**Indiana Family Preservation Services**

**Agenda and Questions**

**March 3, 2022**

1. Concrete supports reminder—Please complete this form for any concrete spend, and send to Bridget McIntyre ([*Bridget.McIntyre@dcs.in.gov*](mailto:Bridget.McIntyre@dcs.in.gov)) or the Child Welfare Plan ([*ChildWelfarePlan@dcs.in.gov*](mailto:ChildWelfarePlan@dcs.in.gov)):

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

Let Bridget know if did not receive the agenda.

1. Current case information: *(as of 3/3/22)*

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| --- | --- |
| **Region** | **Family Pres Case Count** |
| 1 | 126 |
| 2 | 55 |
| 3 | 100 |
| 4 | 94 |
| 5 | 46 |
| 6 | 64 |
| 7 | 98 |
| 8 | 86 |
| 9 | 78 |
| 10 | 197 |
| 11 | 97 |
| 12 | 56 |
| 13 | 68 |
| 14 | 54 |
| 15 | 73 |
| 16 | 114 |
| 17 | 51 |
| 18 | 88 |
| **Grand Total** | **1545** |

*Up 8 cases from 2/18/22 meeting.*

1. *“Family Pres Fridays” for DCS staff update*

*Meeting was held on 2/25.*

* Still hoping for better attendance for FPS Fridays.
* Those that attended were really engaged.
* Providers can encourage FCMs to attend FPS Friday.
* Providers can also refer FCMs to David, Austin, and their RSCs.
* Next one scheduled for 3/25.

1. Discussion about research on impact of removing infants.

[NCCPR Child Welfare Blog: And now there are (at least) five - no, SIX: Still ANOTHER study confirms that, in typical cases, children do better in their own homes than in foster care (nccprblog.org)](https://www.nccprblog.org/2018/08/and-now-there-are-at-least-five-still.html)

“OK, the foster care apologists might say, but what about just infants. If we limit the study to just infants will we get the results we want?  No. Not even when the infants are born with cocaine in their systems.

University of Florida researchers [studied](https://www.sciencedaily.com/releases/1998/05/980505092617.htm) two groups of such children; one group was placed in foster care, another left with birth mothers able to care for them.  After six months, the babies were tested using all the usual measures of infant development: rolling over, sitting up, reaching out.  Typically, the children left with their birth mothers did better.  For the foster children, the separation from their mothers was more toxic than the cocaine.”

From the referenced study:

“Six months after birth, babies who went to live with a relative or foster parent were significantly less likely to smile, reach, roll over or sit up compared with children who remained with their mothers, though their motor and neurological development still was considered within normal range. Furthermore, a related study showed many of these infants weighed less and were shorter.”

“…But it was the babies who were immediately placed in foster care after birth that were at greatest risk for lowered motor development…”

* There is compelling research which is linked in the agenda – providers are encouraged to read the entire article
* This link recognizes the value in family preservation which is based in science.
* There was a lot of assumptions in the ‘80s and what the crack cocaine epidemic did to families.
  + Drug exposed babies were automatically placed in foster care.
* U of F research examined the impact of cocaine positive infants.
  + All typical measures of infant development were used.
  + Infants left with their birth mothers were in the normal range 6 months after birth and did better.
  + Babies placed in foster care were behind in smiling, reaching, rolling over, and engaging.
  + The babies who were placed in foster care after birth were at the greatest risk for lowered motor development.
  + The assumption that an infant born positive is better off in foster care is not supported by research.
* This is a reminder of why we’re doing FPS.
* Resources are available to have mothers placed in treatment with their babies.
  + These programs are available in Indiana.
* A positive drug screen is just a piece of the puzzle of the bigger picture.
* We need to be thoughtful on how we intervene, in order to prevent unnecessary harm
* The DCS numbers are showing we’re removing fewer children without an increase in fatalities and near fatalities.
  + David will share research about how keeping the children with the parents create better outcomes for parents as well next time.
  + We do need to remember the importance of thoughtful safety planning and the safety checks.
  + Providers have worked with mothers with their children removed who were traumatized as children who lose hope.
* Removal adds to trauma and increases ACE scores which increases risk of substance abuse disorders as adults.
  + A provider noted they have been using ACE scores in their substance abuse treatment group.
  + They had only one client who didn’t have a score of 4 or higher.
  + Most of their clients have diagnoses of PTSD as well.
* Meth positive does not automatically result in a removal.
  + Safety planning and using a sober caregiver are options.
  + Black and white planning isn’t appropriate.
* Only 3 states had more kids (20,000) in foster care in 2017 than Indiana and the third highest fatality rate.
  + We are at half that at around 10,000 kids in care present day.
* Some kids will have to be removed no matter what is done, but it needs to be thoughtful.
* Poverty also does not equal neglect.
* We also need to ensure families know what resources are available in the community to address their own needs.
* Refer to the INFPS page on the DCS website for resources
  + Providers need to continue to use the Protective Factors survey which should result in conversations with families of protective factors.
  + This should result in treatment plans to increase protective factors.
  + The first survey is to be done within 30 days of the of the referral and then every 3 months.
  + IAs are usually 6 month cases which would result in 3 surveys.

