**Indiana Family Preservation Services**

**Agenda and Questions**

**January 21, 2022**

1. *Brian Goodwin to provide evaluation and survey update.*
	1. Getting close to the end of the evaluation period
	2. Document sent to update everyone regarding the survey
		1. Providers have responded to resolve issues – thank you!
		2. We are working to wrap these up as soon as possible
	3. Any questions/comments – email brian.goodwin@dcs.in.gov
2. Concrete supports reminder—Please complete this form for any concrete spend, and send to Bridget McIntyre (*Bridget.McIntyre@dcs.in.gov*) or the Child Welfare Plan (*ChildWelfarePlan@dcs.in.gov*):

 <https://www.in.gov/dcs/files/Expense-Tracking-Agencies.xlsx>

1. Current case information: *(as of 1/20/22)*

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| --- | --- |
| **Regions** | **Family Pres Case Count** |
| 1 | 121 |
| 2 | 55 |
| 3 | 99 |
| 4 | 93 |
| 5 | 60 |
| 6 | 51 |
| 7 | 90 |
| 8 | 74 |
| 9 | 76 |
| 10 | 185 |
| 11 | 98 |
| 12 | 64 |
| 13 | 64 |
| 14 | 58 |
| 15 | 69 |
| 16 | 110 |
| 17 | 57 |
| 18 | 94 |
| **Grand Total** | **1518** |
|  |  |

* 1. Case number have significantly decreased because we found a KidTraks error that was resolved, eliminating many older cases that were actually closed.
		1. 75 cases within the evaluation group were actually closed
	2. These numbers are accurate, as the data has been corrected
	3. Some have noticed these numbers are different than what is on the DCS website – why is that?
		1. Data reported on website is per child, this data is per referral.
		2. Example – one Family Pres referral with three kids will report as ‘one’ on this data, but ‘three’ on the website
		3. Additionally, TTV cases reported on website are reported as in-home, but would not qualify for Family Preservation
	4. IA and In-Home CHINS are closing faster than they were historically
1. *“Family Pres Fridays” for DCS staff update*

 *Next meeting with FCMs is 1/28. Hopefully this will help us with our teaming of cases.*

