

Evaluation of the Indiana Department of Child Services



The Child Welfare Policy and Practice Group

June 18, 2018



Acknowledgements

The Child Welfare Policy and Practice Group wishes to thank the 592 DCS internal and external respondents for their contributions to this evaluation. Their constructive and candid feedback permitted evaluators to deepen their understanding of system functioning and child and family outcomes.

Additionally, reviewers wish to acknowledge the direct assistance of the many staff within DCS who went out of their way to respond to requests for documents and data and, in some instances to review these with members of the CWG team to ensure their correct interpretation. Particular recognition is deserved by David Clark and Nicole Ford in the DCS central office who were consistently and tirelessly available to assist reviewers, often during times that extended well beyond regular work hours.

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Executive Summary

Purpose and Context of the Assessment

This assessment of the Indiana Department of Child Services (DCS) was undertaken by the Child Welfare Policy and Practice Group (CWG) at the request of Governor Eric Holcomb, who asked CWG to:

- Examine the current performance of the child welfare functions of the agency and compare it to generally accepted national practice standards and outcome measures
- Identify prominent strengths and challenges
- Produce recommendations for changes in any areas needing improvement

Assessment activities began in January 2018 around the same time Terry Stigdon, the current Director of DCS, assumed her role. DCS had been dealing with rising numbers of child abuse and neglect referrals for several years and an increasing number of children entering out-of-home care. According to federal AFCARS data (Adoption and Foster Care Analysis and reporting System):

- In September 2005, DCS reported 10,767 children in out-of-home care.
- As of September 2017, DCS reported 20,394 children in out-of-home care, an additional 9,627 children or an 89.4 percent increase. These data indicate the number of children in out-of-home care increased somewhat during the period from 2005 to 2010 and remained fairly stable in 2011 and 2012, before starting a much more dramatic upward trend in 2014.
- As of 2017, Indiana's rate of children in out-of-home care was about 13 children for every 1,000 in the state and is over twice the national average.

During the same 12-year period as above, three neighboring states experienced decreases in the number of children in out-of-home care (per AFCARS):

- Illinois = 13.1 percent decrease
- Kentucky = 17.3 percent increase
- Michigan = 39.4 percent decrease
- Ohio = 9.8 percent decrease

The increase of children in out-of-home care was seen as reflecting the epidemic of opioid addiction which has become a nationwide issue, but with greater acuity in Indiana than in some other states.

In addition to Indiana having a higher number of children in out-of-home care, Indiana also has a higher-than-average number of children being referred to child protection. In 2016, Indiana's rate of referral to child protection, calculated as the number of referrals for every 1,000 children in the state's population, was 108.2 compared to a national average of 55.6. Only Washington, D.C., Vermont and West Virginia had higher rates of referrals. Of the referrals it received, Indiana screens in a somewhat higher-than-average number and completes a

substantially greater number of assessments or investigations on those referrals than do most states.

- Indiana's screen-in rate in 2016 was 66 percent compared to 58 percent nationally
- Indiana completed 93.1 child abuse and neglect assessments for every 1,000 children in the state's population in 2016. This was the third highest rate in the nation, exceeded only by Washington, D.C. at 106.3 and West Virginia at 139.8.
- The rate of reports assessed in Indiana grew by almost 63 percent from state fiscal year 2013 to state fiscal year 2017.

Also important to note is that in five years, external evaluators have prepared five evaluation reports about DCS, requiring much time on behalf of evaluators and DCS staff and leadership. A large number of these recommendations have not yet been implemented.

Methodology

CWG's assessment activities focused on state level operations in Indianapolis and also on five regions of the state. The regions were selected based on size and geographic location, as well as demographic factors such as the incidence of poverty and substance abuse, both associated with a greater need for child welfare services. The following five counties and their corresponding DCS regions were selected: Allen, Clark, Lake, Marion and Vanderburgh.

Members of the CWG team reviewed internal documents including DCS policy, reports of quantitative data indicators, and quality assurance reports. CWG conducted interviews with representatives of DCS staff at all levels, as well as with key individuals in state partner agencies, service provider organizations, the courts and legal system, service recipients, foster and adoptive parents and other external stakeholders such as representatives of advocacy organizations. A total of 592 individuals were interviewed in 283 sessions. CWG reviewers spent at least the hour equivalent of a full work day shadowing DCS family case managers (FCM) in the central intake unit and in county offices of the five sampled regions. They also examined indicators of organizational capacity such as budgets, service contracts and data describing the child welfare workforce and workloads. Lastly, they conducted a review of a small sample of case record documents representing child protection assessments and ongoing services to families and children.

Findings

Analysis of data collected in the assessment revealed a number of notable strengths and challenges in DCS.

Strengths

- There is a high level of interest in and support of DCS at both the executive and legislative levels. The State Budget Agency has assisted DCS financially in the past several years by substantially augmenting the DCS general fund appropriation.

- Director Stigdon has been regularly interacting with front-line staff, partner agencies, and others to learn more about the system and solicit feedback about system strengths and challenges. Director Stigdon also has a strong interest in expanding the agency's investment in evidence-based prevention efforts.
- DCS staff are consistent advocates for children and families throughout the state.
- Almost half of the children who are in out-of-home care in Indiana are placed with relatives, which is associated with lessening child trauma and increasing placement stability. Nationally, Indiana is among the states with the greatest percent of children in kinship settings.
- DCS has a defined practice model that aligns with prevailing standards of family-centered practice.
- DCS has strong relationships with partner agencies and service providers at the state level and in many counties and communities.
- DCS has an overall collaborative and cooperative relationship with the courts.
- DCS policy is available online and accessible both internally and externally.
- DCS offers specialty teams (e.g., clinicians, educational consultants, medical consultants) to support case managers and supervisors.
- The state has a relatively large number of private-sector service providers who want a closer partnership with DCS.
- DCS makes ongoing use of Casey Family Program's Permanency Roundtable model for children and youth remaining in out-of-home care without reaching permanency goals.
- DCS has a well-structured training section and partnership with Indiana University's School of Social Work.
- The DCS draft federal Program Improvement Plan contains many strategies that are responsive to challenges the system faces.
- The state supports legal representation of all parties in Child in Need of Services (CHINS) court proceedings.
- DCS is in the process of hiring the 16 new attorney positions created this year to help address high workloads.
- Overall, permanency outcomes for children in out-of-home care in Indiana meet or approach national standards.
- Regular stakeholder meetings within each of the regions have been described as helpful in ensuring awareness of policies and external information, and promoting partnership.

Challenges

- Indiana has a very high rate of children in out-of-home care relative to surrounding states and nationally.
- DCS has a high rate of child abuse and neglect referrals and broad mandates for child welfare involvement relative to surrounding states and nationally.
- Indiana has an exceptionally high rate of court involvement in child welfare cases. While this adds oversight to child welfare cases, it also results in higher staff caseloads, more staff time in court and higher DCS costs.

- The DCS data system does not allow for staff at all levels to easily assess performance in relation to key safety, permanency and well-being outcomes for children and families served by DCS.
- There is an uneven organizational climate and culture across counties. This contributes to low morale and possibly affects turnover, performance and outcomes in some offices.
- DCS experiences uneven workloads that, in some instances, far exceed current caseload standards for family case managers and also for many agency attorneys.
- DCS has had a highly centralized management and approval process which results in unnecessary workloads and delayed services for some children and families.
- Opportunities for professional development and career advancement of front-line staff are very restricted.
- DCS has an uneven interpretation and implementation of policies across counties.
- DCS' legal operations attorneys experience very high workloads and turnover, and many have limited trial experience.
- Some jurisdictions have very poor agency/court relationships that potentially have an adverse impact on the disclosure of case information and on family case manager turnover.
- Daycare/childcare payments are not provided to foster parents; they are expected to use their per diem. Foster parents have voiced this as a disincentive for recruitment and retention as well as a financial challenge.
- Relative/kinship caregivers must assume responsibility for child care payment challenges after the first six months of the child's placement.

The following are some particularly notable data related to the findings of the assessment:

- The number of court-involved cases in DCS is more than double the national average.
- Only three states have a higher rate of abuse and neglect referrals than Indiana.
- Indiana accepts more abuse and neglect reports than the national average.
- Only two states had a higher rate of completed child protection assessments than Indiana.
- Despite completing more assessments than almost any state, Indiana substantiated only 15 percent of those assessments.
- The rate of abuse and neglect reports grew by almost 63 percent from SFY 13 to SFY 17.
- 55 percent of removals in 2017 were related to parental substance abuse.
- DCS barely misses the federal standard for repeat maltreatment
- Indiana's rate of children in care is 13.0 (per 1,000 children) compared with the national average of 5.6.
- Indiana's rate of children entering care is 8 (per 1,000 children) compared with the national rate of 3.6.
- Nearly 45 percent of family case managers have caseloads above the state standard.
- DCS' supervision standard is 1 to 7+ compared to the national standard of 1 to 5.
- There are 530 children in care on the Child Care and Development Fund (CCDF) wait list for childcare vouchers.

- In SFY 2017, DCS spent \$24,933,487 on drug testing/supplies and \$4,538,182 on drug treatment.

Recommendations

CWG recommends the following actions to build on DCS' strengths and address its most significant challenges.

1. Intervention by DCS must not be the first resource for families struggling with substance abuse and mental health needs. Treatment and support must be available outside of DCS for direct self-referral with outreach to be sure parents and other community groups coming into contact with parents know about those resources.
2. DCS should strengthen and expand the Sobriety Treatment and Recovery Teams (START) model, and consider other models such as the Parent-Child Assistance Program (PCAP) developed by the University of Washington (<http://depts.washington.edu/pcapuw/>).
3. Indiana should re-examine its broad definitions of neglect and the term "custodian" against those of neighboring states and other states that more narrowly define these terms, either to: (1) exclude neglect which is based solely on poverty or limited, one-time lapses in parental judgment; (2) limit the definition of custodian to one who is assigned consistent caregiving responsibility (e.g., a day care provider) by the child's legal parent; (3) redefine sexual abuse assessments under the purview of DCS as those in which a caregiver is the alleged perpetrator; and (4) require that the statutory elements of a report be met for DCS to initiate an assessment regardless of the ages of the children involved.
4. The provision for a one-hour-response time for the initiation of child protection assessments should be reconsidered in favor of a 24-hour response within which DCS would exercise discretion to deploy staff more quickly.
5. The 30-day assessment time limit should be extended to 60 days, with supervisory oversight to ensure timely completion and service provision.
6. Court oversight is obviously necessary when children cannot be made safe at home and in selected other situations when families cannot be voluntarily engaged to work toward the changes needed to protect their children. There is, however, no evidence that it is required to successfully affect all child welfare intervention. Indiana children and families would likely benefit from lower rates of court involvement in the context of child welfare intervention. DCS should attempt to engage families voluntarily in services to support child safety and well-being whenever possible.
7. DCS should reclaim the family-centered practice model that it adopted shortly after its formation. This will require: (1) a return to valuing and consistently soliciting and using

the input of families and their support systems both in ongoing casework and in regular child and family team meetings; (2) learning to recognize and mobilize family protective factors that can help promote child safety even when some safety threats exits; (3) achieving an understanding of the harmful effects of child removal and disrupted attachment for children as a counterbalance in considering whether removal is the safest course of action to address safety threats; and (4) increasing both the number and skill level of peer practice coaches available to staff.

