targeted system improvements. The flexibility of the Title IV-E Waiver allows DCS to remain anchored in a general theory of change on behalf of children and families in Indiana and drives this general theory of change toward more specific initiatives that support the DCS Practice Model.

DCS has begun implementing a variety of data evaluation techniques to change the agency to a culture of learning. Through the use of consultants, in conjunction with state resources, DCS has begun to analyze and learn from data with targeted management staff. This was the first step in beginning the agency shift to a culture of learning. In June, DCS hired a Child Welfare Outcomes Director whose chief responsibilities include data management and analysis of data within all DCS applications. DCS has adopted the CQI model and has several projects identified for implementation.

1. CQI Structure

DCS is evaluating progress in achieving CQI goals from a completion perspective as opposed to a more quantified data analysis method. To evaluate the agency's progress in achieving its CQI goal and objectives, the agency will monitor its success in timely developing a policy and organizational structure to support its utilization of a CQI framework. In addition, the agency will develop a process and monitor progress for identifying opportunities to utilize CQI to further analyze problem areas and identify strategies for improvement. During this year, DCS has been successful in developing a decision-making structure within the executive staff and field staff through the CQI Steering Committee and workgroups.

2. Organizational Structure

The Director of Child Welfare Outcomes was recently hired and will serve as the agency analyst for all qualitative and quantitative data. The Director of Child Welfare Outcomes will assist the CQI Steering Committee in evaluating agency data to drive initiatives, interventions and service delivery.

DCS remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and a broader service array. DCS has routinely monitored the effectiveness of the Practice Model in order to establish the goals and direction of the agency, Waiver spending, training, and service delivery. To further support these efforts; DCS is implementing a Continuous Quality Improvement (CQI) process that will serve as the foundation for setting agency priorities, structure for internal and external collaborations, and

interventions as well as the continuum of service provision. DCS is committed to developing a CQI approach that will serve as the basis for evaluating and improving child welfare practice.

3. CQI Steering Committee

DCS established a CQI Steering Committee to set agency priorities and oversee implementation and ongoing activities regarding DCS initiatives. The CQI Steering Committee is comprised of the executive staff from all DCS divisions, demonstrating the agency's commitment to continuous quality improvement and implementation of effective interventions and services to children and families. The CQI Steering Committee has been involved in establishing CQI structure as core to prioritizing initiatives, and monitoring and tracking of implemented interventions and services delivered. The CQI Steering Committee will continue to monitor and shape the CQI efforts driving interventions and service delivery.

DCS Administration partnered with several external consultants to assist in evaluating the agency's qualitative and quantitative data sets, as well as providing recommendations for priority setting to the CQI Steering Committee. DCS partnered with Case Commons, Casey Family Services, Katts, Sapper, and Miller (KSM) Consulting, Indiana University, and Deloitte Consulting LLP.

4. Data Analysis

DCS utilized a number of resources, including contracts with Case Commons and Katts, Sapper and Miller Consulting (KSM) to conduct an in-depth analysis of MaGIK data to assess entry and exit cohorts. The data revealed that children in care remained relatively stable even though there was a marked increase in the number of assessments, many of which were unsubstantiated. More recent analysis indicates that the rate of increase in new assessments is slowing down. Moreover, analysis has identified a new trend of increasing open cases and the agency is beginning to analyse agency data to identify the root cause(s) of this increase.

Casey Family Programs partnered with DCS to assist the agency in determining why more children were entering the system and what other contributors have resulted in an increase in children under state supervision. A team of agency executives reviewed existing intake practices, processes, supporting policies, completed safety/risk assessment tools and substantiation/case decisions to determine the cause of increased caseloads. As a result, three counties (Lake, Allen, and DeKalb) were identified to assess differences in how decisions are made and to determine an effective strategy for improvement. In the fall of 2015, Casey Family Programs will co-facilitate county stakeholder meetings with local DCS management, DCS executives, DCS Central Office staff, and external partners (service providers, judges, etc.) to gain a better understanding of the data and formulate action plans. To further explore data and impact change in county caseloads, each of these counties has selected PDSA team members to begin working on a goal to reduce children/youth entering the system. In July 2015, Casey Family Programs and the Director of Child Welfare Outcomes will meet with local PDSA team members from Lake, Allen, and DeKalb counties, DCS Executive staff, DCS PQI staff, and DCS Service Consultant staff to review quantitative and qualitative data with teams and kickoff the use of PDSA Cycles as a CQI model for DCS. These PDSA groups are scheduled to report their goals, progress, and results to the CQI Steering Committee routinely.

In preparation for the start of statewide PDSA Cycles in the field, DCS PQI staff piloted a PDSA project in August 2014. The strategy implemented is to assign PQI as Site Leads to specific QSR review teams. PQI Site Leads will serve as regional contacts, assist with troubleshooting, and will spend time with each regional review team staffing cases and assisting with identifying appropriate indicators for improvement. Although preliminary

data indicates QSR scores have improved through the selected strategy, the project will not be completed until summer 2015.

KSM Consulting was hired to review DCS' current organizational structure and data/reporting tools and to identify opportunities for improvement. KSM Consulting identified the location of all internal quantitative and qualitative data sets. They have made recommendations to the CQI Steering Committee to improve data quality and consolidate data sources to address federal/state reporting needs. Reporting needs include AFCARs and NCANDS, CFSP, APSR, the state's "Good to Great" Plan, Practice Indicator reports, Governor's Key Practice Indicators, and Title IV-E Waiver Reports. KSM designed a roadmap to assist the CQI Steering Committee in setting priorities for implementation of recommendations. KSM's recommendations include the following:

- Implementation of a robust data management initiative and supporting roles
- Cleansing existing applications and database infrastructure
- Creating a centralized analytics platform

5. Indiana University (IU)

QSR Process and Data

Indiana University (IU) staff completed work with DCS PQI staff to match previous rounds to new data tables for Round 4 and returned previous converted rounds to the PQI team. IU staff also completed work with PQI staff to redesign the database to capture data consistent with all previous rounds of the QSR. PQI is working to match MaGIK identification numbers to all File Maker data files for combined data analysis with MaGIK data.

Expansion of QSR Indicators

In spring 2015, IU staff worked with PQI staff to expand several QSR Indicators. The expanded indicators will measure mothers, fathers, children/youth, and resource parents separately using current timeframes and the last 12 months to assess consistency in the fidelity of practice over time to the TEAPI Model. Furthermore, CFSR questions regarding safety, timely initiation, preventative services, permanency, and quality of FCM contacts were added to the end of the QSR Protocol for the following reason:

- DCS can measure the above mentioned questions similarly to the CFSR tool,
- DCS can obtain reliable qualitative data,
- Data obtained, from the established QSR process, can inform the CQI Steering Committee and field management staff on progress toward federally set goals before, during, and after the CFSR in 2016, and
- Data can be utilized to assess improvement for Indiana's Program Improvement Plan.

The number of cases pulled for review will remain the same and encompass existing case types and assessment cases beginning round five in September 2015. PQI is currently working on a plan to train reviewers on changes to the QSR Protocol. Changes to the QSR Protocol will be integrated into related PQI and Staff Development trainings.

DCS is working closely with Probation representatives through the upcoming CFSR process and Probation Improvement Project to integrate the review of these cases into the QSR process during round six of the QSR.

DCS is also expanding QSR Indicators to align them with the Child and Family Service Review (CFSR) Onsite Review Instrument (OSRI). This includes expanding the following indicators:

- Team Formation,
- Team Functioning,
- Assessing and Understanding the Child,
- Assessing and Understanding the Family,
- Intervention Adequacy.

These indicators will measure current practice over the past 90 days, as well as over the past 12 months. Further, mother, father, child, and resource parents will be rated individually during both time frames.

The Office of Data Management (ODM) is developing DCS reports from MaGIK and data validation questions which have been added to the RPS tool in order to measure federal requirements before, during and after the federal review scheduled in Indiana in 2016. These qualitative and quantitative data reports, in conjunction with other DCS reports, will assess practice and monitor progress toward improvements.

Quality Service Review Indicator	Baseline 4/2007 -6/2009	Round 2 8/2009 -7/2011	Round 3 9/2011 – 8/2013	Round 4 9/2013 – 3/2015
Intervention Adequacy	50%	63%	69%	59%
Resource Availability	75%	88%	93%	94%

* Includes all but Regions 6, 13, and 1

The most up-to-date statewide data for the QSR demonstrates Intervention Adequacy remains an area of opportunity despite the availability of resources. Trends in this area revealed services implemented were insufficient or underpowered to meet identified and underlying needs of children/youth and/or families. Further, parents’ lack of engagement hindered their progress toward identification of underlying needs and their individual treatment goals. Reviewers also noted assessments were either not completed or not taken into consideration when determining appropriate service needs. Analysis conducted by Indiana University on QSR data supports more thorough assessments as a basis for better outcomes for children and families. As a response, the state has developed a service mapping program to match the model and intensity of services to individual needs.

Title IV-E Waiver Project

Indiana University partnered with DCS to develop and monitor the IV-E Waiver Demonstration. The Waiver period is for five years, beginning July 1, 2012. Through the Waiver, DCS has utilized innovative methods to ensure families are provided with services that meet their needs and, when possible, allow children to remain safely in their home. Waiver funding is integral to the agency’s delivery of services. Waiver funding enables DCS to offer an expanded array of concrete goods and services to help families succeed. These types of services are typically only available through other funding sources. Some of the concrete services supported by Waiver funding include: payment of utility bills, vehicle repairs, before/after school care, respite care, baby monitors, and cleaning of the home environment. These are valuable services for families that often prevent the need for removal. For new programs funded by the Waiver, DCS will move towards a CQI driven method of evaluating service needs, quality of services, and the impact that those services have on child and family outcomes.

The CQI Steering Committee has been involved in establishing CQI as core to services delivered under the Waiver. The CQI Steering Committee will continue to monitor and shape the CQI efforts driving service delivery. In addition to the CQI Steering Committee, there are several work groups that help support the Waiver.

6. Deloitte Consulting LLP

DCS commissioned Deloitte Consulting, LLP to conduct a Caseload and Workload Analysis. The Caseload and Workload Analysis assessed the current state of DCS field operations and evaluated the caseload standards in light of existing agency practices, activities, and performance. Included in this assessment was an analysis of DCS' current practices set against leading national child welfare practices that are aligned with improvement in caseload management and service delivery. Deloitte provided a prioritized roadmap and profile for each recommended option that DCS should consider implementing to improve its ability to meet future caseload standards while improving services to children and families.

Based on the Deloitte recommendations, the CQI Steering Committee identified the following priorities:

- Hire additional field staff for compliance with the 1:12 and 1:17 caseload ratios
- Improve organizational efficiencies
- Enhance staff training on use of existing technologies
- Improve data-driven decision making

7. Work Groups

In addition to the CQI Steering Committee, work groups were assigned to assess qualitative and quantitative data results from consultants and DCS reports and identify next steps toward achieving each of the agency's goals for safety, permanency, well-being and CQI. Executive staff were assigned as Leads for the identified goals and objectives. Current work groups have been established for Family Centered Treatment (FCT) team, Enhanced Multidisciplinary team, CANS Committee team, Substance/CMHC team, Placement Permanency Options and Supports team, Foster Care Supervisors/Managers team, Post Adoption/SNAP/LCPA/Service Providers team, Placement Matching team, Concurrent planning team, Case Plan and Transition Plan team, Father Engagement/Providers/Investigators/Field/Legal team, CQI Central team, Evidence Based Practices and Service Mapping team, Collaborative Care Management team, Waiver Communications and Training Team, and Practice Model Refresh team. Each Lead initially determined internal staff representatives needed to serve as group members and sub group members. External stakeholder group members are selected according to objective goal and member's subject matter expertise. Leads establish a subgroup specifically assigned to CQI to monitor, track and adjust strategies related to implementation, communications, logistical issues, and fidelity to models chosen. The subgroup reports findings to the work group. Leaders report progress and findings to the CQI Steering Committee. Currently, Leaders have been assigned to all agency goals.

- a) Develop regional CQI teams that include regional arms of central office to improve the flow of information and facilitate performance improvement and problem-solving at the local level.

See the Data Analysis section above. Casey Family Programs and KSM are assisting with this objective. This Objective has not been completed.

- b) Establish policy work group to define and draft agency policy around CQI including administrative structure, quality data collection, and processes for ongoing case reviews, data analysis and dissemination, and providing feedback.

See Work Group section above. This Objective has not been completed.

- c) Engage stakeholders around CQI including revisiting the composition of and role of regional service

councils.

Further analysis of this Objective is necessary. This Objective has not been completed.

- d) Implement a train the trainer on CQI processes for performance and quality improvement staff and regional coordinators so they can serve as CQI experts on the regional teams.

Further analysis of this Objective is necessary. This Objective has not been completed In 2014, DCS staff in PQI and Research and Evaluation division, Service Coordinators, Providers, and some DCS Executives participated in two sessions of Train the Trainer on the Plan-Do-Study-Act (PDSA) model. These individuals will serve CQI Experts on regional teams.

- e) Provide support to service providers as they identify ways to incorporate CQI processes into their way of doing business.

DCS provided a presentation to providers in Fall of 2014 on CQI, QSR, and data and how they can assist them in planning. Additional work was done with Fathers Engagement providers throughout Indiana. Further analysis of this Objective is necessary. This Objective has not been completed.

OBJECTIVE 4.2 EVALUATE CURRENT QUALITY IMPROVEMENT AND QUALITY ASSURANCE POLICIES AND PROCESSES AND IMPLEMENT STRATEGIES TO FURTHER ENHANCE THESE SYSTEMS AND INTEGRATE THEM INTO THE LARGER AGENCY CQI MODEL.

- a) Continue development of a QSR process for collaborative care.

In 2014, DCS began piloting the Collaborative Care (CC) QSR process. The pilot round will be completed in October 2015. DCS plans to develop an electronic reviewer file to support the capacity to conduct a statistically valid pull in future rounds without overly burdening Collaborative Care case management staff. Currently, 3CMs manually prepare cases for review. A statistically valid pull for Collaborative Care cases is not feasible as it would require 3CMs to prepare multiple cases. The electronic reviewer file will pull documentation for reviewer evaluation which will support both the expanded pull for the CC QSR, QSR, and upcoming CFSR by lessening the workload on 3CMs and FCMs.

- b) Continue further development of automated QAR reports.

Initial QAR reports have completed the mapping and data pull verification stages. The reports should be released by summer 2015. QAR reports will be similar to other DCS reports which inform the agency of results on a statewide level, as well as to the employee level for all regions.

The automation of ongoing cases and Older Youth Services cases for QAR reports remains under construction in MaGIK. "Real time" and quarterly reports will be available in MaGIK in fall 2015. The reports will enable supervisors to monitor cases and make changes to them on an ongoing basis. The reports will assist FCM Supervisors in engaging in ongoing conversations with FCMs on areas of strength and those needing improvement. The statewide data will be used to track progress and make adjustments to current strategies.

Automated assessment and ongoing data reports are in the initial phases of development. The most critical QAR questions will be measured in MaGIK. After these reports are rolled out and refined, additional questions will be added to the QAR in MaGIK .

OBJECTIVE 4.3 IMPROVE UTILIZATION OF INFORMATION SYSTEMS AND DATA FROM A VARIETY OF SOURCES TO SUPPORT THE MANNER IN WHICH THE AGENCY ASSESSES SYSTEM PERFORMANCE TO SUPPORT SYSTEM IMPROVEMENT.

- a) Improve manner in which we structure our data to provide more timely access to satisfy individual data requests.

DCS has adopted the Plan-Do-Study-Act (PDSA) CQI model. Additional projects have been identified and will be implemented as data becomes available. This Objective has not been completed.

- b) Build staff capacity to utilize data for decision-making.

As discussed in the Organizational Structure section above, DCS created a new position and hired the Director of Child Welfare Outcomes Director in June of 2015. His primary responsibilities include data management, reporting, and analysis. DCS has also received preliminary recommendations on data strategy from KSM Consulting which include an organizational redesign and restructured data model. Implementation of these recommendations will commence during the first quarter of state fiscal year 2016.

- c) Integrate qualitative and quantitative data to provide a more comprehensive view of child welfare system strengths and areas for improvement.

See Data Analysis section above. This Objective has not been completed.

CQI MEASURES OF PROGRESS

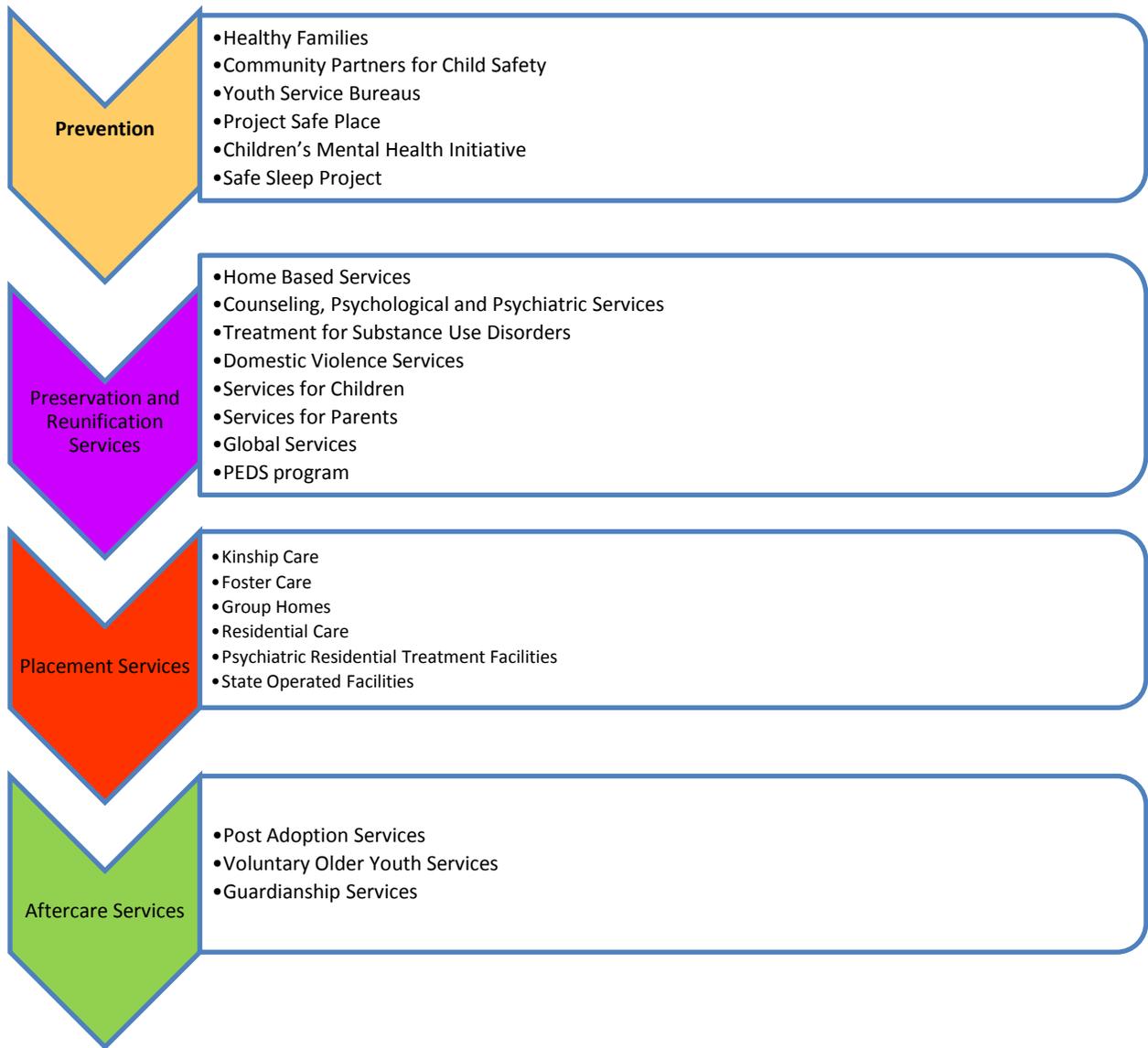
DCS continues to measure progress on the CQI goal from a completion perspective instead of a more quantified data analysis method. DCS has successfully made initial steps implementing CQI into its organizational structure. With the recent addition of the Director of Child Welfare Outcomes, DCS hopes to continue integration of CQI by capturing additional data, streamlining reports, implementing data modelling, and developing management dashboards to facilitate more real-time decision-making and further analysis of progress on all of the CFSP goals and objectives. During FFY 2014-2015, DCS successfully developed a decision-making structure within the executive staff and field staff through the CQI Steering Committee and workgroups.