* 1. Next session is next Friday, January 28
	2. Number of attendees is growing
1. Questions received:
2. We are consistently having FCMs say to families that “it is just marijuana”, “I have bigger fish to fry”, “just give me two screens that are clean back-to-back and we are good”, etc. I am seeing it in all regions we serve. This is causing a lot of issues with treatment recommendations, ethics, and legal concerns etc.  Example: we complete a substance use assessment, make recommendations, and then the FCM tells the family they do not see why “that” (lock box) is necessary…
	1. Many parents are in Medicated assisted treatment-Buprenorphine or Methadone. The lock box is a prerequisite to the adult receiving "take home" privilege. It means the clinic is allowing the adult to bring home Buprenorphine or Methadone. The lock boxes are to keep kids safe. The medication is dangerous to children. We need to know when parents are on MAT. The team needs to know about "Medicated Assisted Treatment".
		1. We have many parents with Opioid addiction issues. Methadone and Buprenorphine are lifelines for parents in recovery.
	2. DCS involvement shouldn’t be necessary to get substance use assistance or treatment
		1. Setting up support systems ;
		Connecting them to outside services organically ( ymca, school programs etc )
	3. At times we have been told by the FCM that if the parents drink a lot of alcohol or use some drugs, and the kids are not around, it is ok?
		1. What are the risks to the children?
		2. We are looking at this from two lenses – treatment and child welfare
			1. Treatment recommendations don’t always completely align with child welfare recommendations
			2. Child Welfare indicates the need for the children to be present/affected by use
			3. Abstinence only models do not show a lot of positive outcomes when it comes to people reaching and maintaining recovery—everyone has their own path; med assisted and other models show higher rates of treatment success, particularly with regard to helping people with substance use disorder be able to function
	4. Is a harm reduction approach something that we should take a closer look at?
		1. Research supports these types of models
		2. <https://harmreduction.org/about-us/principles-of-harm-reduction/>
	5. I’m assuming that there are other factors ( beside marijuana )
	in the case that caused us to be involved. We have to look at the entire family picture as we make case decisions—when, where is substance use occurring? Where are the children? Is there a sober caregiver? What are the risks to child safety?
	6. We've tried this intervention, even with heroine usage and in both cases, the kids were removed b/c parents STILL used with kids present!
		1. When there are imminent SAFETY concerns – call the FCM/Supervisor, LOD, local office right away
		2. Call the hotline if you do not get an answer
		3. ALWAYS file a report if you feel a child is being abused or neglected—we’re all mandated reporters.
	7. We should expect some relapse – the road to recovery from addiction is rarely, if ever, a straight path
	8. It seems to me that the conflict comes when an FCM is undermining the treatment provider
		1. Leads to family resistance
		2. Not getting invited to court
		3. Not being included in meetings regarding case progress/decisions
	9. Cases opening because of substance use/domestic violence with substance use as a trigger
		1. We can’t even get in the home to do our checklists
		2. This remains a safety issue when the cause for involvement continues and the case closes unsuccessfully (esp. IA)
		3. We have many FCMs tell our parents that they don't think they needed therapy from our assessment. They stop complying after that happens, so then they are getting no support or help
		4. My thought is for service providers to continue to contact DCS FCMs for meetings (some meetings should involve the client as well) to discuss the expectation re substance use while the case is open.  It is important that EVERYONE INVOLVED (DCS, service provider and client) is on the same page.  Service providers have the clinical experience and clinical recommendations that some FCMs do not have (some, not all) – it is our responsibility as trauma-informed and strengths-based service providers to take initiative to advocate for the client’s wellbeing and recovery, so meetings are important, even if that means having 3, 4 or 5 meetings until everyone involved is on the same page for that particular case.
		5. The DCS fatalities report that was just released for 2020 shows DV and substance abuse as two of the highest contributing factors leading to fatalities
	10. An important skill of the service provider is testimony and court reports
		1. Clearly explain your position to the court so they understand what you are seeing and treating.
		2. Some providers reporting that they are not invited to court or asked to provide reports
		3. Ensure that monthly reports and weekly safety checks are also thorough and clear so that the local office can understand what you’re seeing/doing
	11. Encourage participation in CFTMs and provider meetings
		1. Regular conversations with provider, DCS, and Family will promote better outcomes
		2. There are more team meetings. But I think the FCMs are struggling with not being the only one to outline services anymore. So they tell clients that they don't think they need this/that service, so engaging them becomes almost impossible
		3. I have been encouraged by biannual plans in several regions that include DCS action steps towards improved teaming with consistency around CFTM's, preparation before the meeting, objective identification of behaviors the family needs to take to work towards closure, and improved skill sets through trainings for FCM's to be able to facilitate effective CFTM's.
	12. Important to note that the rate of repeat maltreatment after a year post case-closure is 5.9% after Family Preservation services
		1. Rate of removal from African American children is about 5%
		2. Caucasian children removal rate is closer to 8%
	13. SO WHAT DO WE DO?
		1. If FCMs continue to tell families they don’t need to follow recommendations from provider, don’t need to comply, etc. – what can we do?
		2. Work up the chain of command – talk to supervisor, LOD, RM, Central Office Leadership
		3. Communicate concerns through a child safety lens
			1. Be consistent – communicate in court testimony, monthly reports, emails to team
			2. If you can make that connection based on best observation and clinical judgement, be consistent, and let the entire team know (FCM, Supervisor, court, GAL/CASA)
		4. If they are not hearing what you’re saying – rethink how you are saying it – is there a better way to communicate the message?
3. As FPS has been in place for a year and a half now, has the process of submitting referrals been reassessed putting safeguards in place ensuring the correct referral is being submitted if family preservation referrals is required, instead of individual services, or vice versa? If not, is there a plan for these safeguards to eventually be put into place? For example, if a family has an IA case, with no removals, and the case manager attempts to submit a casework referral, is there a way to prevent this or flag it, causing further information to be needed before the referral can be submitted or approved? We are still seeing individual service referrals, like casework and therapy, being approved on IA and in home CHINS cases when FPS should be required. This often causes delays in our approval process or starting services for families as the referrals frequently do not contain information identifying the case plan, so further communication is needed before proceeding.
	1. If you are experiencing this, reach out to referral@dcs.in.gov or childwelfareplan@dcs.in.gov , or your Regional Services Coordinator
		1. We can work with the FCM to get the correct referrals in place
	2. David we have been speaking to LODs about cases where HBT or HBC was sent and FPS was needed. The issue is the number of referrals we receive where there are no indicators whatsoever for if the case should have FPS or a single service like HBC because we do not know if it is an IA, in home CHINS, or out of home CHINS. We spend a lot of time having to follow up on this.
		1. Providers do not need to know if it’s an IA or In-Home CHINS
		2. Follow up – the provider gets a HBCW referral and doesn’t know if it’s IA/In-Home OR out-of-home CHINS
		3. As FCMs get more comfortable, the referrals should be more accurate
		4. You can also ask the family when you make your first contact with them
			1. If family confirms that the child has never been removed, you can then ask the FCM for a Family Pres referral instead
4. What is the protocol for CFTMs? How often, who can request it, etc.?

*Answer:* A CFT Meeting may be completed upon the request of any team member (including noncustodial and incarcerated parents), prior to case closure, and at case junctures beginning in the assessment phase (if DCS involvement will continue), and throughout the life of the case.” <https://www.in.gov/dcs/files/5.07.pdf>

* 1. Also see notes in discussion above
	2. Remember that the family selects the Child and Family Team
		1. If the family knows your intention is to help them stay together as a family unit, they are more likely to want to add you to the team
1. Family Reunification RFI
	1. Response was good
	2. Still thinking through how this service would come together effectively
	3. MUCH more complex than family preservation
	4. Goal is to facilitate safe reunification as quickly as possible
	5. Support child’s placement while waiting for reunification
	6. This asks a lot of the providers, so we are working through what that will look like.
2. Anything else?

Next meeting 2/4/2022 @ 1:00 EST

THANK YOU!