8. Throughout the country, youth who exit the foster care system without permanency have extremely poor outcomes. DCS already permits youth age 19-21 to continue to receive services. CWG recommends that DCS consider extending the age in which foster youth can receive services to age 23. DCS should also facilitate the involvement of its collaborative care staff with youth in care at age 16 to help them begin considering the option to remain in care past age 18.
9. The development of a trusting working alliance between child welfare case managers and families receiving services has been identified as a key factor in supporting positive outcomes. To better facilitate this, DCS should: (1) establish a caseload standard of no more than 17 families (not children) for in-home services and no more than 15 children for out-of-home care caseloads; (2) Require that case managers visit with parents in their own homes at least once per month once caseloads approach the caseload target.
10. DCS should create a small unit made up of data professionals which can take responsibility for analyzing the voluminous data currently being collected. This group would also identify new opportunities to assess the effects of system interventions in the lives of children and families. These professionals should work closely with child welfare program leadership to identify a limited set of key outcome and process measures that can be displayed in regular management reports. The key outcomes and process measures should be disaggregated by region and county so that staff at all levels of the organization can regularly assess their performance and use data to develop and test questions about practices that improve safety and permanency outcomes for children and families.
11. DCS needs to strengthen its quality assurance capacity by: (1) ensuring those leading the QA work have either practice experience or the opportunity to learn in sufficient depth what front-line child welfare practice and supervision involve; (2) identifying a limited set of key data indicators to be gathered and reported; (3) considering adding or reassigning resources to build its Quality Service Review expertise and capacity; and (4) continuing the child death review process and taking active steps to involve sister state agencies, community partners, providers and the public in developing a deeper and more contextualized understanding of the factors contributing to child deaths and of those factors promoting child safety.

12. The supervisor-to-caseworker ratio should be reduced to one supervisor for every five family case managers. Reviewers found that supervisors in DCS have between six and 11 family case managers under their supervision. The Child Welfare League of America (CWLA) standard for front-line supervisors is one to five. The role of the supervisor is critically important in child welfare.
13. DCS should conduct an inquiry into the extent to which culture and climate are factors negatively impacting recruiting, retaining and developing high performing front-line staff, and develop and institute a plan to create and sustain a more productive and proficient work environment.
14. Both DCS personnel and others who work with DCS spoke frequently to reviewers of the “culture of fear” that exists among front line staff. This is, unfortunately, not an unusual finding in child welfare agencies today. However, child welfare staff who are unduly fearful to the extent that they place concern about the proximal consequences of personal liability related to case actions above the immediate and long-term well-being of children and families do not produce the best outcomes. In the experience of reviewers, such fear can only be mitigated when top leadership clearly communicates a commitment to support frontline personnel unless they commit fraud or are grossly negligent in performing their duties.
15. DCS should develop a clear strategy for recruiting and retaining front line staff and providing them with meaningful and ongoing professional development. Suggested components of such a plan would include: (1) establishing selection criteria that state a preference for staff with the BSW or MSW; (2) considering whether pay is commensurate with that of other positions in Indiana requiring similar education and equal pressures related to job stress, potential liability and after-hours work; (3) providing a career that affords higher pay to staff with social work degrees and has opportunities for advancement in pay and status based on acquisition of additional certifications in specific practice skills; (4) providing ongoing training opportunities for all front-line staff and middle managers that provide exposure to cutting-edge knowledge in the child welfare field; (5) working in partnership with state university schools of social work to improve recruitment of social work graduates and developing incentives (including higher rates of pay) for staff to pursue the MSW.
16. DCS should identify opportunities to work toward decentralizing decisions that directly affect work with children and families. This would involve: (1) forming a work group of local FCMs, supervisors, county office directors and selected state office staff to review local decision-making authority and its limits related both to policy and spending; (2) attending in particular to policy revisions that better facilitate immediate access to funds to meet concrete needs of families as a means of addressing child safety.
17. DCS should critically assess counties that are outliers in the time of involvement in CHINS cases from open to closure to determine what factors contribute to cases

remaining open for lengths of time that exceed the state average by 20 percent or more.

18. DCS should hire or contract with a Medicaid expert with experience in working with child welfare and behavioral health systems to assist it in maximizing the use of Medicaid for services.
19. DCS should critically assess and take steps to resolve factors that contribute to attorney turnover and lack of expertise in planning and participating in evidentiary hearings.
20. DCS should engage providers immediately in a demonstration of partnership, with a focus on what the provider community needs in order to best serve children and families. This may include, for example, assessment of current policies or procedures, including audit requirements, data collection or strengthening assessment of outcomes for services.

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State of Indiana
Department of Child Services
Evaluation of the DCS Child Welfare System
June 18, 2018

I. Purpose, Scope, and Context of the Assessment

The Child Welfare Policy and Practice Group (CWG) began the assessment in January 2018 at the request of Indiana Governor Eric Holcomb. Governor Holcomb sought an external assessment of the Department of Child Services (DCS) for the purpose of determining how Indiana's child welfare system is functioning with respect to nationally accepted standards of child safety, permanency, and well-being. Specifically, he asked CWG to:

- Examine the current performance of the agency and compare it to generally accepted national practice standards and outcome measures;
- Identify prominent strengths and challenges; and
- Produce recommendations for changes in any areas needing improvement.

The Indiana DCS was created in January 2005 by executive order of then Governor Mitch Daniels. The agency's charge is to execute the state's functions related to child support enforcement and child welfare, which had formerly been carried out by personnel in the state's Family and Social Services Administration, a large multiservice organization that performs functions related to financial and medical assistance, mental health and substance abuse treatment, and services to the developmentally disabled. Services were provided through county offices that were largely locally funded.

Governor Holcomb appointed the current director of DCS, Terry Stigdon, in December 2017, and she began work in January 2018. She is the third DCS director, following James Payne who served from 2005-12 and Mary Beth Bonaventura, who was appointed in 2013 and stepped down in December 2017.

It is important to note that Stigdon, who began working a few weeks after this assessment was launched, has been fully supportive. She has strongly endorsed the assessment work and has urged the participation of DCS staff and external stakeholders. At her request, the assessment team extended interviews substantially beyond the pool of participants included in the original assessment plan. She and her leadership team cooperated fully in ensuring Child Welfare Group representatives had access to all requested records, data, and personnel at all levels. She requested that staff at all levels of the organization be available for interviews and respond to requests for specific information. All DCS personnel contacted, whether for interviews, data,

or specific follow-up requests for clarification or additional details were likewise responsive and helpful.

Additionally, reviewers wish to acknowledge the independence granted to CWG throughout the review as well as the expressed interest and support of members of the Indiana legislature, several of whom were interviewed in an effort to understand their specific experiences and concerns with DCS and the services it provides to their constituents

There has been strong interest from the Indiana legislature in the review, with members expressing interest in what the legislature could do to assist DCS in improving.

The legislature has recently passed and the Governor has signed several statutes relative to child welfare, including a Foster Parent Bill of Rights and legislation facilitating the acquisition of a driver's license for foster youth.

II. Methodology

The Child Welfare Group's approach to conducting the assessment of DCS included an array of methods as described below:

Stakeholder Interviews

The four-person review team conducted both individual and group interviews with people who are in a position to be knowledgeable of DCS work from a variety of perspectives. These included community organizations linked to the department, advocacy organizations, youth and parents served by DCS, public and private providers of treatment and placement services, foster and adoptive parents, legal partners (including judges, attorneys and advocates who represent all parties involved in Child in Need of Services proceedings), representatives of law enforcement, mandated reporter groups such as education and medical professionals, and DCS front-line caseworkers, supervisors, managers, and central office leadership.

CWG conducted three weeks of interviews in Indianapolis with DCS leadership, legislators, representatives of other state agencies that interact with DCS, and state-level representatives of advocacy and provider organizations. One member of the assessment team spent at least a week in each of five regions where they conducted interviews with DCS managers, supervisors, and case managers as well as with local foster and adoptive families, service providers, educators, law enforcement, and medical professionals, judges and attorneys involved in CHINS proceedings, and youth. The regions included in the review were selected based on their geographic distribution in the state, relative population size, and the presence of factors such as poverty and higher rates of substance abuse that are often associated with greater need for child welfare services. Regions of focus were Region 1 (Lake County), Region 4 (Adams, Allen, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, and Whitley counties), Region 10 (Marion County), Region 18 (Clark, Floyd, Harrison, Scott, and Washington counties), and Region 16 (Gibson, Knox, Pike, Posey, Vanderburgh, and Warrick counties).

Over the course of the assessment, a total of 592 people were included in 283 interview sessions. This total does not include some individuals who were contacted for follow-up interviews as additional questions arose about their respective areas of knowledge.

Shadowing and Observation of Intake and Casework Activities

Members of the CWG team spent the hour equivalent of at least one day in each of the five regions and in the Indianapolis location of the DCS Intake Unit (i.e., “Hotline”) assigned to family case managers (FCM’s) and/or supervisors as they went about their work. This included observation of regular activities such as accompanying FCMs as they conducted child abuse and neglect assessments, attended or facilitated Child and Family Team Meetings, participated in court hearings or consultation with attorneys, visited children in schools, and interacted with other services providers.

Information System, Data and Trend Analysis

CWG examined quantitative outcome and internal management data to assess the activity of DCS in relation to intake and action on reports of maltreatment, achievement of safety, permanency and well-being, compliance with current policies and procedures, and the value of selected metrics related to improved performance. This analysis also included attention to key measures that were not available or were difficult for staff to access as important gauges of performance.

Organizational Structure and Capacity

In conducting the review, CWG gathered facts and impressions about current structure and organizational capacity, the sufficiency of the resources that support DCS functions, the capacity and role definition of the front line workforce, business processes and technology that support critical areas of work, the adequacy of pre-service and in-service training and professional development, accountability processes such as quality assurance reviews and quality improvement mechanisms, and managerial practices.

Identification of Resources and Resource Needs

To analyze resource needs, CWG examined the agency’s budget and budget trends, referral practices and resource availability and accessibility, provider and resource payment rates, and federal revenue utilization. Reviewers also explored practices related to referral processes and interaction with providers to coordinate services around individual family needs as well as major areas of unmet need.

Review of Policies and Procedures

CWG reviewed the policies that guide child welfare practice to understand the degree to which DCS’s own stated model of practice comports with generally accepted practice standards in the field of child welfare and to understand the capacity of the organization. Reviewers also examined the service and licensing standards that ensure the quality of contracted services

Review of State Statutes Related to Child Welfare Practice

CWG reviewed Indiana statutes that define child abuse and neglect and regulate child welfare practice and compared them with those of surrounding states. Reviewers included West Virginia in the comparison group because of the high rate of opioid use and out of home care of children in that state. CWG compared Indiana’s criminal statutes related to illegal substance

use against those of the comparison states to determine whether these might result in higher or lower rates of incarceration of parents in Indiana.