DCS remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and a broader service array. DCS has routinely monitored the effectiveness of the Practice Model in order to establish the goals and direction of the agency, Title IV-E Waiver spending, training, and service delivery. To further support these efforts, DCS is implementing a Continuous Quality Improvement (CQI) process that will serve as the foundation for setting agency priorities, structure for internal and external collaborations, and interventions as well as the continuum of service provision. DCS is committed to developing a sustainable CQI approach that will serve as the basis for evaluating and improving child welfare practice.

V. UPDATE ON SERVICE DESCRIPTION

A. CHILD AND FAMILY SERVICES CONTINUUM (45 CFR 1357.15(N))

DCS provides a full continuum of services state-wide. Those services can be categorized in the following manner:



1. Prevention Services

Kids First Trust Fund

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

Youth Service Bureau

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

Project Safe Place

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

Community-Based Child Abuse Prevention

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

Healthy Families Indiana (HFI)

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

Community Partners for Child Safety (CPCS)

The purpose of this service is to develop a child abuse prevention service array that can be delivered in every region of the state. This service builds community resources that promote support to families identified through self-referral or other community agency referral to a service that will connect families to the resources needed to strengthen the family and prevent child abuse and neglect. It is intended, through the delivery of these prevention services, that the need for referral to Child Protective Services will not be necessary. Community resources include, but are not limited to: schools, social services agencies, local DCS offices, Healthy Families Indiana, Prevent Child Abuse Indiana Chapters, Youth Services Bureaus, Child Advocacy Centers, the faith-based community, local school systems and Twelve Step Programs.

Maternal Infant Early Childhood Home Visiting (MIECHV)

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

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

Children’s Mental Health Initiative

The Children’s Mental Health Initiative (CMHI) provides service access for children with significant mental

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

The Children's Mental Health Initiative is collaboration between DCS and the local Access Sites, Community Mental Health Centers and the Division of Mental Health and Addiction. Available services include:

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

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

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

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

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

2. Preservation and Reunification Services

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

Home Based Services

- Comprehensive Home Based Services
- Homebuilders
- Home-Based Family Centered Casework Services
- Home-Based Family Centered Therapy Services
- Homemaker/Parent Aid
- Child Parent Psychotherapy

Counseling, Psychological and Psychiatric Services

- Counseling
- Clinical Interview and Assessment
- Bonding and Attachment Assessment
- Trauma Assessment
- Psychological Testing
- Neuropsychological Testing
- Functional Family Therapy
- Medication Evaluation and Medication Monitoring
- Parent and Family Functioning Assessment

Treatment for Substance Use Disorder

- Drug Screens
- Substance Use Disorder Assessment
- Detoxification Services-Inpatient
- Detoxification Services-Outpatient
- Outpatient Services
- Intensive Outpatient Treatment
- Residential Services
- Housing with Supportive Services for Addictions
- Sobriety Treatment and Recovery Teams (START)

Domestic Violence Services

- Batterers Intervention Program
- Victim and Child Services

Services for Children

- Child Advocacy Center Interview
- Services for Sexually Maladaptive Youth
- Day Treatment
- Day Reporting
- Tutoring
- Transition from Restrictive Placements
- Cross Systems Care Coordination
- Children's Mental Health Wraparound Services
- Services for Truancy
- Older Youth Services
- Therapeutic Services for Autism
- LGBTQ Services

Services for Parents

- Support Services for Parents of CHINS
- Parent Education
- Father Engagement Services
- Groups for Non-offending Parents
- Apartment Based Family Preservation
- Visitation Supervision

Global Services

- Special Services and Products
- Travel
- Rent & Utilities
- Special Occasions
- Extracurricular Activities

These services are provided according to service standards found at: <http://www.in.gov/dcs/3159.htm>. Service enhancements during the next 5 years include continued expansion of the home-based service array. Services currently available under the array include:

Home Based Services			
Service Standard	Duration	Intensity	Conditions/Service Summary
Homebuilders ® (Must call provider referral line first to determine appropriateness of services) (Master's Level or Bachelors with 2 yr experience)	4 – 6 Weeks	Minimum of 40 hours of face to face and additional collateral contacts	Placement Prevention: Provision of intensive services to prevent the child's removal from the home, other less intensive services have been utilized or are not appropriate or Reunification: it is an unusually complex situation and less intensive services are not sufficient for reunification to occur. Services are available 24/7 Maximum case load of 2-3

Home-Based Therapy (HBT) (Master's Level)	Up to 6 months	1-8 direct face-to face service hrs/week (intensity of service should decrease over the duration of the referral)	Structured, goal-oriented, time-limited therapy in the natural environment to assist in recovering from physical, sexual, emotional abuse, and neglect, mental illness, personality/behavior disorder, developmental disability, dysfunctional family of origin, and current family dysfunction. Service is available 24/7. Beginning 7/1/11, some providers will have a 1 hour response time for families in crisis. Maximum case load of 12.
Home-Based Casework (HBC) (Bachelor's Level)	Up to 6 months	direct face-to-face service hours/week (intensity of service should decrease over the duration of the referral)	Home-Based Casework services typically focus on assisting the family with complex needs, such as behavior modification techniques, managing crisis, navigating services systems and assistance with developing short and long term goals. Service is available 24/7. Beginning 7/1/11, some providers will have a 1 hour response time for families in crisis. Maximum case load of 12.
Homemaker/ Parent Aid (HM/PA) (Para-professional)	Up to 6 months	1-8 direct face-to-face service hours/week	Assistance and support to parents who are unable to appropriately fulfill parenting and/or homemaking functions, by assisting the family through advocating, teaching, demonstrating, monitoring, and/or role modeling new, appropriate skills for coping. Some providers have a 1 hour response time for families in crisis. Maximum case load of 12.
Comprehensive Home Based Services	Up to 6 months	5-8 direct hours with or on behalf of the family	Utilizing an evidence based model to assist families with high need for multiple home based intensive services. Additionally, will provide: supervised visits, transportation, parent education, homemaker/parent aid, and case management. Some evidence based models require a therapist to provide home based clinical services and treatment. These services are provided by one agency. This is referable through service mapping or the Regional Services Coordinator Maximum case load of 5-8.

Comprehensive Home-Based Services

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

In addition, Family Centered Treatment is being supported by DCS as a model of Comprehensive Home-Based Services. This service provides intensive therapeutic services to families with children at risk of placement or to support the family in transitioning the child from residential placement back to the family. This model also is

effective in working with families who have very complex needs. The service works to implement sustainable value change that will improve life functioning and prevent future system involvement.

Services Available Through Comprehensive Home Based Services		
Service Standard	Target Population	Service Summary
FCT – Family Centered Therapy	<ul style="list-style-type: none"> ● Families that are resistant to services ● Families that have had multiple, unsuccessful attempts at home based services ● Traditional services that are unable to successfully meet the underlying need ● Families that have experienced family violence ● Families that have previous DCS involvement ● High risk juveniles who are not responding to typical community based services ● Juveniles who have been found to need residential placement or are returning from incarceration or residential placement 	<p>This program offers an average of 6 months of evidenced based practice that quickly engages the entire family (family as defined by the family members) through a four phase process. The therapist works intensively with the family to help them understand what their values are and helps motivate them to a sustainable value change that will improve the lives of the whole family.</p>
MI – Motivational Interviewing	<ul style="list-style-type: none"> ● effective in facilitating many types of behavior change ● addictions ● non-compliance and running away of teens ● discipline practices of parents. 	<p>This program offers direct, client-centered counseling approaches for therapists to help clients/families clarify and resolve their ambivalence about change. Motivational Interviewing identifies strategies for practitioners including related tasks for the clients within each stage of change to minimize and overcome resistance. This model has been shown to be effective in facilitating many types of behavior change including addictions, non-compliance, running away behaviors in teens, and inappropriate discipline practices of parents.</p>
TFCBT – Trauma Focused Cognitive Behavioral Therapy	<ul style="list-style-type: none"> ● Children ages 3-18 who have experienced trauma ● Children who may be experiencing significant emotional problems ● Children with PTSD 	<p>This program offers treatment of youth ages 3-18 who have experienced trauma. The treatment includes child-parent sessions, uses psycho education, parenting skills, stress management, cognitive coping, etc. to enhance future safety. Treatment assists the family in working through trauma in order to prevent future behaviors related to trauma, and a non-offending adult caregiver must be available to participate in services.</p>

<p>AFCBT – Alternative Family Cognitive Behavioral Therapy</p>	<ul style="list-style-type: none"> ● Children diagnosed with behavior problems ● Children with Conduct Disorder ● Children with Oppositional Defiant Disorder ● Families with a history of physical force and conflict 	<p>This program offers treatment to improve relationships between children and parents/caregivers by strengthening healthy parenting practices. In addition, services enhance child coping and social skills, maintains family safety, reduces coercive practices by caregivers and other family members, reduces the use of physical force by caregivers and the child and/ or improves child safety/welfare and family functioning.</p>
<p>ABA – Applied Behavioral Analysis</p>	<ul style="list-style-type: none"> ● Children with a diagnosis on the Autism Spectrum 	<p>This program offers treatment for youth with autism diagnosis to improve functional capacity in speech and language, activities of daily living, repetitive behaviors and intensive intervention for development of social and academic skills.</p>
<p>CPP – Child Parent Psychotherapy</p>	<ul style="list-style-type: none"> ● Children ages 0-5 who have experienced trauma ● Children who have been victims of maltreatment ● Children who have witnessed DV ● Children with attachment disorders ● Toddlers of depressed mothers 	<p>This program offers techniques to support and strengthen the caregiver and child relationship as an avenue for restoring and protecting the child’s mental health, improve child and parent domains, and increase the caregiver's ability to interact in positive ways with the child(ren). This model is based on attachment theory but integrates other behavioral therapies.</p>
<p>IN-AJSOP</p>	<p>Children with sexually maladaptive behaviors and their families</p>	<p>This program offers treatment to youth who have exhibited inappropriate sexually aggressive behavior. The youth may be reintegrating into the community following out-of-home placement for treatment of sexually maladaptive behaviors. Youth may have sexually maladaptive behaviors and co-occurring mental health, intellectual disabilities or autism spectrum diagnoses. CBT-IN-AJSOP focuses on skill development for youth, family members and members of the community to manage and reduce risk. Youth and families learn specific skills including the identification of distorted thinking, the modification of beliefs, the practice of pro social skills, and the changing of specific behaviors</p>
<p>Intercept</p>	<p>Children of any age with serious emotional and behavioral problems</p>	<p>Treatment is family-centered and includes strength-based interventions, including family therapy using multiple evidence based models (EBM), mental health treatment for caregivers, parenting skills education, educational</p>

		interventions, and development of positive peer groups.
--	--	---

Sobriety Treatment and Recovery Teams

DCS is currently piloting a promising practice program that has shown very positive outcomes with families in Kentucky. The program combines a specially trained Family Case Manager, Family Mentor, and Treatment Coordinator to serve families where there are children under the age of 5 and the parent struggles with a substance use disorder. The Family Mentor is someone who has had history with the child welfare system and is currently in recovery. The program is being piloted in Monroe County. Currently there are three active Family Case Managers, one Family Mentor and one Treatment Coordinator with the ability to add 2 additional mentors. It is estimated that the full team will be serving approximately 30 families at any given time. DCS is expanding this program into Vigo County in 2015.

Adolescent Community Reinforcement Approach (ACRA)

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

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

Trauma Assessments, TF-CBT, CPP

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

Child Parent Psychotherapy (CPP) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) are two of the possible models that could be utilized. DCS has trained a cohort of 28 therapists to provide Child Parent Psychotherapy. This first cohort of trained therapists includes 9 teams of 3 therapists from within the CMHC network and one additional DCS clinician. These therapists completed their training in May 2014, but will receive another year of consultation through the Child Trauma Training Institute as they begin to fully implement the model. DCS will evaluate the need and ability to train additional clinicians to ensure service availability for children in need. DCS began offering training to a second cohort of clinicians to ensure service availability for children in need. DCS has trained approximately 300 clinicians throughout the state to provide TF-CBT. These

agencies are both CMHC's and community-based providers and will ensure that TF-CBT is available for children and families in need.

Parent Child Interaction Therapy

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

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

Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) Services

DCS, with technical assistance from Gary Malon, revised policies and service standards, and developed a resource list for staff and providers to utilize to ensure appropriate services are provided to clients who identify as Lesbian, Gay, Bisexual, Transgender or Questioning.

Foster Care

DCS will continue to provide access to foster homes throughout the state. Foster homes are licensed through DCS and through licensed child placing agencies. More detailed information can be found in the Foster and Adoptive Parent Licensing, Recruitment, and Retention section.

Kinship Care

DCS remains committed to securing the most family-like setting for a child when removal from the home occurs. DCS will first consider placing a child with an appropriate noncustodial parent. If placement with a noncustodial parent is not possible, DCS will look to relatives. DCS changed statute effective July 2014, to include in the definition of "relative," "any other individual with whom a child has an established and significant relationship." DCS is in the process of establishing policy and practice around the new statutory definition.

DCS utilizes Relative Support Specialists to assist in supporting relative resources. These staff are relatively new, thus their duties are still being formalized.. The Specialists main duties are to inform the relative care placements of support services available to them to promote child permanency, stability and well-being. DCS ensures appropriate services are in place for both the child and the relative caregiver. DCS continues to monitor the relative placement to ensure a safe environment with appropriate supervision is being provided.

Adoption Services

See Services Description, Adoption Promotion and Support Services below for additional information on the types of Adoption Services provided.

Independent Living: Older Youth Services

The service array for Independent Living is described in detail in Section VII, Chafee Foster Care Independence Program.

B. SERVICE COORDINATION (45 CFR 1357.15(M))

DCS has built an extensive network of Federal, State, local and private partnerships and collaborations to support child maltreatment and prevention programs and activities. The DCS Prevention Team and the Community Partners for Child Safety contracted providers build on these efforts to promote and support families by connecting families with a continuum of services and resources needed to strengthen the family and prevent child abuse and neglect.

More specifically, federal funds awarded to Indiana and the extensive collaboration and coordination between State agencies, both directly and in-directly, result in the following partnerships, ultimately supporting communities and families at the local level.

1. Indiana State Department of Health

The Indiana State Department of Health (ISDH) houses a number of divisions that receive federal funding to administer several programs that are vital to families and children in Indiana. At the state level, a number of partnerships have been formed between DCS and ISDH in an effort to better coordinate federal and state resources.

Maternal and Child Health (MCH):

At the state level, MCH is funded in large part by the federal Maternal and Child Health Bureau (MCHB) Title V Block Grants. MCH also houses a number of projects, programs and services that are vital to the families and children served by CPCS, as outlined in more detail below.

Early Childhood Comprehensive System (ECCS) and Project LAUNCH:

Indiana's ECCS grant provided the impetus for a much needed collaboration of statewide early childhood organizations to come together with the goal to develop coordinated services and policies so that children arrive at school healthy, safe, ready to learn, and able to succeed. Indiana has utilized the ECCS model very successfully to help build a state infrastructure that better meets the needs of infants and toddlers with social-emotional challenges. With the incorporation of Project LAUNCH in 2012 along with a shift in federal focus at HRSA to funding project focused initiatives as opposed to infrastructure-building, the ECCS partnership has reengaged its purpose and is now actively involved in quality improvement initiatives that target a broad range of needs in early childhood, including social-emotional health, behavioral health, and integrating physical health. Home visiting programs from across the state continue to play a pivotal role in identifying at-risk children at the earliest opportunity so that improvements in behavioral health outcomes are optimized.

Some other efforts supported by ECCS (which includes Project LAUNCH co-lead, DMHA, the state's Single

State Agency for Substance Abuse Services) served to move the infant mental health agenda forward in Indiana:

- Development and dissemination of a module clarifying reimbursement for IMH services in Community Mental Health Center (CMHC) systems
- Coordination with Indiana University School of Social Work for graduate level classes: Early Childhood Diagnosis, a one credit course on Diagnostic Criteria Zero to Three-Revised (DC0-3R) and a 3-credit course titled Advanced Issues in Early Childhood Mental Health which provides overview of important foundational areas of early childhood mental health.
- Adoption of Michigan Association for Infant Mental Health Endorsement (IMH-E®), a widely used set of competencies and a credentialing process for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health. ISDH, Indiana Head Start State Collaborative, and DCS supported the Endorsement. DMHA provided additional funding for the training of a cadre of providers who received intensive IMH-E® training and supervision.
- Awareness and training activities such as white papers on IMH assessment and intervention through Indiana's Early Intervention System, a discussion paper on early intervention and autism, a Crosswalk between the DC 0-3R, DSM, and ICD systems, and presentations to Early Intervention Service Coordinators and foster care parents on ECMH/IMH
- A white paper was published, Providing Services to Infants, Toddlers and Preschoolers within a Recovery-Oriented Behavioral Health Care System which reviews the Medicaid Rehabilitation Option that supports the acquisition of skills that lead to recovery and optimum functioning of individuals with mental health challenges.
- Development of resources including Family Resource Fact Sheets, a developmental calendar, and a Child's Wellness Passport with a special health care needs addendum
- The Bureau of Child Development and the Indiana Association for Child Care Resource and Referral supported the creation and presentation of the Infant Mental Health Modules

Collaborative work of the ECCS is championed by recent legislation that established the Indiana Commission on Improving the Status of Children (CISC) under a new law signed by Governor Pence on April 30, 2013. This 18-member Commission consists of leadership from all three branches of government. CISC is charged with studying and evaluating services for vulnerable youth, promoting information sharing and best practices, and reviewing and making recommendations concerning pending legislation. This broad-based state commission studies and evaluates state agency policy and practice as well as proposes legislation that affects the well-being and best interests of children in Indiana. Enhancement and expansion of our statewide home visiting programs aligns well with this multi-tiered, action-oriented, outcome-expected approach.

In addition to CISC, the Governor has formed an appointed Early Learning Advisory Committee (ELAC) that was established in 2013 by the Indiana General Assembly. Committee membership is appointed by the governor and includes representation from Bureau of Child Care, Department of Education, Head Start, Cummins, Eli Lilly, and Wellborn Baptist Foundation. The State Young Child Wellness Council has an ELAC representative from the Bureau of Child Care and the Head Start State Collaboration Office who participate on Project LAUNCH. The ELAC's responsibilities include:

1. Conducting periodic statewide needs assessments concerning quality and availability of early education programs for children from birth to the age of school entry, including the availability of high quality prekindergarten education for low income children in Indiana.
2. Identifying opportunities for and barriers to collaboration and coordination among federally and state

funded child development, child care, and early childhood education programs and services, including governmental agencies that administer programs and services.

3. Assessing capacity and effectiveness of two and four year public and private higher education institutions in Indiana for support and development of early educators including professional development and career advancement plans and practice or internships with or prekindergarten programs.
4. Recommending to the Division procedures, policies, and eligibility criteria for the Early Education Matching Grant program.

The DCS Prevention Manager (CBCAP Lead) and MIECHV Coordinator are active members of Project LAUNCH including , the *Home Visiting Sub-committee and the ECCS Social Emotional Sub-committee* which is also chaired by the Director from the Riley Child Development Center (RCDC, described in more detail below).

Social Emotional Sub-committee

The work of the Social Emotional Sub-committee centers around increasing the number of direct service providers with knowledge, practical skills and specialization in the effects and treatment of mitigating toxic stress and trauma as well as enhancing linkages and cooperation across systems serving infants and children. The Social Emotional Sub-committee is focused on outreach and supportive efforts to increase the number of professionals and paraprofessionals in the state that are endorsed by the Indiana Association for Infant and Toddler Mental Health (IAITMH).

Endorsement Process

The Endorsement process will increase the mental health workforce capacity and create an integrated infrastructure that will ensure that all Indiana families with very young children have access to well-trained providers in their home communities.