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1. Questions received:
   1. What are providers to do when concrete assistance goes from covering expenses to keep the children safe and in the home to becoming a large ongoing monthly expense?  We have a family (opened for educational neglect) that has had a recent tragedy in their lives and has no income.  Caregiver is not motivated to come to therapy to address depression or look for employment and is unable to pay any of the monthly bills. Community resources have been contacted but due to past due balances from previous addresses we are not having much luck.  CFT has met but no sustainable plan put in place.

* The provider is able to motivate the family to locate resources to address their needs.
* The default is always to have CFTMs to keep talking.
* Depression saps motivation.
  + Is the mother receiving treatment or medication for her depression?
  + Is there something we can do that we haven’t yet to increase her motivation?
* A provider suggested working with the FCM to even play “good cop/bad cop” to motivate the family to come to the table.
  + The CFT is the place to be the most creative to address the needs.
  + The providers doing FPS shouldn’t be the “bad cop.”
  + If that comes up, let David know.
  + Follow up: concrete supports were used to help the mother move out of state to escape her abuser which allowed her to quickly find a place to live and a job.
  + Concrete spend should be minor.
  + A good example is a mom with 7 kids who was facing neglect because she couldn’t transport them. The FPS provider bought them a used van which is something we couldn’t have done prior to FPS.
  1. So I know COVID numbers are decreasing but we still have a number of families experiencing symptoms and fevers that we screen for before going into a home for a face to face meeting. If, we have a family that has COVID or is COVID symptomatic, is there any work around to turn on an FP referral with a virtual session?
* If you know there is covid in the house, don’t go into the house.
* Talk with the CFT to make sure virtual services are appropriate.
* If there isn’t verification that there is covid, we still need to be doing home based services.
* If you can provide your EBM effectively through Zoom, you can do some virtual.
* The service standard says that services can be provided outside of the home which can include virtual.
* Providers need to see all of the children weekly.
  + The weekly in-home safety checks have to be completed in the home in person.
* Precautions to prevent covid---handwashing, masks, etc—should be used to prevent the spread. Child safety is first.
* There are DV situations were people need to be in the home to see if the batterer is there or signs of the batterer is there.
  1. Question & Background: We experienced a family that needed emergency housing and declined to go to a shelter despite our agency finding a long-term shelter-to-apartment transition program. We purchased a 30 day stay at an extended stay, and the family damaged the property and our agency was both threatened to be sued and told we may not be able to use the properties anymore. Our liability insurance only extends to our property, therefore we required the parent sign for financial responsibility moving this upset her and she switched agencies. Has anyone else dealt with this and have any suggestions on how we could have handled this from a liability position? The family has a history of leaving damages to apartments and have caused eviction as well.
* As these rare cases occur, the CFT needs to discuss what needs to happen next.
* Concrete supports isn’t a means to get providers to pay for things.
* They are used to prevent removal.
* The team would need to decide what to do if a family doesn’t want to go to a shelter, including court intervention. Providers can also reach out to the DCS Regional Services Coordinator for assistance

1. Anything else?

Next meeting 3/18/2022 @ 1:00 EST

THANK YOU!