Staffing

CWG assessed DCS staffing levels and their compatibility with statutory caseload standards and workload. To the extent data were available, assessment of caseload focused on actual caseloads among front-line case-carrying staff, not just averages derived from dividing the entire DCS caseload by the total number of FCMs or averaging across longer spans of time. Within the workload analysis, reviewers also focused on the relationship of required tasks and procedures to the attainment of desired outcomes for children and families. This included attending to whether staff were occupied in tracking and documenting data that are not used or which do not materially strengthen outcomes and whether there are unnecessary layers of administrative approvals that create additional work for staff and delays for families.

In terms of staffing, CWG also looked at the responsibility of front-line supervisors with regard to the breadth of program oversight and the ratio of supervisors to FCMs and other subordinate staff.

Review of Prior Management and Workload Analysis Reports

Members of the assessment team reviewed a variety of internal and external reports related to DCS management and workload completed within the past few years. Chief among these were the Efficiency Assessment and Recommendations completed by Alvarez and Marsal in March 2017 and the Caseload and Workload Analysis completed by Deloitte in March 2015.

Assessment of Factors Influencing Agency Culture and Climate

Data from interviews and observations of front-line staff and middle managers offered an important lens on the shared norms and values within DCS, the extent to which they influence practice and staff behavior, and the degree to which staff, especially FCMs and supervisors, reflect experiences of personal reward and professional growth in their work.

Review of Case Files

CWG conducted a review of a small sample of cases in a randomly selected assortment of assessment, in-home, and out-of-home care cases, to assess DCS' practice related to assessing reports of child maltreatment, family involvement, case planning, and intervention strategies.

Placement Resource Assessment

Reviewers used both DCS data and information from DCS staff, foster parent, and provider interviews to explore the sufficiency of child placement resources, issues related to quality of placements, and practices related to placement development, selection, utilization, and retention. As a large portion of children removed from their parents in Indiana are placed with relatives, this part of the assessment also focused on supports provided to relative caregivers.

Review of Quality Assurance Reports and Processes

CWG reviewed a sample of quality assurance reports, the processes for providing feedback of quality assurance reviews to field staff and for design and implementation of efforts to make strategic changes in practice directed toward improving specific outcomes.

Limitations of the Assessment

Despite the consistent cooperation and considerable effort of the DCS data team, the agency's current automated data system did not provide the desired level of detail for some quantitative indicators. Some of the requested data elements were not available and others could not be disaggregated in a way that allowed reviewers to assess subgroups in certain data categories. For example, it was not possible to identify the number of dually adjudicated youth who are transferred from probation to DCS because their designation is changed to match that of other DCS children upon transfer from probation caseloads. Likewise, children who are removed from their custodial parent and placed with another parent, are not identified as part of the out-of-home care population despite being the subjects of removal and in the custody of DCS.

The compressed time frame of this assessment did not allow for taping and full transcription and coding of interview data. Rather members of the CWG team relied on detailed notes that were later transcribed and reviewed to identify common themes across various groups of DCS and staff and system stakeholders.

III. Findings of the Review

A. Overall Strengths and Challenges in DCS

Strengths

- There is considerable interest and support at both the executive and legislative branch levels of Indiana government in the well-being of the state's children and families and, more specifically, in the services provided by DCS. Governor Holcomb made finding solutions to combat the opioid drug epidemic one of the "five pillars" of his administration's agenda and supported legislation creating a Foster Parent Bill of Rights and facilitating acquisition of a driver's license by youth in foster care, both of which were passed in the most recent session.
- The State Budget Agency has assisted DCS financially in the past several years by substantially augmenting the DCS general fund appropriation.
- Director Stigdon has been regularly interacting with staff at the front-line, partner agencies and others to learn more about the system and solicit feedback about system strengths and challenges. She is also strongly interested in expanding the agency's investment in evidence-based prevention efforts.
- DCS staff are consistent advocates for children and families throughout the state
- DCS places a high percentage of children with relatives, which is associated with the lessening of child trauma and producing positive outcomes. Nationally, Indiana is among the states with the greatest percent of children in kinship settings
- DCS has a defined practice model that is in keeping with prevailing standards of family-centered practice.
- DCS has strong relationships with partner agencies and service providers at the state level and in many counties and communities.
- There is an overall collaborative and cooperative relationship between DCS and the courts
- On-line DCS policy is accessible both internally and externally.

- DCS offers specialty teams (e.g., clinicians, educational consultants, medical consultants) to offer consultation and support for case managers and supervisors.
- The state has a relatively large number of private sector service providers who want a closer partnership with DCS.
- DCS makes ongoing use of Casey Family Program's Permanency Roundtable model for children and youth remaining in out of home care without reaching permanency goals.
- DCS has a well-structured training section and partnership with the Indiana University School of Social Work.
- The DCS draft federal Program Improvement Plan (PIP) contains many strategies that are responsive to challenges the system faces.
- The state supports legal representation of all parties in Child in Need of Services court proceedings.
- Regular meetings within each of the Regions have been described as increasingly helpful in ensuring a statewide awareness of policies, procedures, internal and external information, and partnership between counties.

Challenges

- Indiana has a very high rate of children in out of home care relative to surrounding states and nationally.
- DCS has a high rate of child abuse and neglect referrals and broad mandates for child welfare involvement relative to surrounding states and nationally.
- Indiana has an exceptionally high rate of court involvement in child welfare cases. While this adds oversight to child welfare cases, it results in higher staff caseloads, more staff time in court and higher DCS and court costs.
- The DCS data system does not allow for staff at all levels to easily assess performance in relation to key safety, permanency, and well-being outcomes for children and families served by DCS.
- Indiana's rate of referral to child protection, calculated as the number of referrals for every 1,000 children in the state's population, was 108.2 in 2016, the most recent year for which federal comparative data are available. This compares with a national average of 55.6.
- There is an uneven organizational climate and culture across counties, contributing to low morale and possibly affecting turnover, performance, and child/family outcomes in some offices.
- DCS is experiencing uneven workloads that, in some instances, far exceed current caseload standards, for Family Case Managers and also for many agency attorneys.
- DCS has had a highly centralized management and approval process that is reported to result in unnecessary workload burdens and delayed services for some children and families,
- Opportunities for professional development and career advancement of front line staff are limited.
- There is uneven interpretation and implementation of policies across counties.

- Some jurisdictions have very poor agency-court relationships that potentially have an adverse impact on the disclosure of important information and thus decision making on behalf of families and children. Such agency-court tension is also a potential cause of child welfare staff turnover.
- Foster parents do not receive daycare/childcare payments; they are expected to use their per diem which is largely insufficient. Foster parents have voiced this as a disincentive for recruitment and retention of child placement resources, as well as a financial challenge
- Relative/kinship caregivers are faced with child care payment challenges after the first six months of the child's placement. This potential financial hardship has been cited as a reason that some families are unable to care for a relative child.

B. Findings Related to Recommendations of Prior DCS Evaluations

DCS provided CWG with copies of prior DCS evaluation reports prepared by external evaluators dating back to 2013. These included the following:

- 2013 Enhancing Front-End Performance – Thomas Morton and Rebecca Jones Gaston
- 2013 Staging a Turnaround: An Examination of the Factors Influencing Turnover Among Case Management Staff at the Indiana Department of Child Services – Doris B.B. Tolliver, Esq., Chief of Staff, Indiana DCS, Christopher O.L.H. Porter, Ph.D and Noah F. Matthews, Kelly School of Business-Indianapolis
- 2015 Caseload and Workload Analysis – Deloitte
- 2015 Comprehensive Organizational Health Assessment - National Child Welfare Workforce Institute
- 2017 Department of Child Services Operations Assessment and Recommendations – Alvarez & Marsal

Determining the full extent to which DCS implemented the many recommendations found in these reports is beyond the scope of this review. However, CWG did assess key findings and recommendations that corresponded to system challenges encountered in the CWG review. Some of those prior findings and recommendations are:

Enhancing Front-End Performance

“Testing positive for illegal drugs commonly leads to removal even when no other evidence is provided to establish actual child endangerment.” CWG found that this practice continues to be evident in removal decisions. Evaluators believe that the practice is a significant contributor to the high number of children in care.

“Staff like the questions in the Functional Family Assessment, but appear not to use it in the field as part of the family's assessment.” CWG reviewers were advised that this instrument is still not regularly used, mainly due to workload demands. CWG found a pattern of inattention to parent history and their underlying needs, which means that interventions to help parents improve their parental capacity may be ineffective. Unsuccessful family supports and plans can result in failed reunifications efforts, which cause the number of children in care to grow.

“Drug treatment options that would permit children to remain with parents were unavailable.” CWG interviews confirm that the lack of drug treatment remains a serious obstacle to reunification.

“Based on staff responses, the greatest external influence over placement decisions appears to be the courts.” CWG believes that this factor remains as the main variable in placement decisions, illustrating the need for better communication and a clearer understanding of decision options between DCS and the courts.

Staging a Turnaround:

“There are limited, but nevertheless, complex and potentially meaningful benefits of selecting case management staff with backgrounds in social work.” This corresponds with one of CWG’s findings and recommendations.”

“Case managers generally report a lack of support from the Department of Child Services and these feelings are one of the most significant predictors of turnover intentions.” CWG found significant numbers of DCS family case managers who feel unsupported by the DCS central office.

Caseload and Workload Analysis:

“Improve the current caseload count calculation for reporting compliance with the 1:12 and 1:17 caseload ratios in order to increase the accuracy and usefulness of the calculation in making data-informed management decisions.” DCS has not yet been able to determine caseloads with the degree of accuracy needed for sound management decision-making or reporting to governance entities.

“Utilize workforce analytics to identify current and forecasted staffing needs and build a comprehensive recruiting and retention strategy to minimize staffing shortages.” DCS has not accomplished this, as implementation is contingent on maintaining an accurate caseload count.

Comprehensive Organizational Health Assessment:

“Build relationships between local and central offices to foster mutual understanding of roles and responsibilities, perhaps exploring strategies such as job shadowing for Director-level staff, town hall-style forums and avenues for balancing punishment with positive reinforcement of casework practice.” The CWG review confirmed that many local staff continue to feel estranged from and unappreciated by the central office and threatened by negative sanctions regarding their performance.

“Develop a more inclusive and distributive leadership model that invites decision-making at levels of the organization so that policy and practice guidelines are informed by the field.” CWG makes a similar recommendation referencing decentralization of decision-making.

“Revise the system for evaluating caseworker performance by measuring casework quality and ensuring reasonable performance expectations.” The CWG review revealed that family case managers feel that their performance against the “Dashboard indicators”, which are largely compliance measures, constitute their performance expectations. Quality measures are minimal.

Efficiency Assessment:

“Shift healthcare and healthcare Coordination from DCS to Medicaid.” CWG is recommending that DCS hire or contract with a healthcare expert to assist in increasing Medicaid claiming, especially in behavioral health. DCS has already begun taking steps to replace some DCS-paid residential treatment costs with Medicaid dollars; however opportunities to maximize Medicaid in other areas should be explored.

“Dedicate a Provider relations Function to Oversee Provider Relations Issues” DCS is now considering implementing this recommendation.

“Expand the BSW Scholarship Program (to stabilize turnover)” Implementing this recommendation was deferred, due to insufficient funding.

Next Steps

It would be impossible for DCS to successfully implement the collective recommendations in these prior evaluations, nor should they attempt to at this point. DCS should, however, review these reports as background in considering the recommendations made by CWG, as they provide useful analysis and background relevant to the recommendations in this report.