Beginning in 2010, support to implement the Endorsement® process in Indiana has been provided by the Indiana Head Start Collaboration and the Department of Child Services. Benefits of the Endorsement® program are numerous for children and families, providers, agencies, and systems of care. Individuals who have earned the Endorsement® cite the program as leading to an increase in professional development, including the completion of a degree or adding a graduate degree. In addition to the positive provider experiences, families have benefitted from greater access to well-trained providers whether their family is in need of high quality child care or the services of a mental health professional.

Agencies have found the Endorsement® helpful in structuring training and ensuring a well-prepared early child care and intervention workforce. Finally, systems have realized improvements in agreement about best practices, increased workforce capacity, and even cost savings because prevention and promotion of behavioural health by workers at Levels I and II reduces the need for services at more costly levels.

In addition, the DCS Services Division is also in discussions to explore how the agency can support efforts of contracted providers for Prevention, Preservation and Intervention services to achieve and maintain the Endorsement. In recent years, IAITMH® has also received expanded support through various state initiatives to stream-line the endorsement process and enhance the training available. In FY2014, the number of HFI staff in Indiana that had achieved the endorsement more than doubled, largely in-part by efforts to coordinate stakeholders and leverage multiple funding opportunities including a grant from the Indiana State Department of Health. By coordinating efforts between state and community stakeholders, the DCS Prevention Unit significantly contributed to existing efforts to expand the availability of competent individuals by supporting efforts of DCS

HFI providers to complete the endorsement.

Enhanced Home Visitation

Another Project LAUNCH committee that the Prevention Manager and MIECHV Coordinator are actively engaged involves Enhanced Home Visitation to a local community in the state. Through a grant awarded by Project LAUNCH in 2014 to One Community One Family, Inc., a private non-profit serving families and children in the South Eastern corner of the state. There are plans to enhance upon the providers current scope of work by including Incredible Years services to families who are eligible.

Home visiting staff in the region will also receive enhanced trainings in Motivational Interviewing, Trauma-Informed Approaches, and Mental Health First Aid in order to improve outcomes for families and children. Additionally, selected programs serving young children in the region, including at least one HFI site, will receive mental health consultation that will serve to bolster their knowledge and continually serve families in the most effective manner. Such partnerships and collaborations further demonstrate the strength and positive impacts of the DCS Prevention Teams relationships with ISDH have had to further larger prevention efforts for Indiana families and children.

Maternal Infant Early Childhood Home Visiting (MIECHV)

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

Evaluation Advisory Board (EAB) and the Indiana Home Visiting Advisory Board (INHVAB)

As part of the MIECHV partnership between DCS and ISDH, Indiana created the MIECHV Evaluation Advisory Board (EAB) and the Indiana Home Visiting Advisory Board (INHVAB). The EAB is lead by the MIECHV external evaluation team from Indiana University and includes stakeholders from DCS, HFI, ISDH, and NFP to review and advise on the MIECHV evaluation studies being completed in Indiana. The INHVAB includes stakeholders from DCS, HFI, ISDH, and NFP for the purpose of identifying aspects of the MIECHV project that should inform policy for home visiting within Indiana. The INHVAB also serves as the oversight committee for MIECHV Continuous Quality Improvement (CQI) development and activities. DCS leaders believe that these advisory boards not only provide benefits to both HFI and NFP, these boards have and will continue to serve as catalysts for increasing collaboration and relationship building between DCS and ISDH, which will ultimately result in improved coordination and quality of home visiting services in Indiana.

Local Safe Sleep

Safe Sleep-At the local level, ISDH is also reaching out to many HFI and CPCS providers to coordinate safe sleep education and outreach efforts as well as develop formal Memorandum of Understanding (MOU) through which the provider will become a crib distribution site for the Safe Sleep program in their local communities.

2. Family and Social Services Administration (FSSA):

FSSA houses a number of divisions that receive federal funding to administer several programs that are vital to families and children in Indiana. At the state level, a number of partnerships have been formed between DCS and FSSA in an effort to better coordinate federal and state resources.

Department of Mental Health and Addiction (DMHA)

As stated previously, the Children's Mental Health Initiative (CMHI) is a collaboration between DCS and DMHA and local Community Mental Health Centers who serve as access sites to ensure children are served in the most appropriate system to meet their needs. At the local level, partnerships between Community Partners for Child Services (CPCS) providers and local access sites are beginning to develop as the CMHI project spreads throughout the state and the benefits of collaboration efforts are realized.

Department of Family Resources (DFR)

FSSA's DFR houses a number of programs and services which are valuable resources for families and children. Therefore it is vital for DCS, the Prevention Team and local CPCS providers to develop and maintain strong partnerships as outlined below.

Housed in DFR, the Indiana Bureau of Child Care is funded by the Child Care and Development Fund (CCDF) and Temporary Assistance to Needy Families (TANF) to provide a number of services to low income families. Indiana Code (IC) 12-17.2 establishes the authority for DFR to regulate child care in the State. It also authorizes the division to adopt rules to implement the federal CCDF voucher program. Access to affordable, quality childcare is often a need for many families receiving CPCS services therefore it is vital at the local level for CPCS providers to have well established referral and outreach relationships with their local CCDF providers.

Indiana Head Start

Also housed in DFR, the Indiana Head Start Collaboration Office (IHSCO) and the Prevention Manager (CBCAP Lead) have a long time partnership which includes annual financial support from the IHSCO for the Institute for Strengthening Families conferences which allows for significant attendance from Head Start and Early Head Start Program staff. In addition, the Prevention Manager is an active member of the IHSCO Bi-Annual Multi-Agency Advisory Council which brings partners and potential partners together to discuss the plans of the Collaboration office and discover how members might collaborate for the benefit of Indiana's youngest Hoosiers and their families. IHSCO members include: the Bureau of Child Development, Head Start and Early Head Start, Maternal and Child Health (MCH), Sunny Start and DCS Prevention Services.

The Collaboration Office completed a statewide needs assessment in preparation for the 2009-2013 State Plan. The needs assessment reported data in the following areas: early childhood education and transition, professional development, child care, services to children with disabilities, services to children experiencing hopelessness, and community based services. DCS is an active partner with the Head Start Collaboration Office and works to develop intermediate and advanced training seminars at the Institute for Strengthening Families scheduled in April and September of each year.

At the local level, Federal grants are provided directly to local public and private non-profit and for-profit agencies to provide Head Start and Early Head Start programs which are comprehensive child development services to economically disadvantaged children and families, with a special focus on helping preschoolers

develop the early reading and math skills they need to be successful in school. In FY 1995, the Early Head Start program was established to serve children from birth to three years of age in recognition of the mounting evidence that the earliest years matter a great deal to children's growth and development.

Head Start programs promote school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families. They engage parents in their children's learning and help them in making progress toward their educational, literacy and employment goals. Significant emphasis is placed on the involvement of parents in the administration of local Head Start programs. Many of the CPCS providers in the state are active members of their local Head Start and Early Head Start Advisory Boards and use the Head Start model of engaging parents in leadership activities as models for their own current and future plans for such within CPCS programs. Such sharing of effective practices further demonstrates the strength and extensive nature of such relationships.

Bureau of Child Developmental Services

At the state level, FSSA's Bureau of Child Developmental Services administers the First Steps System which is Indiana's Early Intervention Program, Part C of the Individuals with Disabilities Education Act (IDEA). First Steps is a family-centered, locally-based, coordinated system that provides early intervention services to infants and young children with disabilities or who are developmentally vulnerable. First Steps brings together families and professionals from education, health and social service agencies. By coordinating locally available services, First Steps is working to give Indiana's children and their families the widest possible array of early intervention resources. Families who are eligible to participate in Indiana's First Steps System include children ages birth to three years, who are experiencing developmental delays and/or have a diagnosed condition that has a high probability of resulting in developmental delay.

First Steps

At the state level, First Steps is advised by the Interagency Coordinating Council (ICC). The ICC is a federally mandated group that assists and advises the state's program of early intervention services for infants and toddlers with disabilities and their families. It is a Governor-appointed council that includes membership of all pertinent state agencies/departments, service providers, and family consumers. In 2014, the Prevention Program Manager (CBCAP Lead) has been invited to and will participate in ICC quarterly meetings. In addition, many First Steps providers regularly participate in the training opportunities available through the Institute for Strengthening Families.

At the local level, many of the CPCS providers have developed reciprocal referral relationships with their local First Steps offices as part of the outreach efforts to support families of children with disabilities.

3. Additional Collaborations Furthering Service Coordination

Governor's Domestic Violence Prevention and Treatment

The Governor's Domestic Violence Prevention and Treatment Council is administered by the Indiana Criminal Justice Institute (ICJI) under I.C. 5-2-6.6. The Governor's Domestic Violence Prevention and Treatment Council (DVPT) is responsible for developing a state-wide domestic violence and sexual assault strategic plan that includes analysis of: existing programs and services, gaps in services, funding, staffing and other resource needs and gaps and emerging issues and challenges for the delivery of services. In 2014 the Prevention Manager

(CBCAP Lead) was invited to serve on the council.

National Resource Center for Child Protective Services (NRCPS):

The NRCPS provides free on-site training and technical assistance to State and Tribal child welfare agencies through funding provided by the Children's Bureau, U. S. Department of Health and Human Services. In 2013, DCS requested assistance from NRCPS for possible revision of Batterer Intervention Service standards and to ensure alignment of Domestic Violence policy and practice with national standards. One of the recommendations from NRCPS as a result of their assessment is for DCS to participate on the Indiana Coalition Against Domestic Violence (ICADV) workgroup as they consider revisions to their Batterers Intervention Program standards. Additional recommendations from NRCPS are currently under consideration with DCS leadership.

Indiana Coalition Against Domestic Violence (ICADV):

The Indiana Coalition Against Domestic Violence is a statewide alliance of domestic violence programs, support agencies and concerned individuals. ICADV provides technical assistance, resources, information and training to those who serve victims of domestic violence; and promote social and systems change through public policy, public awareness and education.

ICADV also developed Indiana's Batterers' Intervention Program (BIP) Standards and certification process to ensure overall quality and consistency for service providers who work with men who batter. An ICADV certified BIP is a community program that makes victim safety its first priority, establishes accountability for batterers and promotes a coordinated community response. These standards were developed by a committee of the Indiana Coalition Against Domestic Violence and were first adopted in November 2001 and is currently in the process of reviewing and updating the standards.

The ICADV BIP Standards are the result of extensive work among members of this committee and a review of the standards in other states. Many individuals from all areas of the state of Indiana participated in the process of developing these standards including judges, defense attorneys, prosecutors, law enforcement, probation officers, substance abuse counselors, mental health counselors, marriage and family therapists, social workers, clergy, academics, community activists, politicians, victim advocates, BIP providers, survivors, and many other concerned citizens. In 2014, the Prevention Manager (CBCAP Lead) was identified as the DCS staff person assigned to participate as a member of the committee which currently meets monthly to update the standards.

Participation of the Prevention Manager in this workgroup is vital to building relationships with ICADV and the larger Domestic Violence infrastructure in the state and for creating the opportunity for future collaboration and partnerships which will result in more coordinated prevention and intervention efforts across the state.

Riley Child Development Center (RCDC)

RCDS is housed in Riley Hospital for Children and their mission is to provide leadership education excellence in neurodevelopment and related disabilities to professionals who are preparing for careers in health care and other fields which enhance the quality of life for children with developmental disabilities and their families. The mission is achieved primarily through interdisciplinary training of long term trainees at the graduate and postgraduate levels who develop the clinical expertise, competence and leadership attributes that extend basic knowledge and acumen which prepares graduate trainees for leadership roles within local, regional, state and national communities.

Activities of the RCDC reflect a commitment to persons with disabilities and their families through the pursuit of

new knowledge by way of critical inquiry and research, the provision of professional consultation and technical assistance to state and local health authorities and the provision of continuing education activities for all issues that involve children and families at the local, state, regional and national levels. In addition, the RCDC promotes the inclusion of content regarding children, families and neurodevelopmental disabilities in all curricula within Indiana University.

RCDC activities are culturally sensitive and demonstrate respect for individual differences in behaviors, attitudes, beliefs, interpersonal styles and socioeconomic status. Members of the RCDS work closely with DCS and the Prevention team as part of the planning committee for the Institute for Strengthening Families which helps to ensure there are always affordable training opportunities for individuals seeking to achieve and maintain the IAITMH® Endorsement described above. The strong relationship between the DCS Prevention Team and RCDS has also been critical to establishing future plans for a pathway and to supporting DCS field staff and provides in achieving the Endorsement.

Systems of Care

Systems of Care meet within local communities and are a composed of community agencies, schools, law enforcement, prosecutors and focuses on ensuring that services are available in the community to meet the needs of families. One possible service is high fidelity wraparound that is funded through Medicaid or the Children’s Mental Health Initiative and prevents youth residential placement by provided targeted individual services and family support services for children with high behavioral health needs. Other services include residential services as well as state operated facilities for those children who cannot be safely served in the community.

Regional Service Councils

The Regional Service Councils and Regional Service Coordinators both work to enhance the coordination of services. The original purpose of the Regional Services Council was to: evaluate and address regional service needs; manage regional expenditures; and to serve as a liaison to the community leaders, providers and residents of the Region (See Collaboration section for a complete description). The Regional Service Coordinators and Probation Consultants then work with local agencies through the contracting process to help fill regional service gaps. Additionally, Indiana continues to work with its partner agencies to evaluate progress and identify areas for continued improvement.

4. Provider Workgroups

DCS has worked to engage service provider partners through continued meetings and workgroups. For example, DCS will continue its Yearly CMHC/DCS Collaboration Conference, ongoing meetings with the Community Mental Health Centers, and Regional Collaboration Meetings between DCS and the CMHC’s. Regional Service Coordinators will continue facilitating the ongoing support groups for specific services such as Family Centered Treatment, Father Engagement, Homebuilders, and START. This facilitation includes monthly calls, yearly conferences, and break out workgroups.

Support Groups

The success of these groups has led to the planned expansion into additional support groups including services such as Cross System Care Coordination, Child Parent Psychotherapy, and Diagnostic and Evaluation Services. DCS will continue collaborating with existing statewide associations, such as Indiana Council Community Mental Health Centers Child and Adolescent Committee, Coalition of Family Based Services, and the Indiana

Chapter of National Children's Alliance.

Community-Based Providers and IARCA

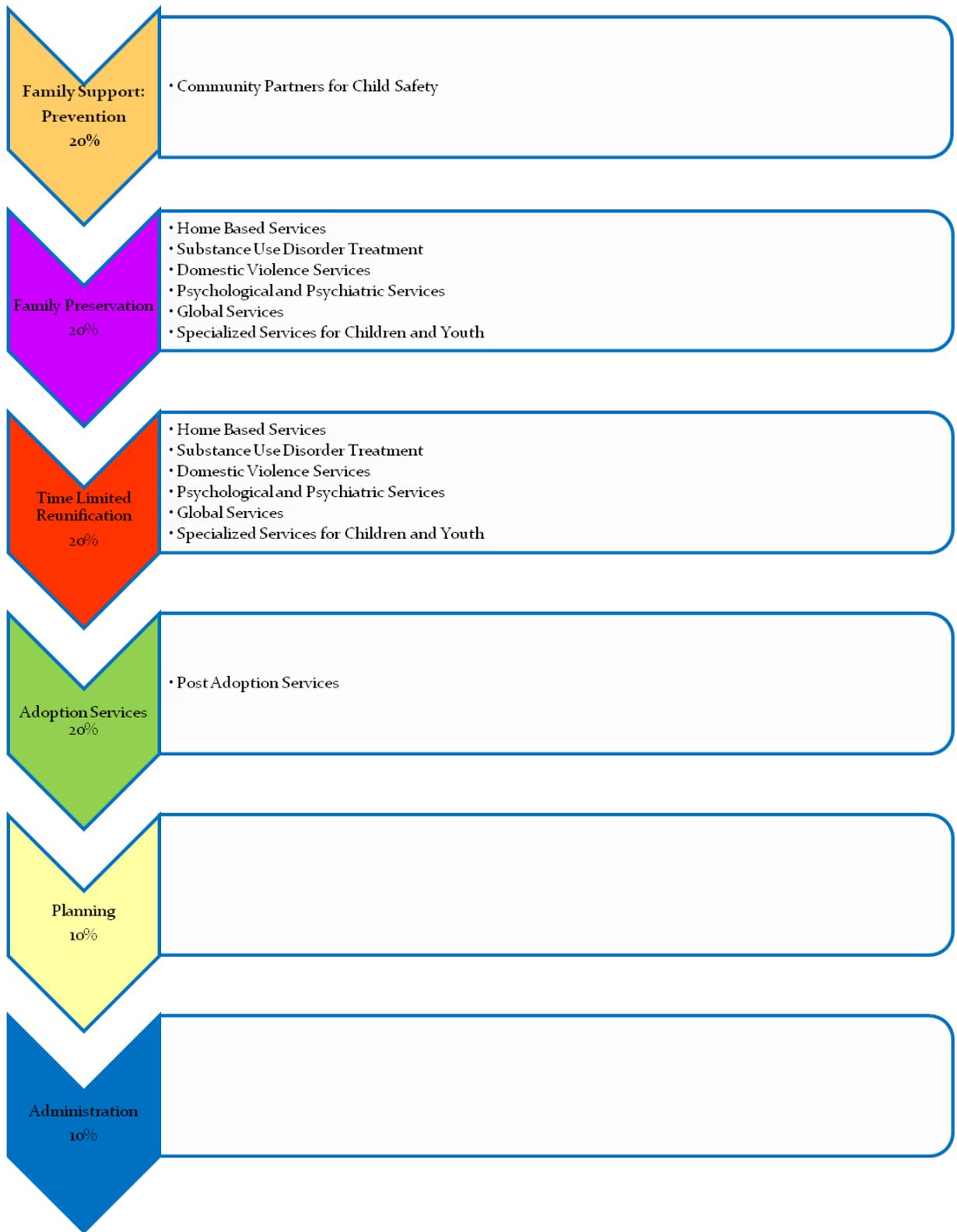
DCS will continue to elicit feedback from a Community Based Provider workgroup regarding referrals, billing, and service standard updates. DCS Executive Management will also continue regular meetings with IARCA leadership to work on systemic provider issues. Currently, DCS is working with IARCA on residential and LCPA rate setting for 2014, on capacity building and on access to psychiatric residential treatment centers, among other things. We are also working with IARCA on any needed modifications to the 2014 LCPA and residential contracts. DCS Placement Support and Compliance will continue monthly conference calls with residential providers and monthly calls with LCPAs to collaborate on residential and foster care issues. In July, the calls will include one hour of training on collaborative care and how it impacts residential providers/foster parents.

For a complete description of collaborative efforts, please review the Collaboration section under General Information above. Many of these efforts are described in more detail in previous sections.

C. SERVICE DESCRIPTION (45 CFR 1357.15(O))

Each region identifies the services needed for their families, and then DCS contracts with agencies through a fair bid process. As part of this identification of services, the regions utilize service data including contracted agencies, service utilization, and service outcome reports to determine which service gaps need to be addressed. These DCS contracts include the specific services and the counties where they will be provided. The service standard defines the family population as a family involved in the Child Welfare or Juvenile Delinquency systems. Additionally, the DCS services standards will be amended to include language ensuring that Lesbian Gay Bisexual Transgender and Questioning youth will have services provided in a culturally sensitive manner.

Information is provided in Service Array Section regarding strengths and gaps in service. DCS has chosen to spend 20% in each of the Title IV-B subpart 2 service categories. DCS continues to allot 10% in planning and 10% in administration. If these funds are not utilized in these areas, the excess will be put back into services. The visual below depicts this breakdown in service categories.



1. Family Preservation (20%)

This category is designed to provide services for children and families to help families (including pre-adoptive and extended families) at risk or in crisis, including services to assist families in preventing disruption and the unnecessary removal of children from their homes (as appropriate). They help to maintain the safety of children in their own homes, support families preparing to reunify or adopt, and assist families in obtaining other services to meet multiple needs.

Reunification services are also included in this category which could assist children in returning to their families or placement in adoption or legal guardianship with relatives. These services may include follow-up care to families to whom the child has been returned after placement and other reunification services.

Services may include but are not limited to:

- Home Based Services
- Substance Use Disorder Treatment
- Domestic Violence Services
- Psychological and Psychiatric Services
- Global Services
- Specialized Services for Children and Youth

The Service section includes a description of available services.

Services are restricted to the following eligibility categories:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

2. Family Support (20%)

This category is designed to cover payment for community-based services which promote the well-being of children and families and are designed to strengthen and stabilize families (including adoptive, foster, and extended families). They are preventive services designed to alleviate stress and help parents care for their children's well-being before a crisis occurs.

Services may include, but are not limited to: Community Partners for Child Safety. The Service section includes a description of these services.

3. Time Limited Family Reunification (20%)

This category covers services and activities that are provided to a child placed in a foster family home or other out-of-home placement and the child's parents or primary caregiver in order to facilitate reunification of the child safely and appropriately within a timely fashion. These services can only be provided during the 15-month period that begins on the date the child is considered to have entered out-of-home care.

Services may include but are not limited to:

- Home Based Services,
- Substance Use Disorder Treatment,
- Domestic Violence Services,
- Psychological and Psychiatric Services ,
- Global Services,
- Specialized Services for Children and Youth.

The Service section includes a description of available services. Services are restricted to those children who meet the eligibility for this category and meet the following criteria:

- 1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
- 2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
- 3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

4. Adoption Promotion and Support Services (20%)

Services and activities available are designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children. Such services and activities are designed to expedite the adoption process and support adoptive families. This includes preparing the child for adoption with regard to loyalty, grief, and loss issues related to their birth family, as well as evaluating a prospective adoptive family and making a recommendation regarding appropriateness of the family to adopt special needs children.

Target Population

- 1) Foster parents and the foster/relative children in their care that have expressed an interest in adoption.
- 2) Pre-adoptive parents and adoptive parents with recently adopted children.
- 3) Long term adoptive parents experiencing challenges with their adopted children.
- 4) Families who have successfully completed the Resource and Adoptive Parent Training (RAPT) and are interested in adopting.
- 5) Families who are interested in parenting children who have suffered abuse or neglect.
- 6) Families who are interested in adopting children with serious medical and/or developmental challenges, older children, and sibling groups who are in the custody of the State of Indiana.

Desired Outcomes

- 1) Minimize the number of disrupted foster/relative placements.
- 2) Minimize the number of disrupted pre-adoptive and adoptive placements.
- 3) Ensure that prospective adoptive families and children free for adoption are adequately prepared for adoption.
- 4) Ensure that each prospective adoptive family is informed of issues related to children with special needs and that informed choices are made when matching children free for adoption and adoptive families.
- 5) Increase the number of adoptive parents available for special needs children.
- 6) Decrease the number of children waiting for adoptive parents.

7) Decrease the number of disrupted adoptions.

Based on the benefits of the Child and Family Team Model and the CANS assessment, the post-adoption service standards were restructured in 2011 with the goal of creating cross-system coordination and adoptive family-centered care for service delivery. Services provided to families include a comprehensive strength-based assessment. This service is based on the belief that children and their families are remarkably resilient and capable of positive development when provided with community-centered support, defined by what is in the best interest of the child. It is meant to provide a comprehensive system of care that allows families to find support after adoption.

To put these beliefs into practice, DCS has developed a delivery system for post adoption services that involves three regionally based contractors. As of July 1, 2014, contractors SAFY, Children's Bureau, and The Villages will begin their 4th year providing post-adoption services to families in the State of Indiana. These 3 agencies provide Care Coordinators located in various regions within the state to oversee intake referrals and provide support to families. The services provided to the client may include, but are not limited to the following: behavioral health care services, respite, parent/child support groups, trauma training, and other services and/or necessary items approved by DCS.

D. SERVICE DECISION-MAKING PROCESS FOR FAMILY SUPPORT SERVICES (45 CFR 1357.15(R))

DCS selects agencies and organizations to provide services through a Request for Proposal (RFP) process. RFPs are issued broadly for services every 4 years. DCS released a Request for Proposals for most Prevention and Community Based services in the fall of 2014 and is currently issuing new contracts to providers to begin July 1, 2015. In the interim, regions can request RFPs to address gaps in services. When an RFP is issued, information is posted to the DCS website and notification is sent to all contracted agencies and at Regional Service Council meetings. Interested agencies submit proposals for the service(s). These proposals are then evaluated, scored, and agencies are selected by the local regional scoring team. The local scoring team submits a recommendation to the Regional Service Council, which has the ability to alter the recommendation. The RSC submits the final recommendations to DCS central office for the final decision to issue a contract. Current Requests for Proposals are found at: <http://www.in.gov/dcs/3151.htm>.

E. POPULATIONS AT GREATEST RISK OF MALTREATMENT (SECTION 432(A)(10) OF THE ACT)

Those children at high risk for maltreatment who do not have involvement with the Department of Child Services are served through prevention services including Healthy Families Indiana and Community Partners for Child Safety. These programs are described in the Service section above. The Healthy Families Indiana process of identifying high risk families is described below.

1. Healthy Families Indiana (HFI)

HFI is credentialed by Healthy Families America as a multi-site statewide program. HFI is an evidence-based, voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education. Best practice shows that providing education and support services to parents around the time of birth and continuing afterwards significantly reduces the risk of child maltreatment.

To be eligible for HFI, families must be referred either prenatally (no earlier than the 6th month of pregnancy) or shortly after birth of the target child and fall at or below 250% of the federal poverty level. Additionally, families must be identified at increased risk for child maltreatment as determined by the Parent Survey Process (formerly the Kempe Family Stress Checklist). Referred families are initially screened by HFI assessment staff utilizing the Parent Survey Process with a Fifteen Item Screen that measures risks based on marital status, employment status, income, housing, phone, education, emergency contacts, substance abuse history, prenatal care, history of abortions, history of psychiatric care, abortion sought or attempted, adoption sought or attempted, marital or family stresses and history of or current depression.

If a family screens positive, the Parent Survey Process continues to Assessment including an in-depth conversational interview by HFI assessment staff with expectant or new parents to learn about their individual experiences, competencies and strengths. HFI staff are trained to engage the family conversationally, weaving in ten areas of focus (parent's childhood experience, lifestyle behaviours and mental health, parenting experience, coping skills and support system, current stresses, anger management skills, expectations of infant's development, plans for discipline, perception of new infant, and bonding and attachment). After the assessment interview is complete, the HFI assessment staff supervisor reviews and scores the results. Potential HFI clients must score above 40 to be eligible for HFI services.

If families score 25 or above and have any of the risk factors outlined below, they may also be offered services. Additionally, if families score 25 or above and have additional risk factors, they may also be offered services.

- Safety concerns expressed by hospital staff,
- Mother or father low functioning,
- Teen parent with no support system,
- Active untreated mental illness,
- Active alcohol/drug abuse,
- Active interpersonal violence reported,
- Cumulative score of 10 or above or 3 on question #10 on the Early Postpartum Depression Scale,
- Target child born at 36 weeks gestation or less,
- Target child diagnosed with significant developmental delays at birth, or
- Family assessment worker witnesses physical punishment of the child at visit.

F. SERVICES FOR CHILDREN UNDER THE AGE OF FIVE (SECTION 422(B)(18) OF THE ACT)

DCS will continue to monitor and support new initiatives which work towards reducing the length of stay for children under 5:

- The Fatherhood Initiative has focused on engaging Fathers in the case plan and increasing their parenting capacity.
- The START program focuses on keeping the child in the home while increasing the accessibility and support for substance using parents. The program will continue to expand throughout the state.
- DCS has trained a cohort of 28 therapists to provide Child Parent Psychotherapy. A second cohort is currently receiving training.
- DCS Comprehensive Service supporting the usage of evidenced based models, PCIT will increase in its availability throughout the state.
- DCS has enhanced the Diagnostic and Evaluation Service Standard to include an Attachment and

Bonding Assessment.

1. Fatherhood Initiative

The Fatherhood Initiative has focused on engaging Fathers in the case plan and increasing their parenting capacity. This effort potentially allows the father or paternal family to be a possible permanency option for the child. One future enhancement could be focusing on co-parenting facilitation for non traditional families in an effort to increase cooperation and communication between the parents.

2. Substance Abuse Treatment and the START Program

START specifically works to increase permanency for children birth – 5 while improving access and availability to substance use services for the caregiver. This is a multi team approach, including a close collaboration between DCS and the CMHC. The CMHC employs a Treatment Coordinator who provides immediate substance use assessments, provides oversight of client treatment plan, and ensures communication with DCS and the mentor about client progress. Another component, the START Mentor, can support the substance using parent through the recovery process.

The program supports the Safely Home, Families First initiative by providing the services and support needed for the parents while in the treatment and recovery process, so they may safely parent their child. Currently there are three active Family Case Managers, one Family Mentor and one Treatment Coordinator with the ability to add 2 additional mentors. It is estimated that the full team will be serving approximately 30 families at any given time. Currently DCS is considering expansion of this program into a neighboring county.

During the biennial planning process, DCS regions identified service areas of improvement including substance use treatment. The START program will continue to expand throughout the state, but other modalities will be researched and considered to work with children with parents affected by substance use. DCS will contact all contracted substance use treatment providers and gather information related to their service availability, treatment modalities, and feedback. This information will be used to enhance this service array.

3. Service Mapping

For those families involved in the child welfare system, DCS **initiated and is piloting** Service Mapping (described in detail in previous sections). Service Mapping **utilizes** the Risk Assessment and CANS to identify those families who are at high risk of repeat maltreatment. Using a developed algorithm, Service Mapping will create service recommendations for evidenced-based models most appropriate for the child and family based on their unique needs.

While there are evidence-based models that will be mapped for the entire age range of children, there are specific models available for young children. These evidenced-based models will include Child Parent Psychotherapy and Parent Child Interactive Therapy. Recognizing the unique needs of this age group, DCS identified specific evidenced-based models, and contracted with agencies for both Child Parent Psychotherapy and Parent Child Interactive Therapy to serve children birth to age 5.

Service Mapping will continue to be evaluated and enhanced through collecting and analyzing service recommendations. The recommendation data along with service referral trends, will provide insight into service gaps within the state, and allow for opportunities to assist in targeted service development.

4. Child Parent Psychotherapy

DCS has trained a cohort of 28 therapists to provide Child Parent Psychotherapy and has started training a second cohort of 15 therapists. This first cohort of trained therapists includes 9 teams of 3 therapists from within the Community Mental Health Center network and one additional DCS clinician. These therapists completed their training in May 2014, but will receive another year of consultation through the Child Trauma Training Institute as they begin to fully implement the model. DCS will evaluate the need and ability to train additional clinicians to ensure service availability for children in need.

5. Parent Child Interactive Therapy

Another State of Indiana Department has trained therapists at CMHCs on PCIT, which DCS children and families will access through our collaboration and master contracts with the CMHC's. Additionally, with the DCS Comprehensive Service supporting the usage of evidenced-based models, PCIT will increase in its availability throughout the state.

PCIT is an evidence-based treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Disruptive behavior is the most common reason for referral of young children for mental health services and can vary from relatively minor infractions such as talking back to significant acts of aggression. The most commonly treated Disruptive Behavior Disorders may be classified as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD), depending on the severity of the behavior and the nature of the presenting problems. The disorders often co-occur with Attention-Deficit Hyperactivity Disorder (ADHD).

PCIT uses a unique combination of behavioral therapy, play therapy, and parent training to teach more effective discipline techniques and improve the parent-child relationship. The model draws on both attachment and social learning theories to achieve authoritative parenting. The authoritative parenting style has been associated with fewer child behavior problems than alternative parenting styles.

6. Attachment and Bonding Assessment

DCS has enhanced the Diagnostic and Evaluation Service Standard to include an Attachment and Bonding Assessment. Contracted agencies were made aware of the service expectation, and will be able to provide this service to children throughout the state. The Attachment and Bonding Assessment will be used to determine the quality and nature of the bond from the child to the child's caretaker. Recommendations will be focused on the child's need that include ways to foster and improve the relationship and attachment quality.

G. SERVICES FOR CHILDREN ADOPTED FROM OTHER COUNTRIES

Post – adoption services provided for children adopted from other countries is the same as services provided to children adopted in the United States. If a child, previously adopted in a foreign country, comes into the care of DCS, their eligibility for services would be the same as any other child who comes into the care of DCS. This is not true as it relates to adoption subsidies as most children adopted from foreign countries are not usually in the care of the Indiana Department of Child Services prior to the adoption, and therefore do not meet eligibility requirements.

VI. PROGRAM SUPPORT

All training is coordinated through the Deputy Director of Staff Development and is incorporated in the DCS Training Plan. The recent expansion of post-training surveys has assisted in measuring the effectiveness of training programs. All training and technical assistance provided to local office and regional manager is included in the DCS Training Plan.

As discussed within this APSR, DCS has developed a position and hired a Deputy Director of Child Welfare Outcomes. This position will be integral to measurements of performance through development of reports and data to assist in meeting agency goals and objective.

DCS collaborate with Indiana University for evaluation of programs and training. DCS has a research and evaluation division to assists with any research needed to assist with goals and objectives. MaGIK will be updated as necessary to add fields and data necessary to measure performance. The DCS Quality Assurance procedures are currently being updated to add additional indicators to assess the quality and accuracy of data.

VII. CONSULTATION AND COORDINATION BETWEEN STATES AND TRIBES

The Pokagon Band of Potawatomi Indians (hereinafter Pokagon Band) officially moved its tribal organization and its tribal court to Dowagiac, Michigan. However, members of this Pokagon Band have lived in the lower Great Lakes area for hundreds of years and the Pokagon Band's homeland covers six northern Indiana counties including LaPorte, St. Joseph, Elkhart, Starke, Marshall, and Kosciusko. The Band also extends through four southwest Michigan counties – Berrien, Cass, Van Buren and Allegan. Despite the Pokagon Band's move to Dowagiac, Michigan, DCS continues to recognize the Pokagon Band as Indiana's only federally recognized Tribe.

DCS has also worked with other tribes as Native American children have come into the DCS system to ensure that the heritage of children with tribal connections is maintained. DCS remains committed to continually working to expand the knowledge of staff regarding native culture and ensuring collaboration and coordination with tribes, their tribal courts, and families of children with tribal connections.

Pokagon Band

In the past, various state staff have met with Social Services Director Mark Pompey, and in moving forward DCS has established partnership/collaboration meetings with representatives from the Pokagon Band twice a year.

On September 25, 2014, DCS staff (Wade Hornbacher, General Counsel; Reba James, Deputy Director of Permanency and Practice Support; Lisa Rich, Deputy Director of Services and Outcomes; and Sheryl Alyea, ICWA Coordinator for the International and Cultural Affairs Program) met with Pokagon's Social Services Director, Mark Pompey, in Dowagiac, Michigan, and toured Pokagon's grounds, properties, executive offices, and the court system. DCS staff learned about the Band's traditions, growth, housing, and both the court and child welfare systems. We discussed differences between state and the Pokagon Band's child welfare cultures, as well as the cultural competence of Indiana service providers. Director Pompey expressed Pokagon's desire to be involved and interact with DCS when Pokagon Band members come to our agency's attention. Other discussion included ongoing issues with joint cases, as well as where processes are running smoothly. Director Pompey noted some concern/interest in the fact that Saint Joseph County in Indiana has a large Pokagon Band population, yet there are very few DCS cases identified from that area. Discussion ensued about the ongoing steps that DCS has put into place to improve 'identification' of the Indian child, including improved forms, education, training, and support for DCS field staff. Director Pompey was provided with a draft of the CFSP, noting the specific areas addressing Pokagon Band interaction with our agency. Director Pompey provided feedback for a couple of

changes which were made, one being referenced as the “Pokagon Band” as opposed to “the Tribe”.

On March 9, 2015, our DCS staff hosted another meeting with Pokagon staff, Social Services Director Mark Pompey and Pokagon Presenting Officer/Prosecutor Annette Nickel, in Indianapolis, IN. As before, we were able to openly discuss any concerns or persistent issues with our mutual cases. In addition, the topics of legacy, confidentiality, parties to a CHINS case, Termination of Parental Rights, IV-E income (per capita/stipends), the updated ICWA Guidelines from February 25th, and ideas for better identifications including checks and balances were discussed. Our Pokagon guests were introduced and given the opportunity to talk with DCS Director Bonaventura. DCS General Counsel, Wade Hornbacher, accompanied our guests on a tour of the Marion County Juvenile Court system during the afternoon.

DCS staff and the Pokagon Band staff plan to meet again in the fall of 2015. In the interim, any concerns will be communicated directly to the DCS ICWA Coordinator of the International and Cultural Affairs Program as there is an established and open line of communication.

American Indian Center of Indiana, Inc.

The DCS ICWA Coordinator had only minimal contact with staff at the American Indian Center of Indiana, Inc. (AICI) located in Indianapolis, Indiana, over this past year due to the AICI Director having had numerous health challenges. However, in April 2015, the DCS ICWA Coordinator was contacted by the Executive Director, Kerry Steiner, of the Indiana Native American Indian Affairs Commission (INAIAC) for some information. The DCS ICWA Coordinator learned, through that conversation, that the AICI Director had returned to work and that INAIAC Director Steiner has been a long term volunteer at AICI. DCS will move forward to develop a collaborative relationship with the Center staff.

Indiana Native American Indian Affairs Commission

INAIACI Executive Director, Kerry Steiner, contacted the DCS ICWA Coordinator in April 2015 and requested that she provide a presentation at the Commission’s May meeting which is open to the public. The DCS ICWA Coordinator provided a brief presentation at the May 2015 meeting. The focus of her presentation was on the importance of identification of the Indian child and their families and providing a culturally appropriate experience during their DCS intervention. She also mentioned the ongoing need for American Indian/Native Alaskan foster parents/families and foster parents/families knowledgeable and willing to provide cultural access for Indian children. Due to the questions and comments, the presentation appeared to be well received.

1. Ongoing Coordination and Collaboration with Tribes

Improved collaboration efforts will focus on preserving the children’s connections to their families and tribes, and also preserving the Indian culture so it continues to thrive.

The state is utilizing already existing Permanency Roundtables (PRTs) for identifying and reviewing ICWA cases and as a means of checks and balances for identification, compliance and services. In addition, the state has initiated the development of a Multi-Cultural Team that will exist as an interim level support between the field staff and DCS Administration. This team will be managed by the International and Cultural Affairs Program Liaison within the Permanency and Practice Support Division. The team will be able to provide support, reviews, data and statistics, from a regional level, for the state for both immigration and ICWA cases. To date, thirty of our DCS staff from across the state have volunteered to meet this challenge to help develop this level of field support. At the beginning of July 2015 this group of DCS staff volunteers will come together for a day of

planning, sharing, and learning to implement this additional level of expertise for field support.

2. Child Welfare Services and Protections for Tribal Children

The state's International and Cultural Affairs (ICA) page on the DCS Internet site is available to the public. Updates and resource information are posted for public use. Contact information is posted on the site for questions and requests regarding entering into IV-E agreements. DCS Permanency and Practice Support staff are currently reviewing a draft of a IV-E agreement template for future use. To date, no requests have been received by the state.

3. Assessment of Ongoing Compliance with ICWA

DCS remains compliant with all ICWA requirements in 25USC 1900 et seq., 25 CFR 23 et seq, and 45 CFR 1355-1357.

The state continues to notify Indian parents, tribes, and Indian custodians of state proceedings and their right to intervene. The notification responsibility remains with each local office attorney for a more timely notification process. The state also continues to offer placement preferences and respect the tribe's decisions.

DCS attorneys and family case managers have worked with various tribes throughout the United States. When a child of tribal heritage becomes involved with the Indiana child welfare system, DCS notifies the tribe per ICWA requirements. The attorney and family case manager collaborate with tribal representatives to determine how to proceed, to include them in all aspects of the case, and to transfer jurisdiction to the tribe or place the child with tribal members, if requested.

During this past year the Permanency and Practice Support Referral system through KidTraks initiated a referral for state tracking purposes for 'potential' and 'confirmed' ICWA cases. Adjustments have been made throughout this past year and are continually being monitored for necessary changes in order to achieve a level of accuracy for DCS statistics regarding Indian children within DCS's care.