C. Policy and Practice

The DCS Practice Model

DCS has a strong practice model which incorporates the agency’s vision, mission and values-based practice principles. Stated values include children’s right to be free from abuse and neglect, to appropriate care and a permanent home, that the best place for children is with their own families, that children have a right to permanent and lifelong connections, that parents have the primary responsibility for the care and safety of their children, that individuals are accountable for their own outcomes, including their own growth and development, and that every person has value, worth, and dignity.

The model delineates practice skills that include engaging, teaming, assessing, planning, and intervening:

- Engaging implies establishing trusting relationships with families and children to accomplish goals related to child safety and permanency.
- Teaming involves including families in the assessment and service planning process and in identifying others who can provide needed resources and supports.
- Assessing is the process of gathering information about families’ presenting and underlying strengths and needs.
- Planning is the skill needed to construct a course of action uniquely suited to each individual family, and intervening involves the matching and accessing of actions which will improve family functioning, decrease risks, and promote child safety and permanence.

The model calls for the continual building of the above-listed skills throughout the career of the child welfare professional.

Analysis of DCS Child Welfare Policy

DCS has an on-line policy manual that addresses each phase of the agency's responsibility in intervening with families to identify and remedy threats to child safety and permanency. It is well-organized and readily accessible on line. It was an invaluable resource for reviewers during this assessment, and when CWG had questions or requests for clarification, staff were promptly helpful with clarifications. Individual sections of policy are primarily concise. References to relevant laws, forms and/or tools, and other sections of policy may be accessed through hyperlinks embedded in each section.

The manual includes detailed guidance for the "Hotline" (i.e., the DCS centralized intake system for reports of suspected child maltreatment), for the assessment of accepted reports of child abuse and neglect, and for ongoing services, both for children and families served in their own homes and for those in which one or more children have been placed in out of home care.

Reviewers found much policy content to be consistent with principles of family-centered practice. There is, for example, detailed guidance for forming and using family teams and for preparing families for participation in family team meetings. Policy pertaining to the initial placement of children in out of home care speaks to the trauma associated with the removal of a child from his or her family and provides a number of ways in which FCMs conducting placements should attempt to mitigate this including, among other measures, involving parents in helping children to prepare the child for moving, using preplacement visits whenever possible to allow the child to become familiar with the new setting, and ensuring that foster parents or other substitute caregivers are provided with detailed information about the child and his or her needs.

Likewise, policy provides appropriate guidance in the area of placement selection when children are removed. Staff are instructed to seek placement with non-custodial parents or other family members before considering moving a child to the home of a family unknown to them and to seek placement in the most family-like placement closest to the child's own community. The fact that almost half of all children in out of home care in Indiana are placed with kin provides evidence that staff adhere to this policy guidance.

Chapter 8, Section 11 contains policy on parental interaction with children who are in out of home care and directs that DCS shall "encourage and support the maximum amount of interaction and involvement that is appropriate between the parent, guardian, or custodian and the child given the need for child safety and well-being, unless otherwise ordered by the court." Further, this section goes on to recommend and describe a variety of forms of parent-child interaction beyond regularly scheduled face-to-face visits including phone calls and emails and involvement of the parent in the child's educational and extracurricular activities as well as in his or her health care. Such involvement is consistent with a focus on reunification as the initial permanency goal for most families.

Despite these notable strengths, there are areas of policy which reviewers found questionable either in terms of their value in protecting children, the practicality and/or feasibility of their application, or in terms of their representing the most helpful, beneficial approach for children

and families. These will be addressed in the order in which they typically occur in the life of a DCS case.

First, although there are some minor inconsistencies in current written policies, it is the understanding of reviewers that all reports made to the DCS centralized unit (aka, "Hotline") must be referred to a county office for a final decision and disposition. This may make sense in situations in which a family clearly lives or is located within the county, particularly if a record clearance indicates current or prior involvement with the family, since information that may not present to centralized intake staff as constituting a report of maltreatment might have meaning in the context of additional information known only in the local county office. Reviewers were told, however, that this practice pertains to all reports, even those in which there is no family history and in which the reporter is unable to give any information that would allow for the identification or location of a family or in which neither the family nor any individuals associated with the report reside in Indiana and the incident in question did not occur in Indiana. A report of alleged maltreatment of a child in, for example, Georgia, with none of the parties involved being residents of, or even visitors to, Indiana, would thus be referred to a local county office for a final decision as to its disposition. When asked to which county such a report would be referred, intake staff indicated that, if a report pertains to a county such a report would be sent, reviewers were told that, if it pertains to a neighboring state, a county bordering that state might be selected. Otherwise, the "default" county is often Marion.

Staff in the county offices frequently voiced frustration at having to deal with reports in which they either have no way to locate the family or in which no one involved in the report lives or is located in their county. In one county staff said, "We get reports that involve children in the Congo that someone hears about on television".

Another area of question in policy is that Indiana accepts reports alleging sexual abuse in which the alleged perpetrator has no relationship to the child (ref. Hotline Ch. 3, Sec 8). Thus in the case of child sexual abuse, the alleged perpetrator need not be a parent, guardian, or custodian as otherwise provided for in Indiana's statute defining child abuse and neglect. Statutory authority for this policy is contained in Indiana Code 31-34-1-3. Reviewers were told that such reports can also include those in which the alleged perpetrator is another child or youth. Among the group of comparison states examined in this review, only West Virginia investigates child on child maltreatment and then only to determine whether the parent has been negligent in exercising supervision to prevent the maltreatment, prevent its recurrence, or obtain needed treatment for the child. The child aggressor is not identified as a perpetrator of maltreatment as he or she is in Indiana.

In situations of child sexual abuse or other alleged maltreatment in which the perpetrator does not meet the statutory definition of a caregiver, most jurisdictions with which reviewers are familiar recommend that the report be referred to law enforcement or to an appropriate administrative authority, as in the case of public schools. Likewise, jurisdictions do not typically charge their child protection systems with responsibility in reports in which legally defined parents or caregivers have not been identified as perpetrators, or as knowingly allowing and/or abetting the alleged maltreatment.

Also of concern, Indiana policy and statute call for DCS staff to initiate assessments within one hour if it is believed that a child may be in danger of imminent bodily harm. Reviewers have seen this requirement in at least one other state and understand that it is well intentioned, attempting to protect children who may be in immediate danger. Its practical value is, however, questionable. Policy does require that DCS request law enforcement accompaniment on all reports requiring a one hour response. This is appropriate since, in the view of this assessment team, law enforcement is usually better situated than child protective services to respond in situations that truly call for immediate intervention to prevent serious bodily harm (e.g., a toddler wandering alone near heavy traffic).

Policy also contains a provision in which the FCM may defer face-to-face contact with the alleged victim by contacting someone else who can provide information about the care and safety of the child, but this is described as occurring only in “extreme” circumstances and still requiring the FCM to make face-to-face contact with the child as soon as possible. The issue of concern related to the one hour response policy is chiefly that the interpretation of “in danger of imminent bodily harm” may be (and in reviewers’ experience usually is) made in any situation in which there is alleged to have been sexual or physical maltreatment and the perpetrator has access to the child. Findings related to implementation of this initiation time frame show that DCS struggles to attain it and that, in many instances, it is impossible to attain in that the assigned DCS caseworker is either on-call and involved in another case situation which cannot be abandoned or the caseworker is physically located more than one hour away.

The most immediate mandated response time in many systems is 24 hours. However, in the experience of reviewers, systems typically exercise sound practices in triaging cases for more immediate response when this is indicated. Examples include calls from law enforcement when they are on-site with children and need assistance, calls from emergency rooms or other medical facilities when children and families are present and child maltreatment is suspected, and calls from schools when children have disclosed maltreatment and are fearful of returning home. Situations that require such immediate response are, however, difficult to precisely define and reviewers believe that doing so is better left to the child welfare agency. Immediate response also carries its own risks since it deprives the assigned caseworker of the opportunity to review historical files that may contain critical information and to plan the assessment in the way most likely to elicit most accurate and complete information.

DCS policy (Ch. 4, Sec. 22) calls for caseworkers to complete assessments within 30 days from the day DCS receives the report. While it is possible for caseworkers to complete many assessments in this time frame, it is the experience of reviewers that caseworkers often require additional time, especially if they are attempting to apply family centered practice principles in order to design and implement an effective safety plan for the family. Assessment staff who were interviewed repeatedly referred to “red dashboards” warning them of overview assessment and related case deadlines. Assessments should be completed as soon as possible both to ensure that children are protected and to provide resolution for families. They should not, however, be unduly hurried based on arbitrary time frames. Other jurisdictions with which reviewers are familiar often allow up to 60 days for assessment completion. Within that time frame, supervisory oversight should ensure that case activities are sequenced and completed in the time frame that promotes the best outcome.

Chapter 4, Section 28 of policy (Involuntary Removals) describes a number of situations under which DCS “will remove a child from his or her parent, guardian, or custodian”. Reviewers understand that this language derives from statute. Policy and law also allow for FCMs to remove children without court orders, or even without the presence of law enforcement if “exigent circumstances” as defined by statute are believed to exist and law enforcement is not available. FCMs are empowered to make a unilateral determination of exigent circumstances but supervisory consultation is required for all decisions to remove. Policy also contains a statement that a child and family team should be formed when a child appears at imminent risk of removal. Taken as a whole, however, this section of policy seems to encourage removal over consideration of other options that might protect the child while avoiding the trauma associated with his or her placement outside of the family. Other jurisdictions’ policies with which reviewers are familiar speak more strongly to efforts to prevent removal and/or to additional levels of review and authorization (e.g., higher administrative authorization, emergency judicial orders, etc.) that are required to take such severe action.

DCS policy pertaining to the development of case plans (Ch. 5, Sec. 8) requires the provision of a case plan with each child involved in a case. The form designated for this purpose also indicates that it is done for the child. Children should certainly have case plans. However, reviewers noted that, while policy requires that parents be engaged and involved in the development of the child’s case plan, it does not seem to at all address case planning with and for parents. If children are to safely remain at home or be reunited with their families, parents must also be the subjects of interventions to help them in building and maintaining caregiving capacity. Neither DCS policy nor the case plan form suggests a focus on detailed planning centered on the needs of parents.

DCS policy pertaining to required contacts with children and families when children are in out of home care (Ch. 8, Sec. 10) requires that family case managers see children and their parents, guardian, or custodian at least monthly. Family case managers must see children in their placements at least every other month, which is appropriate, at a minimum. Visits with parents, on the other hand, while required to be face-to-face, do not have to be made in the parents’ place of residence. While staff are directed to discuss parents’ current needs and progress, the documentation they complete in the Face-to-Face Contact Form is child centered. There is nothing in policy that suggests that the FCM should schedule a meeting with parents that is not incidental to a child and family visit, court hearing, or other event that has another primary focus.

Chapter 8, Section 38 states that “DCS will (emphasis added) recommend to the court a change in placement, if any one (1) of the following exists: 1. Any substantiated CA/N in a resource home by the resource parent(s) or any household member; 2. The child can be placed with his or her siblings”. While these provisions point to situations in which a change in placement may be warranted, the directive that “DCS will recommend to the court a change in placement” omits consideration of other factors that may have critical implications for children’s emotional health and development, such as the nature and extent of any substantiated maltreatment in the resource home and any measures taken or that could be taken to remedy it, the length of the child’s placement and/or his/her level of attachment to the substitute caregivers, other

aspects of the child's placement and placement alternatives, and their advantages or disadvantages given his individual needs and aspirations.