The state is utilizing already existing Permanency Roundtables (PRTs) for identifying and reviewing ICWA cases and as a means of checks and balances for identification, compliance and services. In addition, the state has initiated the development of a Multi-Cultural Team that will exist as an interim regional level support between the field staff and DCS Administration. This team will be managed by the International and Cultural Affairs Program Liaison within the Permanency and Practice Support Division.

4. Notification of State Proceedings

The state continues to notify Indian parents, tribes, and Indian custodians of state proceedings and their right to intervene. This responsibility was given to each local office attorney in order to expedite and provide a more timely notification process. The state has made ICWA policy changes to align with the updated ICWA Guidelines effective in February 2015. The policy is currently in the first phase of review for the approval process. The updated policy also includes the 'active efforts' definition from the new guidelines.

5. Tribal Right to Intervene

The Pokagon Band and their attorney, judges and social services personnel are aware of the tribes right to intervene in Indiana juvenile court proceedings involving children in their tribe and of their ability to request a

transfer of proceedings to their tribal court. Indiana juvenile court judges are also aware of these rights.

Indiana's ICW Notification Form is served on tribes by the DCS local office attorneys and includes language informing the tribe of their right to intervene, and/or have the proceedings transferred to the Tribal Court.

The ICWA Tribal Transfer of Jurisdiction Tool was added to the DCS Child Welfare Policy Manual, Chapter 2.12, for DCS staff's guidance. The IV-E State Plan Amendment which included the Tool was approved in 2015 and is included within policy regarding the transfer of proceedings to the jurisdiction of a tribe.

6. Continued ICWA Compliance

DCS will remain compliant with all ICWA requirements in 25 USC 1900 et seq., 25 CFR 23 et seq, and 45 CFR 1355 – 1357. As stated above, DCS will continue to work with all tribes and specifically with the Pokagon Band of Potawatomi Indians which has members located within Indiana. DCS will continue to maintain ongoing communication and meetings with tribal officers and members. DCS will also continue to coordinate information regarding services and other information that may be of assistance to tribe. DCS will continue its integration of meaningful supports for improved identification of ICWA eligible children, and will continue to refine and improve interactions with American Native tribes in order to ensure that tribal heritage is maintained.

DCS implemented a referral system for the Permanency and Practice Support (PPS) Division, including International and Cultural Affairs (ICA). The PPS referrals for ICA went into effect in 2014 and are being utilized for ICWA tracking within Indiana. We have also opened up communication from within DCS and are utilizing QSR alerts and AFCARS comparisons in ICWA cases. DCS is in the final phase of developing an ICWA Computer Assisted Training (CAT) for field staff training. On June 19th, 2015, Annette Nickel, the Pokagon Presenting Officer/Prosecutor of the Pokagon Band, will provide a presentation at the DCS Attorney's training.

7. Discussions regarding Chafee Foster Care Independence Program

The Pokagon Band cares for their youth and they are not interested in CFCIP. DCS will discuss the CFCIP with the Pokagon Band further as collaborative meetings take place throughout the year.

8. Exchange of CFSP and APSR

Approved copies of the CFSP and APSR have been provided to officials of the Pokagon Band at the DCS/Pokagon Band meeting in the fall of 2014. When new plans/reviews are completed, these will also be exchanged during the semi-annual meetings.

9. Title IV-E Funding for Foster Care, Adoption Assistance and Guardianship Assistance Programs

DCS will follow established procedures for the transfer of responsibility for placement and care of a child to a Tribal Title IV-E agency or Indian Tribe with a Title IV-E agreement. DCS provides additional instruction for DCS staff to follow in the event that the Tribe wishes to enter into an agreement. Policies explaining this procedure can be found in DCS Child Welfare Policy Manual, Chapter 2.12 and the ICWA Tribal Transfer of Jurisdiction Tool can be found within that same policy. DCS is prepared to enter into negotiations with any tribe to share IV-E benefits.

VIII. MONTHLY CASEMANAGER VISIT FORMULA GRANTS AND STANDARDS FOR CASEMANAGER VISITS

DCS requires that family case managers have monthly face-to-face contact with all children under DCS care and supervision and those who are at imminent risk of placement. This includes children and their families participating in an Informal Adjustment (IA). These contacts/visitation must occur in the home. The FCM must document the visit and any new information gained (e.g., health, educational services) in MaGIK within one (1) business day following each visit with the child, and parent, guardian, or custodian.

During critical episodes involving the child and/or family (e.g., potential risk of removal, new child abuse and/or neglect (CA/N) allegations, potential runaway situations, pregnancy of the child, lack of parental contact, etc.), contact must be made within 24 hours of receiving knowledge that a crisis has occurred. The Family Case Manager (FCM) will monitor and evaluate the situation, as well as convene the Child and Family Team (CFT), to assess whether the situation warrants additional services or supports to the family.

While monthly visits conform to DCS policies, best practice indicates a need to see the child on a more frequent basis early on to ensure monitoring and adherence to Visiting and Monitoring of Plans, Family Support/Community Services/ Safety Plan (SF 53243), for example, as determined by the Child and Family Team Meeting process.

Federal Monthly FCM Contacts Progress Report

A chart of Monthly Family Case Manager Visits is listed in the report below which is designed to show a running total of Federal standards for FCM contacts for the year-to-date months within the current federal fiscal year. This report is used to determine the progress of FCM contacts throughout the year. It provides a monthly breakdown of FCM children with whom FCM's have visited and with whom FCM's have visited in the child's home setting.

Monthly Family Case Manager Visits							
	Children with Contacts				Children with Contacts in Home Setting		
Month	Contacted Children	Total Children	Percentage		Contacted Children	Total Children	Percentage
October 2013	9132	9903	92.21%		7449	9903	75.22%
November 2013	9274	10067	92.12%		7404	10067	73.55%
December 2013	9293	10010	92.84%		7428	10010	74.21%
January 2014	8985	9621	93.39%		7306	9621	75.94%
February 2014	9234	9847	93.77%		7281	9847	73.94%
March 2014	9554	10076	94.82%		7757	10076	76.98%

April 2014	9867	10410	94.78%		7788	10410	74.81%
May 2014	10437	10986	95.00%		8418	10437	80.66%
June 2014	10578	11078	95.49%		8984	10578	84.93%
July 2014	10576	11105	95.24%		8914	10576	84.29%
August 2014	10597	11134	95.18%		8612	10597	81.27%
September 2014	11034	11603	95.10%		8822	11034	79.95%

IX. ADOPTION AND LEGAL GUARDIANSHIP INCENTIVE PAYMENTS (SECTION 473A OF THE ACT)

Adoption incentive payments continue to be used to provide a wide spectrum of services and supports to adoptive families and children. A majority of payments are used to pay for adoption and recruitment programs including adoption education events, adoption program development, media events, and projects to inform the public of children waiting to be adopted.

DCS continues to train and educate community partners and mental health providers on the effects of trauma and how it impacts the healthy attachment of children to their families. DCS's contractual relationship with the Children's Bureau (CB), to train and educate community partners and mental health providers on the effects of trauma and its impact on healthy attachment for children and their families, began in 2009. The evidence-based curriculum focuses on a trauma-informed method of addressing attachment issues in children and the training provides information on the biological effects of trauma on the brain, therapeutic interventions that can be effective, and a suggested curriculum that can be implemented for support groups.

The Indiana Heart Gallery, referenced above in the Adoptive Parent Recruitment section, is also implemented through adoption incentive payments. This traveling photographic exhibit showcases remarkable professional portraits of and stories about foster children in Indiana – all of whom long for loving and safe homes. The dramatic photos put a face on a sometimes invisible need and remind families that adoption can change lives. DCS also continues to use adoption incentive payments to contract with AdoptUSKids for online recruiting and national exposure, associated with the Specials Needs Adoption Program (SNAP).

X. CHILD WELFARE WAIVER DEMONSTRATION ACTIVITIES (APPLICABLE STATES ONLY)

A. WAIVER FRAMEWORK AND ACTIVITIES

DCS has had the benefit of participating in a Child Welfare Waiver Demonstration Project (herein referred to as 'Indiana's Waiver project') since 1998. DCS' waiver was extended in 2003, 2005, 2010, and then again in 2012. On September 14, 2012, the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), approved the Waiver Terms and Conditions for an extension of the State's waiver

demonstration project. DCS accepted the Terms and Conditions on September 27, 2012. The waiver period is for five years, beginning July 1, 2012.

The original waiver (1998-June 2012) allowed for only a limited target population to participate in services. However, Indiana's 2012 waiver extension includes all children served by DCS under the age of 18 and their families, as well as a broader array of services. The extension enables waiver service provisions to more closely mirror DCS' TEAPI practice model (Teaming, Engaging, Assessing, Planning and Intervening). The flexibility of Indiana's waiver project better aligns the State's system of care with desired outcomes and DCS' overall philosophy of "Safely Home, Families First."

In conjunction with Safely Home, Families First, Indiana's Waiver project targets both Title IV-E eligible and Title IV-E ineligible children and youth who are at risk of or in out-of-home placement and their parents, siblings and caregivers of those children. Specifically, the target population served will include the following eligibility categories:

- Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or Child in Need of Services (CHINS) status.
- Children and their families with IAs have the status of CHINS or Juvenile Delinquency Juvenile Status Offense (JD/JS).
- Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

Through Indiana's Waiver project, DCS has utilized innovative methods to ensure families are provided with services that meet their needs, and whenever possible, allow children to remain safely in their home. Funding flexibility is integral to the agency's delivery of services and enables DCS to offer an expanded array of concrete goods and services to help families succeed. These types of services include: payment of utility bills, vehicle repairs, before/after school care, respite care, baby monitors, and cleaning of the home environment and are typically only available through other funding sources.

Indiana's Waiver project also allows the State to invest in an improved and expanded array of in-home and community-based family preservation, reunification and adoption services. DCS has implemented new services thanks to Indiana's Waiver project's flexibility such as: a Children's Mental Health Initiative, a family evaluation/multi-disciplinary team, Child Parent Psychotherapy, Sobriety Treatment and Recovery Teams, and comprehensive home-based services, such as family centered treatment, motivational interviewing, and trauma-focused cognitive behavioral therapy.

Child Parent Psychotherapy is an evidence based model which focuses on providing services to families with children age 0-5 who have experienced significant trauma. Services are provided in the home with the caregiver(s) and child, and works to improve the caregiver's understanding of the effects of the trauma and build a strong relationship between the caregiver(s) and child to reduce the effects of the trauma. The program is especially effective with children who have been exposed to domestic violence and/or child abuse.

Sobriety Treatment and Recovery Teams is a promising practice model currently being utilized in Kentucky and is being piloted in Indiana. The program is intended to alter the child welfare and service approach to serving parents with substance use disorders with children under the age of 3. The service includes a triad approach with a specially trained Family Case Manager, a Family Mentor (someone with experience in the child welfare system and a history of addiction), and a Treatment Coordinator. This team provides quick access to assessment and services, as well as increased support and monitoring.

Additionally, Trauma Focused Cognitive Behavioural Therapy (TF-CBT) is another evidence based practice model that is being provided as a component of DCS' Comprehensive Home Based Services. DCS will be utilizing service mapping to identify appropriate families to participate in this service. Children who have experienced significant trauma and have a non-offending caregiver who is able to participate in services will be included in the target population. Children are identified utilizing the Child and Adolescent Needs and Strengths Assessment. DCS provided TF-CBT training opportunities for therapists throughout Indiana during 2014. There are plans to provide additional training in 2015. As of the date of this report, DCS has trained more than 300 therapists in this evidence based practice model.

The purpose of Indiana's Waiver project remains focused on improving the effectiveness and efficiency of child welfare services through expanded eligibility and expanded services. As such, the waiver allows DCS to use a Continuous Quality Improvement (CQI) process as the foundation for their continuum of service provision. DCS has routinely monitored the effectiveness of the practice model in order to establish goals and direction with regards to waiver spending and service delivery. DCS is committed to developing a CQI approach that will serve as the basis for evaluating and improving child welfare practice. For new programs funded by the waiver, DCS will move towards a CQI driven method of evaluating service needs, quality of services, and the impact that those services have on child and family outcomes. Funding flexibility already supports the DCS practice indicators, including:

- Reduced use of substitute care,
- Increased use of relative care,
- Increased placement in own community,
- Reduced use of residential placement,
- Reduced number of placement moves,
- Increased sibling placements,
- Reduced length of stay,
- Increased permanency,
- Increased child & family visits, and
- Reduced incidence of repeat maltreatment.

With a shift in focus to a CQI driven approach, waiver services will be further embedded in our quality improvement processes. As outlined in Goal 4 and associated objectives, we are implementing a CQI approach based on the use of regional CQI teams, engagement of stakeholders, increased education of staff on CQI, provision of CQI support to service providers, improvement in the manner in which data is structured, development of staff capacity to use data for decision making, and the integration of qualitative and quantitative data to provide a comprehensive view of strengths and areas for improvement.

At the core of our CQI approach will be the development of an organizational culture that supports continuous learning. As stated in Positioning Public Child Welfare Guidance, this is important because: "A well-trained, highly skilled, well-resourced and appropriately deployed workforce is foundational to a child welfare agency's ability to achieve best outcomes for children, youth and families it serves."⁵ In partnership with the Michigan

⁵ Positioning Public Child Welfare Guidance can be found at: www.ppcwg.org

Public Health Institute (MPHI) Center for Healthy Communities, DCS will provide key CQI staff and regional coordinators with quality improvement training and technical assistance support during the implementation of CQI. The goal of the training is to educate staff on the basic theory and strategies of quality improvement, the Plan-Do-Study-Act (PDSA) model, and key quality improvement tools. Staff will also learn how to train other CQI staff on the content of the training. Once staff is equipped with the information from the training, they will serve as DCS CQI experts and will train and provide technical assistance to other DCS staff and/or providers so that all staff on the CQI team, as well as those providing core DCS services, will have a common foundation from which to implement CQI.

A Steering Committee was developed to oversee the implementation and ongoing activities of the waiver. The Steering Committee is comprised of executive staff and Deputies from all DCS divisions, demonstrating our commitment to waiver services and the importance of the funding to our organization's service delivery. The Steering Committee has been involved in establishing CQI as core to services delivered under the waiver. The Steering Committee will continue to monitor and shape the CQI efforts driving service delivery.

In addition to the Steering Committee, there are several work groups that help support the Waiver.

1. Communications and Training

The Communications and Training work group is responsible for maintaining the communication plan that encompasses all levels of internal and external stakeholders, as well as facilitating any training necessary to ensure the success of the Waiver.

In alignment with the CQI goals, members of DCS attended a CQI training to help implement the Plan-Do-Study-Act (PDSA) CQI model. The Steering Committee presented this model to the Regional Managers in November. At that same meeting, the Steering Committee, along with IU, presented a review of basic Waiver information, an update on the Waiver evaluation, and provided region-specific data from the 2013 and 2014 FCM survey studies and concrete service data.

2. Fiscal Accounting and Reporting

The Fiscal Accounting and Reporting work group is responsible for all tasks related to cost allocation, fiscal accountability, and reporting for Indiana's Waiver project. The work group has responsibility for assessments of Waiver impact on Title IV-E eligibility and cost allocation systems, as well as internal accounting and reporting systems. This team also monitors financial and caseload data and trends to ensure the cost neutrality provisions of the terms and conditions are met.

The Fiscal Accounting and Reporting work group continued to compile baseline financial data for presentation in the mid-term Child Welfare Waiver Demonstration Project report. This work group and ACF also discussed reconciling the cost neutrality provisions in Indiana's Waiver Terms and Conditions, to the reporting format in Part 3 of the modified CB-496 Foster Care Financial Report. Finally, the work group researched trends in spending for out-of-home care versus in-home care, as well as shifts in placement types from residential care to less restrictive placement types since expansion of the Waiver Demonstration Project in 2012.

3. Evaluation

The Evaluation work group is responsible for maintaining a partnership with the Evaluation Team from I U. The Evaluation work group will also submit ongoing reports in support of the Waiver. The Evaluation team also

includes two sub-groups: an FCT sub-study work group and a Data work group. The Evaluation work group continued monthly meetings for the overall evaluation, monthly data meetings, and bi-weekly FCT sub-study work group meetings. Since the decision to move back to the MaGIK data source, the Evaluation team has been able to access data from baseline and years 1 & 2 of the demonstration period.

In addition to our own CQI process, DCS has contracted with the Indiana University School of Social Work to evaluate the effectiveness of the waiver. The evaluation will test the hypotheses that an expanded array of in-home and community-based care services available through the flexible use of Title IV-E funds will:

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

DCS will utilize the findings of the external evaluator and our CQI process in combination to improve the waiver services provided to the children and families that we serve.

One of the most important products that has been developed as a result of Indiana's Waiver project is Service Mapping. DCS is in the fortunate position, as a result of Indiana's Waiver project, of being able to greatly enhance its community based service array. DCS has chosen to do this by enhancing the service array with multiple Evidence Based Practice models. With this expansion, and each EBP having a specific target population, the service array has become too complex to utilize traditional service referral methods, thus necessitating a more complex system of making referrals. Service mapping provides an electronic service consultant, allowing even inexperienced Family Case Managers to make quality service decisions. The system reduces the use of "cookie cutter" services, by utilizing assessment and other information to recommend services for families based on their individual circumstances, improving the chances for positive outcomes.

The system utilizes information from the Child and Adolescent Needs and Strengths assessment as well as the Structured Decision Making tool for Risk Assessment. In addition the Family Case Manager is asked seven questions about each child and two questions about the family. This information is then paired with the case information (demographics, case type, other information) and contract information to produce service recommendations for the family. The Mapping Engine utilizes more than 100 data points in order to determine individualized services for families out of more than 12,000 different ways for a family to map to a service. In addition to Service Recommendations, the Mapping Engine provides information about service gaps which are essentially summarizing what services would have been mapped had they been available in the community.

Service Mapping is a critical part of the CQI of services and as DCS looks to make improvements, the focus will be on the outcomes of children, youth, and families. The Service Mapping engine will be altered as more information becomes available as to the success of the families involved in the various services. One option would be to provide alternative recommendations for families who are not successful in the recommended services. Additional questions may be added to determine more information about families to improve service recommendations as well.

Programs will be evaluated to determine their effectiveness with specific target populations. The Family Centered Treatment Substudy is one example of how a program evaluation is tied to service mapping because results from this study may expand or eliminate programs or alter the target population served by this specific EBPs. In addition to evaluating at the program level, DCS will evaluate at the provider level and this information will

allow for comparison between providers. Additionally, these evaluations could lead to further refinement of the target population by service provider, further support and training of the provider, or elimination or expansion of some service provider services.

Service gaps will be identified and closely monitored by DCS. The information gathered will assist DCS as regional needs assessments are completed to develop the Biennial Regional Services Strategic Plans. The plan could lead to an expansion or elimination of services in a particular county or region.

B. COORDINATION WITH TITLE IV-B

DCS coordinates the use of IV-B funds with IV-E waiver dollars through use of a matrix that details how each program or service is funded. Examples of services funded by IV-B, but not by the waiver, include post-adoption services, child/parent support services, community partner services, and fatherhood engagement services. We continually review the matrix to ensure that resources are maximized to best serve children and families.

XI. CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) STATE PLAN REQUIREMENTS AND UPDATE

A. SUBSTANTIVE CHANGES TO LAW AND REGULATIONS EFFECTING ELIGIBILITY FOR CAPTA

There have been no substantive changes in Indiana law or regulations that would affect Indiana's eligibility for CAPTA, create any complications in complying with CAPTA regulations, or require changes to Indiana's State Plan.

B. SIGNIFICANT CHANGES IN APPROVED CAPTA STATE PLAN

The State of Indiana has not made any significant changes from the State's previously approved CAPTA plan in how the State proposes to use funds to support the 14 program areas.

C. USE OF CAPTA FUNDS

CAPTA funds were utilized in conjunction with Title IVE Foster Care, Title IV-E Adoption, and Title IV-B, Subpart 2 to support Case Management (case workers and data management) and material assistance payments for concrete services.

D. CRP ANNUAL REPORTS

Indiana Law requires 3 Citizen's Review Panels, a Foster Care Advisory Board, a Child Fatality Review Team and a Child Protection Team. Each panel serves a 3 year term. The foster care advisory board is the only panel that can extend the length of their term beyond three years. All of Indiana's terms expired in June of 2014. DCS had decided to alter the reporting period for Citizens Review Panels to an annual basis to assist new panels in their report preparation. This will also assist DCS in having completed reports and associated responses for APSR reporting periods.

1. Foster Care Advisory Board

A new foster care advisory panel, Heritage Foster and Adoption Support, Inc., in Hendricks County, Indiana, has

been chosen as DCS's new foster care advisory board Citizen Review Panel (CRP). They plan to research the assessment process and its impact on services provided to children.

The 2014 Hendricks County Foster Care Advisory Board Citizens Review Panel (CRP) Annual Report, submitted December 31, 2014, is attached as ATTACHMENT 8. The DCS Response to their report, due June 30, 2015, is attached as ATTACHMENT 9. Four members of the Hendricks County CRP attended the National Citizen's Review conference in Portland, Oregon, April 18 – 20, 2015.

2. Child Fatality Team

The Marion County Citizen Review Panel Annual Report from June, 2014, is attached as ATTACHMENT 6. The DCS response in December of 2014 is attached as ATTACHMENT 7. The three year maximum term for the Marion County Child Fatality Team CRP expired on June 30, 2014.

A new child fatality review team, the Monroe County Child Fatality Team in Bloomington, Indiana, was chosen as Indiana's new Citizen's Review Panel. They were recruited in June of 2014 and their three year term was scheduled to begin on January 1, 2015. However, they notified the DCS CRP in January that their team would not be able to serve as the CRP due to time commitments. DCS is in the process of recruiting a new child fatality team to serve as the CRP.

3. Child Protection Team

A new child protection team, the Switzerland County Child Protection Team, in Switzerland County, Indiana, has been chosen as DCS's new Citizen's Review Panel. They are researching problems associated with babies born with substances in their system. DCS is excited they will be serving in this capacity and looks forward to their report.

The 2014 Switzerland County Child Protection Team Citizens Review Panel (CRP) Annual Report, submitted December 31, 2014, is attached as ATTACHMENT 10. The DCS Response to their report, due June 30, 2015, is attached as ATTACHMENT 11.

E. STATE LIAISON OFFICER INFORMATION

The State Liaison Officer is Kimberley S. Miller, Indiana Department of Child Services, 302 W. Washington St. Room E306, Indianapolis, IN 46204: Kimberley.Miller@dcs.in.gov.

XII. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM (CFCIP)

A. AGENCY ADMINISTERING CFCIP (SECTION 477(B)(2) OF THE ACT)

DCS will administer and supervise contracted providers who deliver CFCIP services directly to eligible youth. Services will be available in all 92 counties across the state. DCS will utilize a fair bid Request for Proposal (RFP) process to award contracts for CFCIP services. The DCS Central Office Older Youth Initiatives (OYI) Team will provide direct oversight of program, service array and service provision of contracted providers or Older Youth Services (OYS) providers. The DCS OYI Team is a cross divisional team made up of key personnel from the Services & Outcomes and Field Operations Divisions.

DCS provides program oversight to the six (6) Older Youth Services (OYS) Providers that provide CFCIP

services through multiple methods. Bi-monthly meetings are held with OYS Providers, DCS OYI program and Collaborative Care (CC) leadership staff. Program success, challenges, potential improvements and best practices are discussed. DCS Collaborative Care Case Managers (3CM), Collaborative Care Supervisors, Independent Living Specialist, OYS provider direct staff and Supervisors come together at the local level (per Service Area, which is comprised of two DCS Regions) to discuss individual cases, local resources and CC practices. DCS Independent Living Specialists are in consistent communication with the OYS Providers to provide technical assistance for program and contract questions. DCS also gathers feedback on service delivery, gaps and quality from youth participating in services provided under the OYS service array. **The DCS OYI team will be implementing continuous quality improvement (CQI) to provide a structured process of ensuring older youth / successful adulthood programs and services are systematically and intentionally improving and increasing positive outcomes for the youth we serve.** Contract compliance is monitored by the DCS fiscal department.

B. DESCRIPTION OF PROGRAM DESIGN AND DELIVERY

1. Current Practice

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

This model places the provider in the role of connecting youth with services provided in the youth's community or through a natural, unpaid connection to the youth rather than by the contracted provider. Over time, the youth should be able to depend on their social network and individual knowledge in order to accomplish tasks related to living independently.

2. Service Delivery

DCS has opted to extend IV-E foster care. In 2009, DCS held focus groups with key Stakeholders, including youth, to assist in restructuring the service delivery of Independent Living Services. The state moved to a Broker of Resources model prior to implementation of Collaborative Care (CC). In addition, DCS **continues to strengthen its focus on assisting youth in transition out of foster care by undergoing changes to meet the requirements of federal regulations; H. R. 4980 "The Preventing Sex Trafficking and Strengthening Families Act. The restructure of DCS policy 11.6 will include a policy name change: Transition Plan for Successful Adulthood. This policy will further empower youth in foster care by starting at age 14; youth will also have a strong voice in choosing who is a part of their team including the selection of two (2) child representatives. One child representative will act as the youths adviser and advocate.** This team should meet every 6 months or more often if a critical case juncture occurs. There are outlined topics to discuss at each meeting, such as youth's housing, employment and educational goals. Steps to reach each goal are identified as well as which member of the youth's team is responsible for assisting this youth in achieving the goal.

In order to support positive youth development during adolescence, services are adjusted to account for the unique needs of youth who are aging out of foster care. Services are designed in such a way to: 1) provide support; and, 2) foster interdependence (different from independence by the inclusion of/emphasis on social

capital) to each youth. This is accomplished by designing services that allow for youth to learn from experiences and mistakes. These experiences and mistakes promote positive brain development at a time when adolescents' brains are in a state of plasticity, allowing youth to gain self-confidence, coping skills, self regulation and resiliency skills. Indiana's "broker of services" model for Chafee Independent Living Services support older youth in this manner by being structured to allow for youth-adult partnerships in the planning process.

Additionally, the standards are structured in a way that allow for a myriad of individuals to role-model, teach, train, monitor, etc. particular IL skills. Youth should have the opportunity to experience situations that build social relationships and networks (i.e. strengthen their social capital). The contracted Older Youth Service provider is not solely responsible for the growth and development of the young person participating in services. All youth should be supported by a team of people including formal and informal connections. Finally, DCS's OYS service standards are designed to give differing levels of support to the youth depending on the youth's skill developmental and comfort level. Youth with less experience may require more guidance and face to face instruction time, while other youth may only need assistance occasionally with less guidance.

The expectation of OYS providers is to serve in the role of community resource broker for youth receiving OYS services (CFCIP). This role focuses on increasing the youth's skills in accessing services within their community and building support networks that will exist after DCS services end. OYS providers need to first seek community resource providers to provide the direct services associated with the outcome areas outlined within the OYS Service Standards. Providers must maintain documentation in the file if no community resource exist thus direct service was provided by the OYS provider. If the OYS provider can document a service gap in a region/county for an outcome area, approval may be granted for that specific region/county, thus documentation would not be needed for each youth seeking services in that region/county. Group services with a pre-approved curriculum by the ILS will not need to seek this additional approval.

Collaborative Care (CC), DCS's program and practice model for case managing older youth in foster care was built upon five foundational pillars: Youth Voice; Social Capital; Relational Permanency; Authentic Youth-Adult Partnerships; Teachable Moments and Adolescent Brain Research. Youth will transition to a 3CM at age 17 ½ (for all youth who will not achieve permanency within 3-6 months after obtaining age 17 ½). The goal of the Collaborative Care program is to help youth practice living interdependently to gain the skills and knowledge to transition successfully out of the foster care system. Identified youth will move into independent living settings (that are developmentally appropriate) that the youth can continue to live in once DCS closes the case. The focal points of this programming are to increase youth voice, offer youth opportunities to practice interdependence, and provide a foundation for gaining the skills needed to build the youth's own social capital. This program also allows youth to voluntarily return to foster care on or after the age of 18.

3. Specific Accomplishments

HELP YOUTH TRANSITION TO SELF-SUFFICIENCY

DCS is undergoing changes in transition planning for youth in care. In accordance with H.R. 4980 "The Preventing Sex Trafficking and Strengthening Families Act" DCS is restructuring transition planning to began at age fourteen (14). By continued utilization of the teaming approach youth may select two (2) persons of their choosing with approval of DCS to assist in the development of the youths plan. DCS is also in cooperating the term successful adulthood to mean services for youth under the age of eighteen (18). DCS continues to improve services for older youth transitioning out of foster care via the Collaborative Care program. Specialized

Collaborative Care Case Managers (3CM) continue to manage all youth at age 17.5. 3CM's case load only comprise of youth 17.5 and older. There is specialized ongoing training for 3CM's that target best practice specifically working with older youth in and transitioning out of foster care. 3CM training focuses on positive youth engagement, which is the foundational pillar of Collaborative Care as well as essential practice and program guidance.

As DCS continues to focus on the wellbeing of youth, in accordance with H.R. 4980 DCS is implementing the "Indiana Youth Bill of Rights" This is a document that describes the rights of a child with respect to education, health, visitation, court participation, the right to be provided various documents specified in the law, and the right to stay safe and avoid exploitation. DCS Family Case Managers (FCM) will begin to engage youth of their right at the age of 14 when they enter into care. As this is a new procedure, process are effectively being put in place to engage all youth currently in care of their rights. DCS is also assessing its procedure to ensure when all youth age out of care they are provided a copy of their vital records which includes birth certificate, state identification, medical records etc.

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

DCS continues to focus on education and employment preparation for older youth in foster care. Service providers and case managers ensure that youth are referred to WorkOne, through DWD for employment related services, TASC classes, and testing.

DCS, foster youth have been prioritized to participate in the Indiana Lt. Governor's State Fair Summer Employment Opportunity Program.

Older youth who are receiving older youth services and have an Individualized Education Plan (IEP) continue to be referred to Vocational Rehabilitation, when appropriate and to DCS Educational Liaisons, if additional education support and advocacy is needed. The partnership between DCS and DWD will continue.

HELP YOUTH PREPARE FOR AND ENTER POST-SECONDARY TRAINING AND EDUCATIONAL INSTITUTIONS

DCS continues to assist youth in identifying and achieving their educational goals. All 3CMs have received training on financial aid and other steps needed for youth to access post secondary education as well as associated funding. In efforts to increase educational resources for foster youth DCS and DWD is specifically identifying youth for recruitment for the JAG program. As explained in the ETV section, DCS contracts with a vendor to provide Education and Training Vouchers (ETV) to eligible youth. This service will continue in 2015. In addition, DCS Educational Liaison train and educate FCMs and youth on educational opportunities as well as provide educational support and advocacy.

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

The Collaborative Care program continues to use positive youth engagement to provide personal and emotional support to youth aging out of foster care. The programmatic foundations is based on authentic youth-adult partnerships, relational permanency, and supporting building positive social network. In efforts to increase the wellbeing of youth DCS has implemented an age requirement. Beginning at age 14, youth will actively

participate in the development of their case plan and Transition Plan for successful Adulthood Youth will also be receive and sign and acknowledgment of rights describing their rights with respect to education, health, visitation, court participation, medical documentation and safety. In addition, youth may select two child representatives to represent the child in the case plan and transition plan for successful adulthood development.

PROVIDE FINANCIAL HOUSING, COUNSELING, EMPLOYMENT, EDUCATION, AND OTHER APPROPRIATE SUPPORT AND SERVICES TO FORMER FOSTER CARE RECIPIENTS BETWEEN 18-21 YEARS OF AGE TO COMPLEMENT THEIR OWN EFFORT TO ACHIEVE SELF-SUFFICIENCY AND TO ASSURE THAT PROGRAM PARTICIPANTS RECOGNIZE AND ACCEPT THEIR PERSONAL RESPONSIBILITY FOR PREPARING FOR AND THEN MAKING THE TRANSITION INTO ADULTHOOD.

DCS continues to provide Chafee Voluntary Services including room and board services to all eligible youth ages 18 – 21. The Collaborative Care program continues to have a re-entry component for those youth who turned 18 in foster care, left the care of DCS, and are in need of supportive services. Youth sign a Voluntary collaborative Care Agreement wherein the youth agrees to be under the supervision of the Juvenile court, to maintain the eligibility requirements for the program, to meet with their assigned 3CM at least once per month, and to actively participate with an OYS provider. As of May 2015, a total of seven (7) youth re-entered foster care through Collaborative Care.

MAKE AVAILABLE VOUCHERS FOR EDUCATION AND TRAINING, INCLUDING POST SECONDARY EDUCATION TO YOUTH WHO HAVE AGED OUT OF FOSTER CARE.

DCS continues to provide ETV funds to eligible students in efforts to support youth's post-secondary education training goals. See Education and Training Voucher section for further details.

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

DCS continues to provide services for youth who transition out of foster care into a kinship guardianship program or adoption on or after the age of 16.

TO ENSURE THAT CHILDREN WHO ARE LIKELY TO REMAIN IN FOSTER CARE UNTIL AGE 18 HAVE ONGOING OPPORTUNITIES TO ENGAGE IN AGE OR DEVELOPMENTALLY-APPROPRIATE ACTIVITIES.

DCS is undergoing changes in policy and practice to ensure youth who are likely to remain in foster care until age 18 have ongoing opportunities to engage in age or developmentally-appropriate activities. DCS has adopted the reasonable and prudent parent standard which is characterized by careful and sensible parental decisions that maintain the health, safety, and best interest of a child. A licensee shall use the reasonable and prudent parent standard when determining whether to allow a youth in foster care to participate in extracurricular, enrichment, cultural, and social activities. Youth age beginning at age 14 will participate in their case planning and transition planning review any age appropriate activities that the child is interested in pursuing is discussed. The youth may select two (2) Child Representatives to advise and advocate for the youth with respect to the application of the reasonable and prudent parent standard to the child.

4. Future Planning

Over the next 5 years, DCS will continue to focus on older youth in care and those transitioning out of care. More specifically, the Older Youth Initiatives Team will continue to build upon the foundations laid to create the Collaborative Care practice model, improve individualized services to the various special needs populations, continue active collaboration with the whole Older Youth Services community (includes DCS program, youth, DCS CC case management, OYS providers and other key stakeholders) and explore strategies to build public awareness regarding the needs of older youth in and those transitioning out of foster care.

A group of young people from the Indiana Youth Advisory Board were asked to review the plan and provide input. Youth were given a summary of how services are being provided currently in the areas outlined in CFSP PI. Youth were asked to provide input on identified areas. Youth in the group focused feedback on training of case managers and Collaborative Care case dismissal reasoning. DCS will continue to gather feedback from youth in the Collaborative Care program, those accessing Voluntary IL Services, those utilizing ETVs and will try to engage those who choose not to participate in any services. DCS will continue to utilize the IYAB for feedback on program implementation and service development and delivery. In the next 5 years, as DCS continues to develop the OYS evaluation, DCS will explore ways of institutionalizing feedback from youth. Some possible methods DCS may explore are adding relevant program questions to the NYTD survey, seeking external funding to host CC focus groups or annual surveys.

DCS is in the process of evaluating all the various sources of data on older youth, the quality of this data and the best way to present this data to internal and external stakeholders. DCS will begin sharing data with the OYS providers and the IYAB. These stakeholders will assist DCS in identifying and prioritizing data elements and analysis that should be shared with stakeholders. DCS will work with the Child Welfare Improvement Committee of the Court Improvement Program at the Judicial Center to identify relevant data points and strategize and develop a communication plan to start a state wide dialogue about current service delivery, service gaps and possible service improvements.

NYTD/NAR - DCS received the final report summarizing findings from the pilot National Youth in Transition Database (NYTD) Assessment Review (NAR) in March of 2015. The findings include ratings (on a 0-4 scale) and narratives regarding the 8 NYTD general requirements and 58 NYTD data elements. Findings were based upon information that was gathered throughout the pre-onsite, onsite and post-onsite phases of the NAR. The report includes the NYTD Quality Improvement Plan (N-QIP), which the state will respond to by June of 2015. The N-QIP requires the state to respond to specific compliance issues, meaning any requirement or element that rated under “4”, that were found during the NAR process. DCS rated “4” on 2 of the 8 general requirements. Of the 6 remaining general requirements, DCS rated a score of “2”. DCS rated “4” on 18 of the 58 data elements, “3” on 19 data elements and “2” on 21 of the data elements. Many of the elements that scored “2” and “3” on the N-QIP can be resolved through code updates, applying skip logic to the survey/updating survey instructions, front end information system modifications and improving the methods of collecting service information from providers. Priority in implementing the needed rectifications relating to compliance issues will be given to those requirements and elements for which DCS rated the lowest. DCS is currently focusing on the following:

- **Development of a “mismatch” report to determine if the demographic information being reported for NYTD matches the information that is recorded in MaGIK. If a youth shows on the list as having a discrepancy in information the FCM, probation officer and service provider will be contacted to rectify the discrepancy and ensure accurate reporting of demographic information. Ex: A service**

- provider reports the youth's last grade completed is 11th grade, but MaGIK shows the youth's last grade completed is 6th grade. The FCM and service provider will be contacted to see which information is most up to date and will be asked to update information that is not accurate.
- Implementation of NYTD service logs as demonstrated during the pilot NYTD Assessment Review (NAR). Updated service logs will eliminate the need for providers/case managers/foster parents to identify services by federal definition. Instead, they will choose the service as defined by DCS' OYS standards and will be mapped on the back end to the federal definition.
 - The methodology used to identify foster care status for youth in the baseline population has been updated. The updated methodology will be submitted to ACF for review. If any problems with the updated methodology are identified, DCS will work with ACF to refine the methodology to ensure accurate reporting.
 - Code has been updated to correctly identify "trial home visit" as not in foster care. The updated code will be submitted to ACF for review. If any problems with the updated code are identified, DCS will work with ACF to refine the code to ensure accurate reporting for element 14.
 - The methodology used to report youth who turn age 17 in one report period and are surveyed timely in the next report period has been updated as specified in Q&A #2.55. The updated methodology will be submitted to ACF for review. If any problems with the updated methodology are identified, DCS will work with ACF to refine the methodology to ensure accurate reporting.
 - Skip logic has been added to the online version of the NYTD survey instrument. Additionally, wording has been added to the paper version of the NYTD survey instrument to provide clearer instructions on which questions should be answered by the youth. The updated survey will be submitted to ACF for review. If any problems with the updated survey are identified, DCS will work with ACF to refine the survey to ensure accuracy.
 - Code will be modified to report "blank" when federally recognized tribal membership or eligibility for membership is not known or pending verification. The updated code will be submitted to ACF for review. If any problems with the updated code are identified, DCS will work with ACF to refine the code to ensure accurate reporting for element 16.
 - Front end system update adding the selections "Tribe not on list", "Information not available" and "Tribal membership pending verification" to the federally-recognized tribe dropdown list regarding Federally-recognized tribes has been requested and is pending. Once these selections have been added to the dropdown list, rules will be implemented on the AFCARS checklist prompting the user to update information as it becomes available if "Tribal membership pending verification" is selected.

C. SERVING YOUTH OF VARIOUS AGES AND STATES OF ACHIEVING INDEPENDENCE

The OYS array (including CFCIP) provides Successful Adulthood services that consist of a series of developmental activities that provide opportunities for young people to gain the skills required to live healthy, productive, and responsible lives as self-sufficient adults. Successful Adulthood services should be seen as a service to young people that will help them transition to adulthood, regardless of whether they end up on their own, are adopted, enter a guardianship or are reunified. OYS should be based on the Casey Life Skills Assessment (CLSA) following the youth's referral for services. Youth receiving OYS must participate directly in designing their program activities, accept personal responsibility for achieving independence, and have opportunities to learn from both positive and negative experiences.

Services are provided according to the developmental needs and differing stages of interdependence of the youth, but should not be seen as a single event, or as being provided in a substitute care setting, but rather as a series of activities designed over time to support the youth in attaining a level of self sufficiency that allows for a productive adult life. Services should address all of the preparatory requirements for interdependent adulthood and recognize the evolving and changing developmental needs of the youth/young adult.