Chapter 7, Section 3 of DCS policy prescribes standards for minimum contacts in in-home services to families and children. This section provides, appropriately in the view of CWG, that DCS will have at least monthly contact with the children and their custodial parent. In addition, it calls for the FCM to "maintain contact with the noncustodial parent and ensure he or she is afforded the opportunity to visit with the child and maintain involvement in the child's life, unless the court has ruled that this is not in the child's best interest". This provision is seen by reviewers as over-reaching on the part of DCS given that children in in-home cases remain under the authority of the custodial parent.

While it might be appropriate for the DCS FCM to explore the nature of the child's relationship with the non-custodial parent and to encourage that parent's participation in the child's life in most instances, that should be done with regard to that parent's situation and professed level of interest, the history of that parent's interaction with the child, the child's feelings about the non-custodial parent, the relationship of that parent with the custodial parent, and the other relationships in the child's life.

DCS policy appropriately includes provisions for providing funds to meet the immediate concrete needs of families (Ch. 16, Sec. 3). It defines specific items/services and amounts that can and cannot be paid for and specifies the procedures that must be completed by FCMs in order to access such emergency funds. In the assessment of reviewers, however, this policy is so restrictive and requires so many assurances and detailed completion of documents on the part of the FCM that its practical utility as a method of engaging families and preventing removal of children due to inadequate housing, utilities, or lack of parental provision of other concrete needs is questionable. The following wording directly from policy is provided by way of illustration:

"Prior to requesting funding from the DCS local office to assist a family in meeting basic needs, the FCM is required to ensure that financial support from extended family members is explored for potential funding assistance as well as the following procedures: Utilities: 1. Contact the Trustee's Office; 2. Contact the utility company (e.g., gas, electric, and water) directly to see about enrolling in a payment plan; 3. Contact local winter assistance and/or summer cooling programs if available in the area; 4. Contact the Energy Assistance Program (EAP); 5. Contact the Salvation Army; and 6. Contact local churches. Transportation: 1. Contact the Salvation Army; 2. Contact the school system; 3. Contact Medicaid Transportation; and 4. Contact churches and community groups that may provide transportation to and from certain types of appointments. The DCS local office should have a mechanism in place to validate the family's participation in the service or event for which the assistance was deemed necessary prior to subsequent disbursements to the family."

Approval process for certain cost exceptions:

FCM ➡ Supervisor ➡ Local Director ➡ Regional Manager ➡ Regional Finance Manager ➡
DCS Central Office

Reviewers were also told that DCS central office memoranda – which may or may not eventually make it into official policy – may supersede DCS policy. Policy that mandated that all reports involving children under the age of three years be accepted for assessment whether or not they met the requirements of a reports of child maltreatment, was first issued in a memorandum and then later incorporated into practice. This practice which, as far as reviewers are aware, set Indiana apart from all other states. DCS amended the practice so that screening out of reports involving children younger than three now requires the regional manager to concur. However, no data were provided to document the extent to which that actually occurs.

Reviewers' attention was called to another such memorandum which addressed investigations in which children tested positive at birth for controlled substances including marijuana. Reviewers do not question that reports of substance use by parents of a newborn should be taken seriously and fully explored. However, this memorandum, which included the directives below, was cited by local office personnel as an example of a communication that had the effect of conveying to staff that they were expected to intervene based solely on evidence of parental substance use without any indication that it had resulted in impairment of the parent's caregiver ability. It included the directives below:

- If you cannot find a nexus between a substance abusing parent and the neglect of the child, you need to ask more questions and glean more evidence.
- It is not okay to have multiple reports of marijuana use, a drug positive infant and documentation of "smelling marijuana" **AND** unsubstantiated. Drug screens for the parent are indicated. Services need to occur. Again, ask more questions.

Application of Practice Model and Policy

Reviewers saw some strong examples of application of practice model principles, especially in the case of Child and Family Team Meetings (CFTM) that were observed and heard evidence of their use in many interviews. Case planning with a family is to be grounded in the principles of the DCS practice model, and case practice in the field to support the overall mission of the agency. The model calls for FCM's to work with families to assess their strengths and needs, identify and gather supports and services, and facilitate a process that places families in the position of having a major voice in case planning.

CFTMs are to be held to create and adjust plans for safety, permanency and well-being as it is the primary venue for identification of underlying needs and for matching services to meet those needs. Teams should consist of formal and informal supports identified by the family and other team members and DCS is to work continuously to engage the family/youth in the CFT Meeting process throughout the life of the case.

Families, FCM's, and other partners were quick to affirm the CFTM as the venue most likely to achieve safety and permanency outcomes. While it is time-consuming to engage and prepare families and other team members; facilitate the meeting; and support case activities, FCM's universally agreed that this is the primary way to get better outcomes for families. Reviewers saw examples of attendance by other professionals, e.g. CASA's, educators, and clinicians. The

broader opportunities for membership of the team were exemplified when attendance was seen by, for example, a parent's Alcoholics Anonymous sponsor, trusted neighbor, or friend. CFTM's have the effect of keeping families at the center of decision-making, and some providers have seen a growing level of attention from the FCM's to supporting families in participating in services rather than simply making referrals.

There are counties where CFTM's are facilitated more frequently than the state standard of every six months or at a critical juncture in the case. Those interviewed in the offices believe that this has helped them reach better outcomes more quickly. The goal in those locations is to have team meetings within 30 days of court and every three months. FCM's described the CFTM as the best opportunity to meet the family's support network, and that they are also a logical venue to discuss concurrent planning in a strengths-based setting. FCM's reported that a shared level of responsibility as demonstrated in the CFTM has contributed to community partners' willingness to participate in difficult discussions and decision-making around safety and permanency. The CFTM, they added, was an excellent venue for finding and supporting extended family. Providers see CFTM's as a significant advance, producing more effective assessment and planning. As an example of their confidence in the process, some Magistrates order CFTM's in order to resolve conflicting points of view that hamper coherent planning. One veteran FCM declared that the implementation of CFTM's was the "best thing DCS has ever done, as they help families see they are not alone."

School administrators in several counties indicated that, as a result of the practice model, they had experienced a greatly-improved level of communication from DCS relative to CHINS and the importance of educators being a part of the planning process for these children. An Assistant Superintendent said that he and the Local Office Director meet regularly to discuss ways to improve outcomes for CHINS; share information about CPS/ongoing cases as possible; and assess working relationships between teachers and FCM's. One principal shared that her first CFTM as a classroom teacher was a "professional turning point" as she heard about the challenges that family was facing. She stressed that it was rewarding to be part of a team solution and that since that first CFTM opportunity she had been an advocate for the process with other educators.

There are serious issues that have undermined the CFTM process during recent years, as turnover and changing central office directives about priorities have impacted the FCM's availability to work with the families in their caseloads. Many veteran DCS staff as well as long time service providers, representatives of partner public systems, and other stakeholders have noted a shift away from the practice model in recent years. One agency administrator said "We aren't particularly parent friendly."

There was wide disparity among individuals involved with a case and their experiences with the CFTMs. Some birth families, foster families, community partners and others reported being included, prepared, and valued in the process. Nevertheless, some birth families interviewed said that they were not prepared for the CFTM and did not understand what was to be discussed. Some did not even know what a CFTM was, explaining that their planning occurred primarily with the FCM telling them what they had to do.

Some foster parents, therapists, extended family, CASA's and others related that they were excluded from CFTMs without knowing why they weren't involved. Frequently, providers described a frustrating lack of involvement, and were left wondering if the FCM forgot to notify them or did not value their input. Others mentioned that CFTM meetings were occurring hurriedly in court either before or right after hearings. They experienced those as cursory and not meaningful. Many providers said that it was rare for them to be invited to CFTM's, but that they are always eager to participate, as outreach and sharing of responsibilities builds a team with visible accountability to the family. There were providers who estimated that they see CFTM's occurring in only about 50% of key decisions. Too frequently, consequential issues surface in court rather than in a CFTM. One provider was frustrated because their local DCS doesn't schedule CFTM's a month in advance and doesn't tell them when they are cancelled. They admitted that it is challenging to schedule attendance unless they get notice a month in advance of the CFTM, but that when they are notified on time they have attended every meeting. Various school administrators and teachers indicate involvement only when there is a problem related to school or educational goals. They expressed interest in contributing to assessment and planning, recommending that they have an opportunity to offer services above and beyond problem-solving. The need for collaboration across organizations, including the courts, adds a layer of complexity to model implementation.

Reviewers continued to hear about the FCM's commitment to families, and their longing to have time to establish meaningful, helpful relationships. Many do recognize the need for sufficient engagement with families and the greater likelihood for success that comes from a strong relationship. FCM's are clearly invested in the process, but were quick to say that they did not have adequate time to get to know the families well enough to ensure the most positive and timely outcomes. One foster parent described having had 10-15 FCM's in seven years. The presenting family issue was addiction, or substance use disorder, but there had been no progress toward consistent sobriety. The foster parent felt that the lack of timely resolution and permanency was tied to the fact that everyone in the case was in a chronic state of re-introduction and re-assessment. This foster parent recognized the FCM time and turnover constraints, but stressed that the ultimate outcome – permanency—was lost in the mix. One judge, noting that turnover and other issues impact the maturity and skills of FCM's, believes that the biggest barrier to outcomes is that "the FCM doesn't have time to make the plan operational." One birth parent summed it up this way: "Every time we get a new case manager, we have to start over." Foster parents and other service providers also expressed concern that FCMs were calling for specific services which may not have been determined to be appropriate for individuals or families. Ultimately, those interviewed expressed a sense of urgency that timely permanency improve and that the status quo did not seem to be benefitting anyone; children, families, or the agencies working on their behalf.

Foster families may attend CFTMs if parents approve, but some foster parents advised that the FCM had not asked the birth family if they could participate. FCM's are to encourage the parent, guardian, or custodian to include the relative or residential placement, foster parent and CASA or GAL as members of the CFT by explaining the benefits to case planning. It is ultimately up to the family to make these decisions, yet the CFTM can be an excellent venue for building partnerships as members who appear to have competing interests come to know and

trust one another. One foster parent said that she had coached and mentored the birth mother of the child in her home, and hosted a mutual celebration party when that child went to live with family. She has remained in invited contact with this birth and extended family. This foster parent called for encouragement to local offices to give foster parents permission to reach out independently to assist birth families to achieve the goals of their case plans.

As confirmation of their confidence in the process, some FCM's suggested that CFTM's should occur early in a case – within a few days of CPS initiation. They contend that this would allow them to engage and assess the family and avoid multiple assessments that can be written into some court orders. They described current CFTM policy and continued to suggest that the central office include them in future policy development relative to the CFTM. Staff were doubtful that many at the central office level know about current line practice, and were adamant that their involvement would strengthen policy.

Case Practice Context

Family Case Managers (FCM's) were consistently professional, cordial and eager to discuss practice, policy, training, and other issues. Their collective advocacy for families became more apparent with each discussion. A promising sense of optimism was expressed by many as they expressed their appreciation for having a voice in the future of child welfare in Indiana. There was, as expected, diversity in the comments and concerns heard from FCMs from across the state. Importantly, there were central themes that emerged as the process continued across the regions.

Some FCM's felt encouraged because of hiring, as vacancies are being filled and there is outreach to the field underway by system leadership. They shared a collective sense of hope that turnover and other barriers were being addressed. There are locations where teamwork is valued and encouraged. Many FCM's spoke to excellent internal supports from peers and supervisors. Some stressed the value of positive county supervision, noting that the same work environment, stressors, and barriers exist statewide, but that staff are most likely to remain with DCS when supervision is strengths-based. Some counties had recently hired FCMs, and current staff were hopeful that this would help with morale. Other FCMs praised Local Office Directors for going "above and beyond", describing an environment where the FCM's experienced "local perks" like pizza Friday, snapshots of excellence, holiday gatherings, and appreciation for their personal lives.

It was clear that, overall, FCMs value the families they serve, and that they have established meaningful and helpful relationships in their communities. Law enforcement officials, judges and magistrates, educators, physicians, foster parents and many others shared that they had experienced excellent and professional practice from many local FCM's, adding that they had great respect for county leadership there as well. There were examples of CFTMs being held in family homes, schools, and other locations requested by families.

Despite an emerging sense of optimism, low morale remains a factor throughout the system. A significant number of staff described what one FCM called a "culture of fear". Some said they did not feel safe to "tell the truth". Most felt unable to take any risks around the flexibility of policy, for example, even if it might lead to better outcomes. Staff feared they would not be

supported if they made a wrong decision. This impacted their confidence in themselves and limited their autonomy to make decisions around case actions, spending, legal recommendations, and other customary casework activities. Further, turnover and the constant state of cases being re-assigned is a stressor to the FCM's as their peers leave. They reminded us that turnover also negatively impacts families, as they were regularly sent to work with families who had just established a relationship with the prior FCM. Families spoke to us about the frustrations of having – in one case - up to six FCM's, and that this had been a barrier to timely permanency and safe case closure.

Many FCM's consistently reported higher-than-standard caseloads. It was not uncommon to hear about caseloads of 25 to 35 children who, by policy, must be seen at least once a month. The Indiana standard is 17 children. One FCM had a caseload of 52 children, and several of the children were placed three to four hours away from the county. Some FCM's described an organizational directive, although perhaps unwritten, that made their own local leaders wary of evaluating them as doing superior work in their jobs without intricate documentation approved by the Regional Manager or higher in the organization.

The "culture of fear" theme was heard within DCS beyond FCMs and also from some representatives of provider organizations and public partner agencies. It was often the response when reviewers asked to what factors they attributed the large increase in the number of children in foster care. In addition, it was mentioned in connection with observations that DCS does not have a learning culture. Reviewers were told several times and by a variety of sources that there is fear of being open about any lack in knowledge, skills, or performance because such disclosures are not viewed as opportunities for learning, but rather for punishment. One FCM remarked, "I'm afraid to ask my supervisor questions because, if it is something I should have already known, I will get a 'negative fact file' (the term for an adverse write-up in the employee's personnel file)"

FCM's who had what they described as supportive supervision considered themselves fortunate. The statewide FCM to supervisor ratio appears to be over one to seven; a respected national standard is one to five. Many supervisors are deployed to additional duties in the county, so actual ratios may more typically be one to nine or as high as one to thirteen. FCM's were adamant that accessible and supportive supervision was critical to performance and morale, but when ratios are as high as these, it is challenging for any supervisor to maintain administrative and clinical guidance with staff.

A number of FCM's described being unable to make decisions or offers for services without fear of reprisal. This assertion was echoed by families, the judiciary, providers and others relative to time spent waiting while decisions are made by upper management or the central office. As an example, some Local Office Directors must access Regional Managers to approve casework recommendations relative to children being in custody 15 of the last 22 months (the time period beyond which termination of parental rights may be pursued) if they and members of the CFTM believe that there are compelling reasons that parental rights should not be terminated.

A perceived “disconnect” from central office was a significant theme for the FCM’s. They voiced consistent appreciation for the outreach demonstrated by new leadership, as many believe central office staff has lost touch with practice in the counties. FCMs referred repeatedly to “red dashboards” and email reminders of overdue deadlines, as opposed to questions about achievement of key performance indicators related to child and family outcomes. FCM’s longed for Central Office to recognize excellence in case practice, not just timeliness and other process data measures. Many believe that the environment and culture of the organization statewide and locally, or both, are driven by process compliance data and not tied to best practices and outcomes. One FCM described it as “management for activity, not accomplishments.”

D. Analysis of Quantitative Data

Analyses in this section are intended to provide a summary depiction of the volume and type of activity performed in DCS as well as outcomes related to child safety and permanency. Data provided pertains to DCS statewide. However, when reviewers noted substantial variation among regions, ranges are provided to give readers some understanding of the degree of difference that exists across the state.

Intake and Assessment

Activities conducted by DCS pursuant to the acceptance of referrals of alleged child maltreatment are termed Assessments. Indiana’s rate of referral to child protection, calculated as the number of referrals for every 1,000 children in the state’s population, was 108.2 in 2016, the most recent year for which federal comparative data are available. This compares with a national average of 55.6. Only DC, Vermont, and West Virginia had higher rates of referral.

Of the referrals it received, Indiana screens in a somewhat higher than average number and completes a substantially greater number of assessments or investigations on those referrals than do most states. The state’s screen-in rate in 2016 was 66% compared to 58% nationally and it completed 93.1 child abuse and neglect assessments for every 1,000 children in the state’s population in 2016. This was the third highest rate in the nation, exceeded only by the District of Columbia at 106.3 and West Virginia at 139.8.

The rate of reports assessed grew by almost 63% from state fiscal year (SFY) 2012/13 to 2016/17 as shown in Table 1 below.

Table 1: Child Abuse and Neglect Assessments:

| SFY | # Assessments (by child victims) | % increase over 2012/13 | # Substantiated | % Substantiated |
|---------|-------------------------------------|----------------------------|-----------------|-----------------|
| 2012/13 | 139,985 | NA | 22,555 | 16.11 |
| 2013/14 | 169,981 | 21 | 25,692 | 15.11 |

| | | | | |
|---------|---------|------|--------|-------|
| 2014/15 | 183,171 | 30.8 | 27,873 | 15.22 |
| 2015/16 | 193,936 | 38.5 | 30,248 | 15.60 |
| 2016/17 | 227,993 | 62.8 | 33,986 | 14.91 |

The following table shows more recent data on average assessment counts for the current and past two state fiscal years (SFY). These figures are family rather than child based and show that the monthly average of assessments rose by 1,367 from 2015 to 2017 and by 384 from 2017 to 2018 indicating that the growth in assessments is slowing.

Table 2: Assessments SFY16-18

| SFY16 Month | Counts | SFY17 Month | Counts | SFY18 Month | Counts |
|------------------------|------------------|------------------------|------------------|--------------------------|----------------|
| 7/1/2015 | 8857 | 7/1/2016 | 9088 | 7/1/2017 | 9057 |
| 8/1/2015 | 8819 | 8/1/2016 | 9764 | 8/1/2017 | 9609 |
| 9/1/2015 | 8847 | 9/1/2016 | 10643 | 9/1/2017 | 11200 |
| 10/1/2015 | 9546 | 10/1/2016 | 11544 | 10/1/2017 | 12283 |
| 11/1/2015 | 8104 | 11/1/2016 | 9880 | 11/1/2017 | 11290 |
| 12/1/2015 | 10120 | 12/1/2016 | 10971 | 12/1/2017 | 11565 |
| 1/1/2016 | 7951 | 1/1/2017 | 9961 | 1/1/2018 | 10904 |
| 2/1/2016 | 8372 | 2/1/2017 | 9632 | 2/1/2018 | 9554 |
| 3/1/2016 | 9564 | 3/1/2017 | 11725 | 3/1/2018 | 11861 |
| 4/1/2016 | 8977 | 4/1/2017 | 9666 | 4/1/2018 | 11057 |
| 5/1/2016 | 10017 | 5/1/2017 | 11936 | 5/1/2018 | 11806 |
| 6/1/2016 | 10925 | 6/1/2017 | 11691 | | |
| Total | 110,099 | | 126,501 | | 120,186 |
| Monthly Average | 9,174.917 | Monthly Average | 10,541.75 | 11 Months Average | 10,926 |

DCS policy provides for the initiation of assessments within three different timelines based on the nature of the report: within one hour, within 24 hours, or within five days. Most recent data show that Indiana struggles to meet timelines for the initiation of assessments. Statewide, face-to-face contact is made with both parents and alleged victims within the designated time frame in 55.8% of assessments. Ratings across regions range from 29.4% to 79.6%. Compliance

with initiation time frames has, however, increased over that of a year ago (May 2017) when it stood at 47.1%.

Only a small minority of assessments that DCS completes result in a substantiated finding of child maltreatment. Reports are more likely to be substantiated for neglect than for physical or sexual abuse, the other two major categories of maltreatment. For the first 11 months of the current SFY, substantiations stand at just under 13%. As in most states, the majority of reports received involve neglect rather than physical or sexual abuse. The most current data show that neglect reports constitute about 75% of assessments with physical abuse accounting for just over 16% and sexual abuse just over 8%.

In Indiana, however, as in other states, neglect is the reason that most children enter foster care. It is very often associated with parental substance abuse. The table below shows numbers and percentages of the four most prevalent factors associated with children's removal over the past five state fiscal years. Totals of greater than 100 per cent across reasons are due to the fact that FCMs can enter more than one reason when children enter out of home care. Additional reasons for removal accounting for lesser numbers of children include physical abuse, parent alcohol abuse, child behavior, parent inability to cope, sexual abuse, and child disability.

Table 3: Most Frequent Reasons for Children's Removal from their Families

| SFY | # Removals | #/% Neglect | #/%Parent Drug | #/% Parent Incarceration | #/% Housing |
|------|------------|-------------|----------------|--------------------------|-------------|
| 2017 | 12779 | 9878/77% | 7015/55% | 1799/14% | 1764/14% |
| 2016 | 12271 | 8847/72% | 6040/49% | 1680/14% | 1598/13% |
| 2015 | 10633 | 7540/71% | 4720/44% | 1493/14% | 1486/14% |
| 2014 | 8424 | 5645/67% | 3290/39% | 1380/16% | 1252/15% |
| 2013 | 9573 | 4928/51% | 2669/28% | 1252/13% | 1016/11% |

The Federal Adoption and Foster Care Analysis and Reporting System (AFCARS) removal questionnaire data show the percentage of removals of children in which parents' drug or alcohol use was indicated as a contributing factor. The data for the past four federal fiscal years are shown in the table below. As a reference point, the most current federal data available (2016) show that parental drug use is indicated in an average of 34% of removals nationally.