OYS follows the broker of resources model and are designed to assist young people by advocating, teaching, training, demonstrating, monitoring and/or role modeling new, appropriate skills in order to enhance self-sufficiency. Services must allow the youth to develop skills based on experiential learning and may include the below outcomes based on the youth's needs as identified through the Independent Living assessment.

DCS is serving the following age groups in the following ways:

Youth under the age of 16

CFCIP are not offered to youth under the age of 16. However, DCS does focus on transition planning for youth at age 14. DCS Policy 11.6 **Transition Plan for Successful Adulthood** states all youth who enter foster care will transition out and all youth need skills, knowledge and abilities to ensure a successful transition home, to a new home, or to their own home. **DCS is improving youth engagement and wellbeing by empowering youth to participate in their transition plan as well as case plan beginning at age 14. Youth now have the ability to select two (2) child representatives to be a part of their team. One representative will represent the youth as an advisor and advocate. In addition, at age 14, youth will receive a list of their rights while in foster care regarding education, health, visitation, court participation, and safety.**

Youth ages 16 to 18

All youth in out of home care receive **Successful Adulthood (SA) services** at the age of 16. Who provides the service depends upon where the youth is placed. If a youth is placed in a residential facility, group home or a Licensed Child Placing Agency home, the facility or agency is responsible for providing the direct **SA** skills education. If a youth is placed in a DCS licensed foster home, a relative home, or another court appointed placement, a referral may be made to the OYS provider (if services are appropriate for the youth). At age 17.5 all youth should be referred to an OYS provider (if services are appropriate for the youth). Youth in Collaborative Care Host Homes and College Dorms, may or may not be referred to an OYS provider. This decision is made with the youth and the youth's team and based upon what resources are being offered by the Host Home adult or college campus.

All services are delivered based upon the broker of resources model and should be based upon the individual youth's abilities and needs.

Youth ages 18-20 in foster care

All OYS are based upon the youth's abilities and needs. **To better equip youth, DCS ensures that all youth 18 and older who have spent six months or more in care are provided the following documentation prior to leaving care: birth certificate, Social Security care, health insurance information, medical records, and a driver's license or State Identification.** The OYS array does not change with age. The method by which services are delivered varies based upon youth's skill level, needs and abilities.

Former foster youth ages 18 through 20

Youth who turned 18 in a foster care placement and are not yet 21 years of age are eligible for Voluntary IL Services. The OYS array is available for youth participating in Voluntary IL Services. Services are to be

administered using the broker of resource model and should be individualized based upon the youth needs and abilities.

Room & Board funds are offered to youth who are participating in Voluntary IL Services only.

Youth, who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption

Youth who transition out of foster care on or after their 16th birthday due to an adoption or guardianship are eligible for OYS array.

DCS utilizes the Casey Life Skills Assessment as a starting point to evaluate what skills, knowledge and abilities a youth needs to focus on while preparing to practice living interdependently. The Independent Living Plan is developed by the youth and OYS provider. The goals should be individualized and based upon the youth's abilities, skill level and needs.

In addition, prior to a youth transferring from a Family Case Manager to a 3CM, a team meeting is held to talk with the youth about their plan for after foster care and what skills and education they need to move forward with their plan. These transition meetings between case managers, the youth and the youth's team should also include discussion about the youth's stage of development, current services being utilized and future service needs.

D. SERVING YOUTH ACROSS THE STATE

1. State's Definition of "room and board"

Below is an excerpt from the OYS Service Standards regarding Room & Board funding:

Room and Board (R&B) expenses are considered as security deposits, rent, utility deposits and utilities. Utilities are limited to electric, gas, water and sewage. These funds are contingent upon availability as well as verification of the youth's eligibility for voluntary services by the IL Specialists. Room and board payments include a maximum lifetime cap of \$3,000 for assistance up to age 21.

Youth may access this assistance as long as they continue to participate in case management services and receive SSI (Supplement Security Income through Social Security) or participate in a full or part time schedule of work (or are actively seeking employment) until the \$3,000 limit is exhausted. While receiving room and board funds, youth are expected to make incremental payments toward their own housing and utility expenses beginning in the third month of assistance and should be prepared to accept full responsibility by the sixth month unless there are extenuating circumstances. In cases where the youth is unable to accept full responsibility for their rent in the sixth month, approval must be received from the DCS IL Specialist to allow payment beyond the fifth month. Requests for an extension of this capped amount will be considered on a case-by-case basis by DCS Older Youth Initiatives Manager or designee, based on availability of funds. Room and Board payments will only be made through a contracted service provider who is providing independent living case management services to the youth.

Youth receiving room and board assistance and planning to attend a post-secondary institution may access room and board funds to obtain off-campus housing prior to beginning their post-secondary program. Deposits for housing on campus may be made through Emancipation Goods and Services funding. Education and Training Voucher (ETV) funds are available for housing for youth attending post-secondary institutions. Those attending school full time or part time may access the ETV Program at www.indiananetv.org. If eligible for ETV funds, housing assistance must be accessed through this program and not Room and Board.

2. Housing Options

Potential housing options for youth accessing Voluntary IL services may include host homes with foster families, relatives other than biological or adoptive parents, or other adults willing to allow the youth to reside in their home with or without compensation. This setting does not require the same responsibilities provided by the host home adult as the Host Home placement type in Collaborative Care. Other housing options may include youth shelters, shared housing, single room occupancy, boarding houses, semi-supervised apartments, their own apartments, subsidized housing, scattered site apartments, and transitional group homes.

Youth aged 18-20 who are eligible may remain in or return to foster care through participation in the Collaborative Care program. For youth whom are in the Collaborative Care program, available placement and housing options include all traditional foster care placements, such as foster home and congregate care, as well as Supervised Independent Living options such as Host Home, College Dorm, own or shared Housing. Youth in Collaborative Care are wards, thus all placements and housing is paid for by DCS.

Youth who wish to leave care at or after the age of 18 and are eligible can access voluntary independent services. The service array is described above. Room & Board funds are reserved for only those youth accessing Voluntary IL Services.

Room and Board funds are not used for youth who enter Collaborative Care. Room and Board funds are reserved for youth who access Voluntary Independent Services.

At this time, DCS does not systemically track program participation per eligibility condition. This information is available through paper records only. During FFY 2013, 713 youth remained in care on their 18th birthday.

Through a team process, placement opportunities are determined giving consideration to the youth's developmental needs. Below is a comparison of placement types in **March 2014 and April 2015**.

Placement Locations	March 2014	April 2015
Relative Home	8%	8.2%
Non Relative Foster Home	41%	36.9%
Residential Setting	16%	18.4%
Own Apartment	18%	14.1%
Shared Housing	2%	1.1%
Host Home	6%	11.3%
College Dorm	5%	5.1%
Other Placement	4%	4.6%

3. Education and Employment

Education and employment preparation for older youth in foster care continues to be a focus. Service providers and case managers continue to ensure that youth are referred to Work One, through the Indiana Department of

Workforce Development (DWD) for employment related coaching, TASC (Test Assessing Secondary Completion) classes, and testing. Specifically, DCS partners with the Department of Workforce Development (DWD) JAG (Jobs for American Graduates) program to identify foster youth in their junior and senior year in high school. Foster Youth continue to be prioritized for local Work One initiatives. More specifically, foster youth have been prioritized to participate in the Indiana Lt. Governor's State Fair Summer Employment Opportunity program.

Older youth who are receiving OYS services and have an Individualized Education Plan (IEP) continue to be referred to Vocational Rehabilitation, when appropriate and to DCS Educational Liaisons if they are in need of additional education support or advocacy.

Youth goals are supported in several ways; this includes youth's educational goals. Youth must address education at each transition planning meeting that starts at age 14. This includes current educational status and future educational goals. Education is an outcome area addressed in the OYS Service Standards and outlines youth outcomes and provider responsibilities that will assist youth achieve the identified core competencies. Education may also be an area that is addressed in the IL Plan developed by the youth and the OYS provider. 3CMs may reach out to the DCS Education Liaisons for assistance with educational issues or barriers. 3CMs receive training in assisting youth apply for post-secondary training or education. Youth who are enrolled in post-secondary training or education and are receiving ETVs can also utilize the regionally based ETV Specialists for assistance.

4. Young adults who are pregnant and parenting

Within the Collaborative Care program, DCS implemented a pilot program that designed a case management system where one case manager managed both the older youth's open DCS case, as well as the open DCS case for the child of the older youth.

DCS ensured that all services were managed with a family centered approach as outlined below.

1. All services are coordinated with one team,
2. Both cases are reviewed by the same Judge virtually simultaneous to one another, and
3. Case planning is used as a means to support the family unit.

Before leaving care, the youth and their team will make sure parenting youth have established sustainable resources, including: established paternity and a child support order entered for their child; developmental needs addressed for their child, including medical and dental health; and supportive, sustainable services are in place and planned around the family unit, through referrals to the Indiana Healthy Families program, First Steps/Head Start and other social services.

Over the next 5 years, DCS will evaluate the effectiveness of this pilot by comparing outcomes of youth in the pilot with a control group of youth in similar situations who had a different case worker than their child. Depending upon the results of the evaluation, DCS may expand this program to other areas across the state.

5. Young adults with histories of substance abuse

This is an identified area of need within the Older Youth population. DCS is currently and will continue to explore transitional housing and programming options for older youth and young adults who suffer from Substance Use/Abuse with existing Substance Abuse Treatment providers within Indiana. See Objective 1.4 Under Plan for Improvement (IV-A). DCS will explore how to develop and implement individualized services to meet the needs of this group of Older Youth and existing services within local communities across the state. DCS

will research if the START program could be effective for youth/young adults. Over the next 5 years all 3CMs and OYS providers will receive training in working with youth who are suffering from Substance Use/Abuse. DCS will explore training materials and opportunities via SAMSHA as well as the Indiana Department of Mental Health and Addictions.

6. Young adults with mental health and/or trafficking histories

These are identified areas of need within the Older Youth Population. DCS is partnering with a small group of Community Mental Health Centers to explore the idea of transition services for youth engaged in mental health services. The identified problem is that at risk youth struggle with continuing to engage in mental health services when they are transitioned from children's services to adult services. Barriers identified are:

- While active in children's mental health services, the provider is responsible for seeking out the client for engagement, whereas, in adult mental health services, the client must seek out services. At risk youth, including foster youth struggle with making this transition.
- Many services provided by the Community Mental Health Center are not well known to youth aging out of care.

Strategies identified thus far to remove barriers include:

- Ensuring key stakeholders and decision makers are invited to this group to ensure an action plan can be developed, and
- Engaging Medicaid regarding what services/reimbursements will be offered as part of MA15. DCS has started meeting with Managed Care Entities to improve service access for youth.

DCS is currently in the exploration/education phase of understanding the impact of Human Trafficking on youth in foster care. DCS has an identified agency lead who works closely with the Attorney General's Human Trafficking initiative. See below for more details. The DCS OYI Team is researching best practices for intervention services, service coordination/management, placement, and aftercare services for this group of older youth. DCS has been working with residential service providers to develop programming appropriate to meet the needs of this population. Residential programs are required to offer Trauma Focused Cognitive Behavioral Therapy as a core program, which should begin to address the youth's trauma history. DCS has also expanded TF-CBT in the Community Based service array and has trained more than 300 clinicians statewide. Over the next 5 years DCS will gain an understanding of the true need of youth who have experienced trafficking, gain an understanding of best practices, develop a more expansive service array to meet the needs of this special group and develop an evaluation of services.

7. Youth with Criminal Histories

The OYS array does not differ for youth who have criminal histories. All youth in foster care experience circumstances that warrant individualized service delivery. Youth Voice and Authentic Youth-Adult Partnerships are foundational pillars for the Collaborative Care model. 3CMs have received training on youth engagement and use these skills to work alongside youth to overcome their pasts and look toward the future. DCS has presented specific training to 3CMs on how to assist youth with expungement of their criminal records. This information is helpful to the 3CMs as they assist youth with overcoming the barriers and stigma of having a criminal history.

8. Young adults with disabilities

3CMs continue to receive on-going training on the process to help youth apply for the Bureau of Developmental Disability Services (BDDS). In addition, on-going training consist of available resources in each DCS Region/County including BDDS, Vocational Rehabilitation, Community Mental Health Centers, Children's Mental Health Wraparound Services, and Housing for youth who struggle with mental health issues.

In some areas designated 3CMs carry a full case load of youth who will transition to adult services through the BDDS. DCS and BDDS have a formalized partnership that allows DCS youth to automatically enter the BDDS system at age 21, if not before.

An identified area of need in this category is youth who have developmental and/or intellectual disabilities, but do not qualify for BDDS. Over the next 5 years DCS will continue to examine how to best meet the needs of this population. The OYI Team will work with the Placement Support and Compliance Division regarding building provider capacity for placement and services. The OYI Team will focus on Older Youth service needs as well as transitioning services for these youth.

Examining data from January to May 2015, youth are leaving the program prior to turning age 20 for many reasons. Many youth are reuniting with biological family and requesting case closure. Some youth are entering adult services so the DCS case is closed. Other youth are struggling to maintain eligibility. Collaborative Care practice is to assist the youth in becoming eligible for services for up to 60 days. If youth have not obtained eligibility by the 60th day, the case needs to move towards case closure.

When a youth is leaving care prior to obtaining 20 years of age, re-entry procedures and procedures to access Voluntary IL Services are explained and given to the youth in writing. All youth continue to receive the full service array with goals focusing on transitioning out of care once it has been decided that the case will move towards case closure. All eligible youth can access Voluntary IL Services, once the case is closed. In most cases, the youth's OYS provider worker will not change if a youth moves from Collaborative Care to Voluntary IL Services. The full OYS array is offered in Voluntary IL Services. In addition Room & Board, funds are available for eligible youth to access.

E. COLLABORATION WITH OTHER PRIVATE AND PUBLIC AGENCIES

DCS' OYI Team identifies public and private entities that might be able to assist youth achieve interdependence. Some examples of partnerships are the Department of Workforce Development, Indiana Connected By 25, One Simple Wish, Indiana Housing and Community Development Authority, Twenty-First Century Scholars, and the Bureau of Developmental Disabilities.

More specifically, the Department of Workforce Development and DCS have created a partnership to work more closely in identifying youth that both agencies serve. Foster youth are prioritized for local Work One initiatives. Currently, DCS is working closely with Department of Workforce Development (DWD) JAG (Jobs for American Graduates) program to identify foster youth in their junior and senior year of high school. Partnering with JAG to specifically recruit foster youth for their program will build better resources for and increase foster youth preparedness for post secondary education and/or employment. This year, foster youth have been prioritized to participate in the Indiana Lt. Governor's State Fair Summer Employment Opportunity program. This program gives older youth ages 18 – 24 the opportunity for employment as well as participate in workshops that focus on employment, education, financial literacy, and daily living.

DCS has partnered with Indiana Connected by 25 (CB25) to further the states work with older youth in foster care. CB25 is a strategy developed by a group of national funders, the Youth Transition Funders Group, which focuses on young people ages 14 to 25 either living in foster care, detained in the juvenile justice system, or who have dropped out, or had to leave school due to the school system not meeting their needs. This organization targets youth currently in foster care and youth who have aged-out of foster care (alumni). CB25 focuses efforts in 5 areas: Housing, Financial Literacy, Health, Education and Employment. CB25 has been able to leverage funding from DCS with private foundational funds to serve Indiana's Older Youth.

DCS has partnered with One Simple Wish, a not for profit organization based out of New Jersey, created in 2008 by a foster/adoptive parent. OSW takes advantage of the internet to bring an awareness to foster youth. OSW is a wish granting program that allows private citizens or organizations to grant wishes posted by youth in foster care. Examples of what youth could wish for include sports equipment/uniforms, name brand clothing/money for a shopping trip, computers, prom dresses, limo for prom, tickets to a theme park or concert, furniture...basically, a wide range of items from practical to fun.

The Indiana Housing and Community Development Authority (IHCDA) and DCS entered a partnership in 2009, starting with sharing information and education on why the two state systems can work together to focus on the housing needs of youth aging out of foster care. There have been three projects supported by IHCDA and the Corporation for Supportive Housing that have focused on making available supportive, affordable housing for current and former foster youth.

DCS has a partnership with the Twenty-First Century Scholars program, which is a program supervised by the State Student Assistance Commission of Indiana (SSACI). SSACI accomplishes its mission with:

- Grant and Scholarship Programs for full-time and part-time college students;
- Early Intervention programs for Twenty-first Century Scholars;
- Research to better understand the needs of Hoosier students and families; and
- Technology to make the delivery of awards as simple as possible for students and colleges.

In addition to making awards, SSACI promotes awareness of Indiana financial assistance programs through its website, guidance counselor workshops, financial aid nights, college fairs, community forums and other statewide events such as College Goal Sunday.

DCS is partnering with Connected by 25 and Cargo Services in the Youth Adult Connections Program (YAC) to focus on providing resources to young adults in foster care graduating from High School that may not be available or possible. Youth selected to participate in YAC exemplified excellence in their schools and community. YAC recognizes the accomplishments of foster youth by providing an opportunity for foster youth to share their success with friends and family.

DCS has partnered with Specialized Alternatives for Families and Youth (SAFY) of America and Stop Child Abuse and Neglect (SCAN) to share information and focus on the housing needs of youth aging out of foster care. Through the partnership of SAFY, SCAN and Brigs they developed the Courtyard apartment complex accommodates current and former foster youth 18 – 25 years or age. The Courtyard provides affordable housing, support, and resources as youth emerge into adulthood. Services include: case management, job/life skills training, parenting education, and access to GED/high school diploma and post-secondary education.

The OYS Team has also partnered with other agencies that may have services that youth can access concurrently or in replacement of CFCIP services. Independent Living Specialists and the Older Youth Initiatives Manager will make themselves available to give presentations to agencies, departments, and companies that interact with

youth on a regular basis. In this way information about available services can be disseminated to the stakeholders in order to better reach youth.

At this given time DCS does not have any campaigns to raise awareness on the needs of youth/young adults in foster care. DCS has consulted with key members of the Older Youth Community on this topic. Both Youth and OYS providers believe pursuing a public awareness campaign may be beneficial for the state. Some suggestions from stakeholders include: utilizing providers to form grassroots campaigns in each community; targeted outreach for Host/Foster Homes for Older Youth; an RFP for Older Youth Community Outreach and/or Training; utilizing social media for cost effectiveness and widespread availability; and work with the IYAB. The Indiana Connected By 25 program identified they are already working with national partners on similar marketing projects aimed at raising public awareness about older youth in foster care and offered to bring DCS to the table.

Over the next 5 years DCS will continue to explore the idea of campaigns to raise awareness of the needs of older youth in foster care. DCS will continue to consult with Older Youth Community as well as the Indiana Governor's Office on such an effort.

1. Federally funded Transitional Living Programs

There are two federally funded transitional living programs in Indiana. When DCS learns of a youth who is homeless that young person is brought into care under a CHINS. Thus that youth is eligible to access CFCIP services.

2. Abstinence Programs

DCS is partnering with a local implementing site for the Federal youth development/pregnancy prevention grant that is specifically for foster youth. DCS' role is to encourage youth to attend education programs/seminars and to provide transportation when appropriate. Currently this program targets youth who reside in and around Marion County.

3. Local Housing Programs

DCS has a partnership with the State level IHCD as described in the collaborations/partnering sections. At the local level, both 3CMs and OYS provider direct staff provide education to youth on local housing programs, if appropriate. **Specifically, DCS has partnered with community stakeholders to ensure youth have an opportunity to reside at the Courtyard, a local affordable housing initiative for youth with identified disabilities.**

4. Programs for disabled Youth

At the State level, DCS has a partnership with BDDS, as described in the collaborations/partnering sections.

5. School to Work Programs

At the State level, DCS has a partnership with the Department for Workforce Development, as described in the collaborations/partnering sections. At the local level 3CMs and OYS providers work with youth to ensure they know why and how to access local Work One offices. 3CMs also encourage youth to join the Jobs for America's Graduates (JAG, a DWD program) when available and appropriate.

6. Plan to coordinate services with local youth shelters and other programs serving young adults at risk of homelessness

The information in the CFSP remains valid. There have been no updates to this section.