Table 4: Child Removals with Indicated Parental Drug or Alcohol Use by SFY

| State Fiscal Year | Parental Drug Use Indicated | Parental Alcohol Use Indicated |
|----------------------|-----------------------------|--------------------------------|
| 2017 | 55.6% | 7.7% |
| Range Across Regions | 28.4% to 76.2% | 5.7% to 14.8% |

| | | |
|----------------------|-----------------|---------------|
| 2016 | 49.5% | 7.9% |
| Range Across Regions | 22.9 % to 67.5% | 4.6% to 10.9% |
| 2015 | 44.5% | 7.1% |
| Range Across Regions | 20.3% to 65.5% | 3.9% to 10% |
| 2014 | 39.1% | 8.4% |
| Range Across Regions | 23.1% to 58.12% | 6.5% to 15.3% |

*Source: MAGIK Monthly Data (DCS)

The incidence of repeat maltreatment for children already determined to be victims of abuse or neglect is an important measure for any child protection system. For that reason, the federal Administration of Children, Youth, and Families has established this as a standard performance measure for child welfare systems receiving federal funding. That standard measures absence of repeat maltreatment occurring within six months of the prior incident and is currently set at 94.6%. Thus the expectation is that at least 94.6% of all children who have been determined to be victims of abuse or neglect will remain free of maltreatment for the six month window following that determination. Point in time ratings for May 2018 and for each of the four preceding years show that Indiana falls just short of that measure although the state's scores have improved slightly since the beginning of this time period.

Table 5: Absence of Repeat Maltreatment within Six Months

| Month/Year | IN DCS | Federal Standard |
|------------|--------|------------------|
| May 2018 | 93.88% | 94.60% |
| May 2017 | 93.34% | 94.60% |
| May 2016 | 93.65% | 94.60% |
| May 2015 | 93.52% | 94.60% |
| May 2014 | 92.66% | 94.60% |

*Source MAGIK Monthly Data (DCS)

Ongoing Service Cases

Ongoing cases in DCS are of four types:

1. Those in which children have been adjudicated as a Child in Need of Services (CHINS) and have been removed from their parents or caregivers and placed in out of home care;
2. Those who are adjudicated as CHINS but remain at home with their parents or caregivers;
3. Children who are subjects of an informal adjustment (IA) agreements, and
4. Children who are enrolled the agency's Collaborative Care (CC) program for older youth or who are assigned to a Collaborative Care Case Manager as they approach age 17.

The table below shows the number of children in each of these categories for each month of the past five years.

Table 6: Five Year Trend Open Cases Statewide For May 2013 to May 2018

| Month | Total IAs | Total CHINS | Total CC | Total Cases | CHINS Own Homes | CHINS Out-of-Home Placements | | | |
|------------|-----------|-------------|----------|-------------|-----------------|------------------------------|--------------|------------------|-------|
| | | | | | | Relative Homes | Foster Homes | Residential Care | Other |
| May 2018 | 3684 | 22092 | 819 | 26595 | 5685 | 8021 | 7237 | 883 | 266 |
| April 2018 | 3804 | 22355 | 825 | 26986 | 5895 | 8068 | 7243 | 888 | 261 |
| March 2018 | 3841 | 22700 | 809 | 27350 | 6078 | 8154 | 7287 | 912 | 269 |
| Feb 2018 | 4003 | 22860 | 806 | 27669 | 6151 | 8225 | 7315 | 895 | 274 |
| Jan 2018 | 4048 | 23078 | 800 | 27926 | 6364 | 8299 | 7210 | 909 | 296 |
| Dec 2017 | 4222 | 23485 | 795 | 28505 | 6655 | 8413 | 7168 | 947 | 302 |
| Nov 2017 | 4207 | 23734 | 801 | 28747 | 6634 | 8544 | 7280 | 965 | 311 |
| Oct 2017 | 4293 | 23965 | 804 | 29073 | 6679 | 8631 | 7373 | 955 | 327 |
| Sept 2017 | 4316 | 24044 | 814 | 29183 | 6840 | 8561 | 7337 | 969 | 337 |
| Aug 2017 | 4359 | 24020 | 813 | 29197 | 7004 | 8521 | 7217 | 955 | 323 |
| July 2017 | 4422 | 23841 | 807 | 29078 | 6956 | 8535 | 7051 | 988 | 311 |
| June 2017 | 4402 | 23947 | 822 | 29173 | 6987 | 8507 | 7154 | 1002 | 297 |
| May 2017 | 4453 | 23995 | 829 | 29280 | 6899 | 8585 | 7201 | 1011 | 299 |
| April 2017 | 4412 | 23789 | 822 | 29026 | 6872 | 8433 | 7165 | 1024 | 295 |
| March 2017 | 4479 | 23611 | 819 | 28911 | 6712 | 8467 | 7133 | 1001 | 298 |
| Feb 2017 | 4343 | 23282 | 813 | 28445 | 6647 | 8309 | 7037 | 996 | 293 |
| Jan 2017 | 4263 | 23120 | 815 | 28208 | 6661 | 8276 | 6942 | 967 | 274 |
| Dec 2016 | 4177 | 23098 | 825 | 28100 | 6722 | 8232 | 6862 | 992 | 290 |
| Nov 2016 | 4117 | 23116 | 815 | 28053 | 6645 | 8269 | 6935 | 990 | 277 |
| Oct 2016 | 4027 | 23048 | 809 | 27888 | 6579 | 8274 | 6915 | 995 | 285 |
| Sept 2016 | 3847 | 23011 | 813 | 27675 | 6800 | 8171 | 6812 | 950 | 278 |
| Aug 2016 | 3673 | 22508 | 816 | 27007 | 6659 | 7906 | 6708 | 956 | 279 |
| July 2016 | 3351 | 21943 | 811 | 26117 | 6431 | 7653 | 6630 | 959 | 270 |

Table 6 continued

| Month | Total IAs | Total CHINS | Total CC | Total Cases | CHINS Own Homes | CHINS Out-of-Home Placements | | | |
|----------------|-----------|-------------|----------|-------------|-----------------|------------------------------|--------------|------------------|-------|
| | | | | | | Relative Homes | Foster Homes | Residential Care | Other |
| June 2016 | 3109 | 21362 | 824 | 25307 | 6106 | 7488 | 6561 | 951 | 256 |
| May 2016 | 2840 | 21053 | 823 | 24732 | 5972 | 7370 | 6501 | 954 | 256 |
| April 2016 | 2868 | 20796 | 805 | 24482 | 5948 | 7216 | 6436 | 931 | 265 |
| March 2016 | 2853 | 20543 | 786 | 24193 | 5900 | 7141 | 6333 | 911 | 258 |
| Feb. 2016 | 2702 | 20210 | 761 | 23682 | 5861 | 6964 | 6215 | 920 | 250 |
| January 2016 | 2655 | 20044 | 733 | 23441 | 5827 | 6881 | 6176 | 908 | 252 |
| December 2015 | 2680 | 19996 | 707 | 23387 | 5880 | 6854 | 6129 | 886 | 247 |
| November 2015 | 2686 | 19949 | 710 | 23351 | 5766 | 6819 | 6216 | 898 | 250 |
| October 2015 | 2702 | 19741 | 699 | 23153 | 5626 | 6797 | 6155 | 908 | 255 |
| September 2015 | 2625 | 19492 | 678 | 22802 | 5709 | 6646 | 6011 | 879 | 247 |
| August 2015 | 2582 | 19081 | 667 | 22338 | 5634 | 6480 | 5867 | 860 | 240 |
| July 2015 | 2604 | 18900 | 667 | 22180 | 5603 | 6383 | 5821 | 856 | 237 |
| June 2015 | 2596 | 18610 | 674 | 21884 | 5484 | 6239 | 5801 | 861 | 225 |
| May 2015 | 2738 | 18483 | 656 | 21893 | 5394 | 6092 | 5871 | 900 | 226 |
| April 2015 | 2688 | 18243 | 677 | 21624 | 5430 | 5961 | 5789 | 838 | 225 |
| March 2015 | 2548 | 17786 | 674 | 21017 | 5274 | 5751 | 5749 | 792 | 220 |
| Feb 2015 | 2474 | 17306 | 674 | 20463 | 5099 | 5561 | 5628 | 804 | 214 |
| Jan 2015 | 2443 | 17036 | 656 | 20148 | 5079 | 5470 | 5471 | 798 | 218 |
| Dec 2014 | 2381 | 16740 | 646 | 19779 | 4879 | 5436 | 5431 | 771 | 223 |
| Nov 2014 | 2375 | 16504 | 651 | 19538 | 4704 | 5329 | 5484 | 777 | 210 |

Table 6 continued

| Month | Total IAs | Total CHINS | Total CC | Total Cases | CHINS Own Homes | CHINS Out-of-Home Placements | | | |
|-------------|-----------|-------------|----------|-------------|-----------------|------------------------------|--------------|------------------|-------|
| | | | | | | Relative Homes | Foster Homes | Residential Care | Other |
| Oct 2014 | 2398 | 16394 | 648 | 19452 | 4700 | 5248 | 5472 | 771 | 203 |
| Sept 2014 | 2392 | 15836 | 649 | 18887 | 4555 | 5070 | 5255 | 758 | 198 |
| August 2014 | 2235 | 15157 | 658 | 18057 | 4419 | 4756 | 5043 | 743 | 196 |
| July 2014 | 2162 | 14953 | 669 | 17792 | 4307 | 4709 | 5038 | 715 | 184 |
| June 2014 | 2028 | 14754 | 680 | 17471 | 4208 | 4619 | 5030 | 716 | 181 |
| May 2014 | 1961 | 14534 | 670 | 17174 | 3952 | 4622 | 5046 | 722 | 192 |
| April 2014 | 1907 | 14355 | 672 | 16943 | 3956 | 4528 | 4961 | 706 | 204 |
| March 2014 | 1854 | 14080 | 678 | 16624 | 3942 | 4393 | 4863 | 679 | 203 |
| Feb 2014 | 1796 | 13780 | 665 | 16252 | 3883 | 4309 | 4737 | 639 | 212 |
| Jan 2014 | 1792 | 13642 | 671 | 16115 | 3954 | 4184 | 4675 | 615 | 214 |
| Dec 2013 | 1740 | 13603 | 646 | 15997 | 3978 | 4146 | 4627 | 634 | 218 |
| Nov 2013 | 1731 | 13885 | 580 | 16229 | 4103 | 4116 | 4787 | 661 | 218 |
| Oct 2013 | 1813 | 13844 | 581 | 16274 | 4131 | 4070 | 4759 | 661 | 223 |
| Sept 2013 | 1836 | 13896 | 569 | 16334 | 4176 | 4114 | 4709 | 675 | 222 |
| Aug 2013 | 1829 | 13711 | 538 | 16113 | 4161 | 4043 | 4625 | 653 | 229 |
| July 2013 | 1867 | 13660 | 432 | 15998 | 4059 | 4002 | 4681 | 704 | 214** |

*Source: MAGIK Data (DCS) **Other – Out of state resource (ICPC); Placement Provider; Unlicensed

Most notably, the above data show that, after peaking at 24,044 in September 2017, the number of CHINS adjudicated children has begun to decline. As of May 2018, that figure stands at 22,092, lower than it has been at any point since July 2016, having dropped by just over 8%. During the past nine months, however, their number still stands at 62% higher than at the beginning of the 2013/14 SFY.

The remaining CHINS are with their families and, along with children involved in IAs, make up the total in-home services population. As of May, those in-home CHINS and IA children totaled 9,369. DCS data show that there are about 1.9 children per family. Thus, these children represent approximately 4,931 families.