F. DETERMINING ELIGIBILITY FOR BENEFITS AND SERVICES (SECTION 477(B)(2)(E) OF THE ACT)

Services to be provided are the same and are based upon the Broker of Matrix section of the OYS Service Standard.

1. CFCIP Services

Eligibility for CFCIP Services starts at age 16. Placement drives who provides services. When youth are placed in a DCS licensed foster home, a relative home or another court appointed placement, a referral is made to an OYS provider. When youth are placed in residential facilities, group homes or a Licensed Child Placing Agency foster home, the facility/agency is responsible for providing the CFCIP Services, according to the OYS Service Standards.

The following youth meet the eligibility requirements for voluntary case management services:

- Youth ages 18 to age 21 who were formerly in foster care after the age of 16 for a period of six (6) months while a CHINS or probation youth or a “ward or in the custody of another state” or
- Youth ages 16 to age 21 who were formerly in foster care for a minimum of six (6) months as a CHINS or probation youth between the ages of 16-18 who have been adopted or placed in a guardianship from foster care and were receiving OYS services prior to the dismissal of their case.

DCS has determined the following former foster youth meet the eligibility requirements for room and board (R&B) services:

- A youth who turns 18 years of age while placed in foster care; or
- A youth who turned 18 years of age in foster care, who was a “ward or in the custody of another state”; or
- A youth age 18 to 21 who was on a trial home visit on his or her 18th birthday or in runaway status with an open CHINS or probation youth case.

DCS will assure that all youth receiving R&B services also receive case management.

2. Collaborative Care

DCS opted into all eligibility criteria outlined in the Fostering Connections Act for extending Title IV-E Foster Care. In addition, DCS decided that youth who are not IV-E eligible are included in the population. Eligibility is determined the same way for all youth in the following categories.

- CHINS: youth who have an open CHINS case are presumed to remain in care until age 20. Under a CHINS case, you can remain in care to the age of 21. Youth receive all the same service and placement options. When it is in the youth’s best interest, the CHINS case will be dismissed and a Collaborative Care court case will open.
- Re-Entry: youth who have aged out of foster care (turned 18 in a foster care placement) either with an

open CHINS or Juvenile Probation case, youth who are 18 years of age, but not yet 20 years of age and meet Collaborative Care eligibility may re-enter foster care. Youth sign the Voluntary Collaborative Care Agreement, agreeing to come back into foster, meet at least monthly with a 3CM and be under the supervisor of the Juvenile Court. Youth who re-enter care can remain in an open Collaborative Care case until one day before their 20th birthday. Youth receive all the same service and placement options.

G. COOPERATION IN NATIONAL EVALUATIONS

The information in the CFSP remains valid. There have been no updates to this section.

H. EDUCATION AND TRAINING VOUCHERS (ETV) PROGRAM

The information in the CFSP remains valid. There have been no updates to this section.

I. CONSULTATION WITH TRIBES (SECTION 477(B)(3)G))

The Pokagon Band of Potawatomi Indians is Indiana's only federally-recognized tribe. When the Pokagon Band intervenes in an Indiana DCS case and assumes jurisdiction, they request that all IV-E benefits be terminated. The Pokagon Band provides income and services for the family and youth as part of their tribal benefits and does not want to participate in Title IV-E. If the child remains under Indiana DCS jurisdiction, the child is eligible for all benefits and programs available to foster children and youth. The Pokagon Band is aware that DCS will assist them if this changes in the future and DCS continues to inform them of new benefits and programs during meetings.

J. CFCIP PROGRAM IMPROVEMENT EFFORTS

DCS will continue its efforts to gather youth feedback and ideas for program improvements. DCS will continue to consult with youth on the Indiana Youth Advisory Board on older youth related agency initiatives. Over the next 5 years, DCS will explore avenues to partner with outside stakeholders to fund and facilitate focus groups to gather feedback from youth involved with the full OYS array as well as others who are involved with the program, such as providers, foster parents, host home adults, etc. DCS will revisit the practice of gathering youth input on new policies and procedures. As DCS develops the OYS evaluation plan, youth feedback, ideas and input will be gathered.

K. CFCIP TRAINING

The OYI team is facilitating quarterly trainings for internal DCS staff in the local offices on CFCIP and OYS. Over the next 5 years, the OYI Team will continue to develop a statewide plan for training internal DCS staff on CFCIP and OYS. The OYI Team will work closely with the DCS Staff Development Division on the development of a Computerized Training to be posted on the DCS Training website. This training can be accessed by DCS staff when the training material is relevant to the DCS staff person. The OYI Team will explore the option of requesting OYS be a reoccurring training topic for the annual Local Office Director and Local Office Supervisor workshops. The OYI team will continue to work closely with the DCS Staff Development Division on updating the Positive Youth Development training curriculum and any additional OYS/CFCIP related trainings.

While reviewing and gathering feedback on the CFSP from the OYS providers, a shared training goal was

developed. The OYI Team will partner with the OYS providers to identify shared training that will focus on best practices in working with Older Youth.

Based upon feedback from youth, the OYI Team will work with the IYAB on creating a workgroup of youth to assist DCS in developing trainings for Case Managers (both DCS and provider) on working with Older Youth in foster care, assisting in transition planning from a youth's perspective and additional topics. The OYI Team will work with the team of youth on developing the trainings; explore methods of training the youth as professional trainers and support youth as trainers.

L. EDUCATION AND TRAINING VOUCHER PROGRAM

DCS will contract with one vendor to administer the ETV program. This vendor is required to create and maintain a web-based application system, funding methodology that ensures ETV award does not exceed the cost of attendance, administer funds directly to students, monitor student grads and offer academic support. The current program model includes student ambassadors and ETV Specialists. The student ambassador role offers peer support to other students and provides education on ETV to new and incoming students. The ETV Specialist role offers support, guidance and advocacy to ETV students and helps student navigate the campus process.

Cost of attendance is determined by each participant's choice of school based on factors such as tuition, fees, books, housing, transportation and other school-related costs unique to the participants' needs at their institution of choice. All ETV participants are required to submit a Cashier statement and Financial Aid statement to their higher education institution. Once cost of attendance is calculated by the school, verification is provided in accordance to the Higher Education Act of 1995, typically either by fax or mail, to the main ETV office with the appropriate staff signatures from the institutions. The ETV Program Manager reviews documents to ensure the ETV funds awarded do not exceed the total costs of attendance.

All financial aid directors at educational institutions that ETV recipients attend are informed each academic year, about the ETV program and ETV aid is reported to the higher education institutions via sharing of documentation. In addition ETV program staff are aware of each student's total financial aid package to ensure that ETV funds are used to fill the funding gaps up to but not exceeding the cost of attendance.

Indiana Connected By 25, Inc, works closely with The Commissioner of Higher Education(CHE) to insure that the ETV staff is update to date on all financial aid rules, regulations, changes and supports. INCBY25 is connected to a listserv sponsored by Department of Education and CHE for higher education Financial Aid directors. ETV staff are also connected to the American Bar Association Center on Children and the Law Foster Care Education group. Higher education institutions are updated each academic year and INCBY25 encourages and has leveraged the institutions to designate a key person to work with ETV students and required documentation.

The ETV staff also works closely with all Financial Aid directors and staff where ETV students are enrolled. The higher education institutions report student grants and additional aid on the financial aid form. INCBY25 tracks all student aid dollars by category and student. To stay ahead of developing issues, and due to the growing number of ETV participants and the various institutions of learning, ETV staff hosted an informational sessions for Financial Aid directors in 2014 -2015. ETV Specialist continues to work with colleges financial aid departments on a local level. ETV staff will be hosting an informational session for Financial Aid directors in 2015-2016.

Finally, Indiana offers a 21st Century scholar's scholarship for low income students that covers tuition only. The

21st Century Scholarship is supported by state funding. INCBY25 works closely with the 21st Century Scholar staff and higher education institutions to address duplication of funds. The ETV staff submits student names to 21st Century Scholars and monitors student funding and progress.

The ETV recipients apply each semester (fall, spring, summer), which allows INCBY25 to track the student's enrollment and pull quantitative data on retention and persistence each academic year. A comparative analysis is completed to extract new applicants in each academic year.

XIV. TARGETED PLANS WITHIN THE CFSP

A. FOSTER AND ADOPTIVE PARENT DILIGENT RECRUITMENT PLAN

The DCS Foster and Adoptive Parent Diligent Recruitment Plan is attached as Attachment 1.

B. HEALTH CARE OVERSIGHT AND COORDINATION PLAN

The DCS Health Care Oversight and Coordination Plan is attached as Attachment 3 (Attachment 4 is an attachment to 3).

C. DISASTER PLAN

The DCS Disaster Plan attached to the CFSP as Attachment 11 was updated June 2014, and there have been no additional updates in the past year and there are no changes needed at this time. DCS was not affected by any disaster in the past year.

D. TRAINING PLAN

The DCS 2015 Training Plan is attached as Attachment 5.

XV. STATISTICAL AND SUPPORTING INFORMATION

A. INFORMATION ON CHILD PROTECTIVE SERVICE WORKFORCE:

FCM Preferred Experience:

- Bachelor's degree from an accredited college/university required.
- At least 15 semester hours or 21 quarter hours in child development; criminology; criminal justice; education; healthcare; home economics; psychology; guidance and counseling; social work; or sociology required (copy of transcript must accompany the application or must be submitted at the time of interview if granted).

FCM Supervisor Preferred Experience:

- Bachelor's degree from an accredited college/university in Child Development, Criminology, Criminal Justice, Education, Healthcare, Home Economics, Psychology, Guidance and Counseling, Social Work, or Sociology or a related field.
- Two (2) years experience in the provision of education or social services to children and/or families. One (1) year of the experience in an administrative, managerial, or supervisory capacity is preferred or accredited graduate training in Social Work.

County Child Welfare Director E4-E7 (Local Office Director) Preferred Experience – Varies

E7: Experience:

- Four (4) years of experience in public welfare, education, public administration, business administration, or social services; plus
- An additional three (3) years of supervisory experience in these areas.
- Education: Bachelor's degree from an accredited four-year college. (Concentration in Business Administration, Child Development, Counseling and Guidance, Economics, Education, Health Care, Home Economics, Law, Psychology, Public Administration, Social Sciences, Social Work, or Sociology preferred.)
- A combination of experience and accredited graduate training in any of the above areas may be considered.

E6: Experience:

- Four (4) years of experience in public welfare, education, public administration, business administration, or social services; plus
- An additional four (4) years of supervisory experience in these areas.
- Education: Bachelor's degree from an accredited four-year college. (Concentration in Business Administration, Child Development, Counseling and Guidance, Economics, Education, Health Care, Home Economics, Law, Psychology, Public Administration, Social Sciences, Social Work, or Sociology preferred.)
- A combination of experience and accredited graduate training in any of the above areas may be considered.

E5: Experience:

- Four (4) years of experience in public welfare, education, public administration, business administration, or social services; plus
- An additional five (5) years of supervisory experience in these areas.
- Education: Bachelor's degree from an accredited four-year college. (Concentration in Business Administration, Child Development, Counseling and Guidance, Economics, Education, Health Care, Home Economics, Law, Psychology, Public Administration, Social Sciences, Social Work, or Sociology preferred.)
- A combination of experience and accredited graduate training in any of the above areas may be considered

E4 : Experience Considered as Regional Managers (Marion & Lake):

- Four (4) years full time professional experience in public welfare; education; public administration or social services; plus
- Six (6) years full time experience in an administration or supervisor capacity in the above areas or as a state-level public welfare consultant.
- Graduation from an accredited four year college.
- Fifteen (15) semester hours in public administration; business administration; or social science; economic; law; child development; education; counseling and guidance; social work; home economics; sociology; psychology; or health care required.
- Substitutions: accredited graduate training in any of the above areas may be substituted for the

required experience with a maximum substitution of two (2) years, except for the administration, supervisor, or consultative experience.

- Full time experience in state social services as a state pat 1, sam pat 4 or higher may sub for the required experience and specialized education on a year for year basis.

Data on the education, qualifications, and training of such personnel

DCS does not track the number of child welfare workers with a Bachelor (BSW) and/or Masters (MSW) of Social Work degree; however, DCS does keep track of the number of staff with Title IV-E Supported Bachelor and Masters of Social work degrees. DCS in partnership with IU continues to offer the IV-E BSW and MSW programs. Participation in these programs are as follows:

In 2014,

- 46 students were selected for the BSW program.
- 23 students were selected for the MSW program.
- 42 BSW students began employment as family case managers in May through August, 2014.

In 2015,

- 50 students were selected for the BSW program.
- 18 MSW students have been accepted in the IV-E MSW Scholars program.
- 34 BSW students will begin employment as family case managers in May and June of 2015.

DCS does not have information available related to the number of years of child welfare experience or other related experience working with children and families.

Child Protective Services Demographics – Age - As of 4/30/15

Family Case Managers and Family Case Manager Trainees – 4/30/2015

22-25	26-30	31-40	41-50	51+	Total
289	513	598	314	188	1902
15.2%	27.0%	31.4%	16.5%	9.9%	100%

FCM Supervisors– 4/30/2015

22-25	26-30	31-40	41-50	51+	Total
2	70	124	83	51	330
0.6%	21.2%	37.6%	25.2%	15.5%	100%

County Welfare Directors – 4/30/2015

26-30	31-40	41-50	50+	Total
1	26	29	30	86
1.2%	30.2%	33.7%	34.9%	100%

Executives – 4/30/2015

26-30	31-40	41-50	51+	Total
5	11	17	27	60
8.3%	18.3%	28.3%	45.0%	100%

Information on caseload or workload requirements for such personnel, including requirements for average number and maximum number of cases per child protective service worker and supervisor (section 106(d)(10) of CAPTA).

Pursuant to IC 31-25-2-5, enacted in the spring of 2007, DCS is required to ensure that Family Case Manager staffing levels are maintained so that each county has enough FCMs to allow caseloads to be at not more than:

- (1) twelve active cases relating to initial assessments, including investigations of an allegation of child abuse or neglect; or
- (2) seventeen children monitored and supervised in active cases relating to ongoing services.

The 12/17 caseload standard is consistent with the Child Welfare League of America’s standards of excellence for services for abused and neglected children and their families.

The issue of caseload data must include the current national discussion regarding caseload definitions. As currently set out in statute, DCS must comply with standards that include 12 new investigations or 17 ongoing children being supervised by a case manager. These definitions are clear in large to medium counties, where the large scale of operations allows FCMs to specialize in either investigations or on-going cases. In smaller counties, however, the issue of mixed caseloads is more difficult to determine, in large part because ongoing caseloads of 17 are fairly static while new investigation caseloads are fluid, changing day to day and week to week. DCS continues to work with national leaders and organizations as these discussions bring more mathematical certainty to those designations.

Using existing monthly data reports, Regional Managers monitor caseloads regionally and locally to allocate staff as needed in individual counties.

Reports are generated monthly to monitor the timely completion of new assessments within 30 days as well as periodic detailed reports which help managers track the length of time various case types remain open. This

allows managers to further analyze how to more consistently provide permanency for those children and thereby close the case. All Regions have formed Permanency Review Teams (PRTs) to review and provide recommendations to local offices for those cases where traditional measures have failed to achieve permanency. Each region reports monthly on the status of all PRT cases to the Permanency and Practice Support Division.

In addition, Regional Managers also monitor the number of overdue assessments or assessments that are not completed within the required thirty day timeframe. Two overdue assessment reports are run on a weekly basis. The first identifies all cases that have been open for 20 to 30 days. This report enables managers to identify assessments that are at risk of becoming overdue (i.e., open for more than 30 days). A second report captures all assessments that have been open for more than 30 days. There is also a supervisory report that tracks assessments that have been sent to a supervisor for approval. This report shows the total number of days an investigation has been open for quick reference.

B. JUVENILE JUSTICE TRANSFERS

This information is available as a part of the Indiana Probation Report prepared by the Indiana Supreme Court Division of State Court Administration at <http://www.in.gov/judiciary/admin/files/rpts-ijjs-2013-probation-v2-statistics.pdf>.

Listed below are the page numbers within the 2013 report where data can be found for juvenile justice transfers. The 2014 juvenile justice transfer data will not be available until September, 2015.

Juvenile Probation	17
Juvenile Probation Referrals 2004-2013	17
Juvenile Probation Supervisions 2004-2013	19
Juvenile Probation Supervisions Method of Disposition	21
Juvenile Supervision Levels	23
Juvenile Supervision as Result of Substance Abuse Convictions 2004-2013	23
Juvenile Supervisions as Result of Sex Offenses 2009-2013	24
Juvenile Supervision Completed Predisposition and Progress Reports	24
Juvenile Law Services Report	25
Juvenile Law Services Financial Report	29

C. SOURCES OF DATA ON CHILD MALTREATMENT DEATHS:

There have been no changes to this section since the CFSP.

D. EDUCATION AND TRAINING VOUCHERS

Education and Training Vouchers:

State: Indiana: Annual Reporting of State Education and Training Vouchers Awarded Total ETVs Awarded
Number of New ETVs

Year (July – June)	Funded Students (unduplicated)	New Funded Students
2014-2015 (not including summer)	297	93
2013-2014	371	140
2012-2013	432	164
2011-2012	421	160
2010-2011	331	186
2009-2010	305	190

The ETV Chart is attached as Attachment 12

E. INTER-COUNTRY ADOPTIONS:

No children adopted from other countries entered into DCS custody as a result of a disruption in placement or dissolution of adoption in FY2014.

XVI. Attachments (Separate Document)

1. Commission on Improving the Status of Children Organization Chart.....	1
2. Foster and Adoptive Parent Diligent Recruitment Plan	3
3. Health Care Oversight Plan (updated 2015)	9
4. Indiana Psychotropic Medication Guidelines 2014 Final.....	32
5. 2015 Training Plan.....	108
6. 2014 Citizens Review Panel Report – Marion County.....	143
7. 2014 Citizens Review Panel Response – Marion County.....	156
8. 2014 Citizens Review Panel Report – Hendricks County.....	159
9. 2014 Citizens Review Panel Response – Hendricks County.....	164
10. 2014 Citizens Review Panel Report – Switzerland County.....	166
11. 2014 Citizens Review Panel Response – Switzerland County.....	170
12. Education and Training Vouchers Awarded.....	175
13. CFS-101, Part I.....	80
14. CFS-101, Part II	182
15. CFS-101, Part III	185
16. DCS Child Welfare Policy Manual Policies:	187
a. 4.0 Diligent Search	188
b. 4.28 Involuntary Removals	193
c. 5.07 Child and Family Team Meetings.....	201
d. 5.08 Developing a Case Plan.....	208
e. 6.8 Three Month Progress Report.....	217
f. 6.10 Permanency Plan.....	221
g. 6.11 Permanency Hearing.....	225
h. 6.14 Children Attending Court.....	229
i. 8.09 Placing and Child in Out-of-Home Care	233
j. 8.16 Resource Parent(s) Role.....	236
k. 8.23 Extracurricular Activities.....	239
l. 8.26 Authorization for Health Care.....	241
m. 8.27 Maintaining Health Records.....	245
n. 8.29 Routine Health Care.....	249

o. 8.41 Transitioning from Out-of-Home Care	252
p. 8.48 Relative Placements.....	254
q. 11.1 Older youth Services.....	260
r. 11.6 Transition Plan for Successful Adulthood.....	263
s. 11.15 Secondary Education.....	269
t. 11.18: Eligibility to Participate in Collaborative Care	273
u. 11.19 Entry into Collaborative Care.....	277
v. 11.20 Youth Adjudicated as Juvenile Delinquents Accessing CC.....	280
w. 11.21 Collaborative Care Case Transfer.....	283
x. 11.22 Voluntary Collaborative Care Agreement	288
y. 11.27 Permanency for Older Youth.....	290
z. 13.1 Conducting Background Checks.....	292
aa. 14.1 Guardianship Assistance Program (Overview).....	298
bb.14.2 Negotiations for GAP Assistance.....	304
cc. 14.3 Modifications/Continuation of GAP Agreement.....	309
17.DCS Forms	314
a. SF2956 - Case Plan	315
b. SF55106 - Relative Home Environment Checklist.....	321
c. SF55211 - Notice to Relative.....	322