Once a CHINS adjudication occurs, DCS tends to be involved with a child and his/her family for well over a year. As of March 2018, the analysis of the length of DCS involvement with all CHINS cases since 2012 showed that the average period of involvement was 423 days. For 16% of the CHINS population, involvement continued for 731 days or more. The statewide of

average of 423 days masks considerable inconsistency across counties as county averages range from 302 to 603 days.

DCS policy calls for family case managers to have at least one face-to-face contact per month with children and parents involved in ongoing cases (CHINS or IA). Rates of monthly contact with children are high. However, contact with parents are much lower, and especially low with fathers as shown in the following:

Table 7: Completed Required Case Contacts

| Month/Year | Child Contact | Mother Contact | Father Contact |
|------------|----------------|------------------|------------------|
| April 2018 | 98% | 41.39% | 19.61% |
| Range | 94.1% to 99.9% | 26.27% to 60.02% | 9.5% to 32.24% |
| April 2017 | 95.9% | 41.78% | 19.54% |
| Range | 90.7 to 99.8% | 28.82% to 64.56% | 10.89% to 37.31% |
| April 2016 | 95.8% | 41.44% | 19.12% |
| Range | 90.8% to 99.2% | 28.03% to 57.36% | 10.53% to 35.65% |

Out-of-Home Care 2005 to 2017

Data from the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) show the changes in Indiana's population of children in out of home care from 2005 to 2017. These data indicate that the number of children in care increased somewhat during the period from 2005 to 2010 and remained fairly stable in 2011 and 2012, before starting a much more dramatic upward trend in 2014. By the last day of September 2017, the number of children in out of home care in Indiana had increased 89.4% over the number in September 2005 and the rate in care per 1,000 children in the population had grown from 6.7 to 13. This compares to a national average rate of about 5.6 as of 2016, the last date for which federal data are available. In terms of the rate of children entering out of home care in a given year (i.e., the rate of children being removed from their families,) Indiana has a rate of 8 per 1, 000 children in the population compared to a national rate of about 3.6.

Table 8: Children In Out-of-Home Care on 9/30 2005-2017

| As of | Count | Rate | Change from 2005 |
|---------|--------|------|------------------|
| 9/30/17 | 20,394 | 13.0 | 89.4% |
| 9/30/16 | 19,209 | 12.2 | 78.4% |
| 9/30/15 | 16,551 | 10.5 | 53.7% |
| 9/30/14 | 13,722 | 8.7 | 27.4% |
| 9/30/13 | 11,814 | 7.4 | 9.7% |
| 9/30/12 | 10,751 | 6.6 | -0.2% |
| 9/30/11 | 10,720 | 6.7 | -0.4% |
| 9/30/10 | 12,262 | 7.7 | 13.9% |
| 9/30/09 | 12,145 | 7.7 | 12.8% |
| 9/30/08 | 11,870 | 7.5 | 10.2% |
| 9/30/07 | 10,870 | 6.9 | 1.9% |
| 9/30/06 | 11,069 | 6.9 | 2.8% |
| 9/30/05 | 10,767 | 6.7 | NA* |
| | | | |

The following table compares changes in out of home care rates in Indiana and adjoining states during the period 2005 to 2017. Three of the five states experienced a decrease in the number of children in care while two, Indiana and Kentucky, experienced an increase. The increase in Indiana, however, exceeded the increase in Kentucky by more than 70%.

Table 9: Children in Out-of-Home Care Contiguous States 2005 to 2016-17

| State | As of | Count | Rate | Change from 2005 |
|-------|-----------|--------|------|------------------|
| IL | 9/30/2005 | 16,402 | 5.1 | |
| | 9/30/2016 | 14,255 | 4.8 | -13.1% |
| IN | 9/30/05 | 10,767 | 6.7 | |
| | 9/30/17 | 20,394 | 13.0 | 89.4% |
| KY | 9/30/2005 | 6,872 | 6.9 | |
| | 9/30/2017 | 8,063 | 8.0 | 17.3% |
| MI | 9/30/2005 | 19,599 | 7.8 | |
| | 9/30/2017 | 11,886 | 5.5 | -39.4% |
| OH | 9/30/2005 | 16,507 | 5.9 | |
| | 9/30/2017 | 14,891 | 5.7 | -9.8% |

Out-of-Home Care 2018

As of the end of May 2018, there were, a total of 16,407 children in out of home care in DCS. This is just under three quarters (74.3%) of the CHINS population. Like the total CHINS population, the number of children in out of home care is now declining after having risen consistently over the past five years as shown in Table 6. The number of children in this category peaked in October 2017, before beginning an incremental drop to its current level representing a 5% decrease as shown in Table 10 below.

Table 10: CHINS Out-of-Home Placements Decline September 2017 to May 2018

| Month | Out-of-Home Placements Total |
|---------------|------------------------------|
| May 2018 | 16,407 |
| April 2018 | 16,461 |
| March 2018 | 16,622 |
| February 2018 | 16,709 |
| January 2018 | 16,715 |

| | |
|----------------|---------|
| December 2017 | 16, 830 |
| November 2017 | 17,100 |
| October 2017 | 17,284 |
| September 2017 | 17,204 |

Of children in out of home care, almost half (49%) are placed with relatives. Placement of children with relatives if they must be removed from their parents is generally considered the least traumatic and most stable of placement options. Indiana's rate of placement with relatives is substantially higher than the national average of 32% as of 2016 and thus represents a strength.

Table 11: Placement Settings for Children in OOHC (point in time data 2016-2018)

| Month | Relative Home | | Non-Relative Foster Home | | Residential | | Other | |
|------------|---------------|------|--------------------------|------|-------------|-----|-------|-----|
| | Count | % | Count | % | Count | % | Count | % |
| March 2016 | 7156 | 48.8 | 6342 | 43.2 | 912 | 6.2 | 258 | 1.8 |
| March 2017 | 8467 | 50.1 | 7133 | 42.2 | 1001 | 5.9 | 298 | 1.8 |
| March 2018 | 8154 | 49.1 | 7287 | 43.8 | 912 | 5.5 | 269 | 1.6 |

Overall, the distribution of placement settings for children in Indiana is favorable. Placement setting has been highly correlated in research with likelihood of reunification and other permanency outside of foster care. Family-like settings, especially those in close proximity to children's families and communities are most conducive to permanency. Indiana has both an extraordinarily high rate of placement of children with relatives and a very low rate of congregate care both of which are considered positives;. By way of reference, the 2016 federal AFCARS data show that about 26% of children nationally were placed with relatives and about 8% were either in group homes or institutions.

A point in time snapshot of placement stability data for May of the current and past five years suggests that children out of home care are relatively stable. The average number of placements was 2.7 in 2013, 2.4 in 2014, 2.1 in 2015, 2 in both 2016 and 2017, and 2.1 in the current year.

Out-of-Home Care Population and Permanency Measures:

States report data on children in foster care twice annually to the federal Administration for Children, Youth and Families. For both data submissions in 2017, the most recent available, Indiana reported entries into out of home care exceeding exits. The 2017 first cohort submission showed 6,188 entries and 5,491 exits for a net gain in the out of home care population of 687 and the second showed 6,517 entries and 5,871 exits for a net gain of 646.

However, based on the more recent data discussed, it appears that that trend is reversing. Measures of children exiting out of home care within 12 months were not available. However, data over the last four quarters show that exits within 24 months have ranged from 74% to 79% with breakdowns into types of permanency as shown below:

- Family reunification: 55% to 60%
- Adoption: 3% to 4%
- Relative Placement: 3%
- Guardianship: 7% to 9%
- Other: <1%
- Emancipation: 2% to 3%
- End of Collaborative Care: <1%
- Transfer: <1%

Of the above foster care discharge reasons, Emancipation, End of Collaborative Care, and Transfer are all interpreted as exits to other than a permanent family. Combining the number of youth in those categories yielded non-permanency discharge rates of 3% to 4%. Most recent federal data (2016) show that, nationally, discharges to emancipation alone average 8%. Against that comparison, DCS' discharges of children to situations not considered permanent and family-based are remarkably low, which is a notable strength.

Child Fatalities

Child protective services are, of course, expected to prevent harm of all degrees to children. Their greatest charge, however, is to prevent child fatalities attributed to abuse and neglect. In this respect, the most recent available data in Indiana are particularly concerning. The table below shows child fatalities in Indiana for the three most recent years of federal data.

Table 12: Child Fatalities Attributed to Abuse and/or Neglect

| FFY | # in Indiana | IN rate per 1,000 children | National average |
|------|--------------|----------------------------|------------------|
| 2016 | 70 | 4.44 | 2.36 |
| 2015 | 34 | 2.15 | 2.25 |
| 2014 | 49 | 3.10 | 2.14 |

Only Arkansas, Mississippi, and West Virginia reported higher rates of abuse and/or neglect related child fatalities in 2016. This number is, however, subject to interpretation since it reflects the number of fatalities connected with substantiated findings of child maltreatment rather than to accidents or other causes. All child fatality assessments in DCS are subject to review and final determination at the central office level. Some information provided in interviews conducted in this assessment suggests that standards for determining substantiation, particularly in the area of neglect, had tightened in DCS in recent years with assessments that had formerly been found unsubstantiated as resulting from child

maltreatment and attributed to accidental causes now being considered deaths due to neglect. In relation to this one interviewee remarked, “Children don’t just have accidents anymore, someone has to be responsible.” Confirmation of this assertion would require a review of a sample of such cases.

E. Service Array

For the most part, DCS appears to have strong relationships with other public agencies who serve families and children involved in child welfare. Representatives of mental health, substance abuse treatment, developmental disabilities, and medical assistance divisions in the Family and Social Services Administration (FSSA) who were interviewed indicated that they were knowledgeable of the needs of DCS-served families and that their respective agencies enjoyed good collaboration with DCS. This was especially apparent at the state level, but seemed to also characterize most relationships at the regional and county levels.

There is a broad spectrum of need in the families and children who become known to DCS and Juvenile Probation. Some need brief referrals as there are no safety issues and families might, for example, only be inquiring about other agencies or available services. At the greatest level of intensity, children or families may need in-patient hospitalization for psychiatric treatment to ensure their safety. Some free or low-cost services are found statewide, and reviewers saw awareness on the part of FCM’s relative to accessing these resources in their communities. Local resources are often able to meet offer immediate assistance around food, furniture, school supplies and others. However, in order to meet the serious and long-term needs presented by some families, DCS must have provider partners in child welfare at both the state and local levels.

Although services may be more concentrated in urban areas, there appears to be some coverage for many services statewide. Services offered include but are not limited to home-based treatment, homemaker, tutoring, visitation, mental health treatment, child placement, home studies for prospective foster and adoptive families, domestic violence victim support and batterer intervention, drug screening, in-patient mental and behavioral health services, youth transition, and services to addicted moms with babies. It was noted that some agencies are also engaged to provide case management in addition to that offered by the DCS FCM. Reviewers had an opportunity to interview a number of service providers, both in groups and individually, over the course of this assessment.

Service providers who enter into contracts with DCS all commit to providing services based on established standards and must provide data relating to identified outcome measures. Federal law calls for states to provide a continuum of services, ranging from prevention to intervention to treatment, for the purpose of: (42 USCS § 621)

- protecting and promoting the welfare of all children;
- preventing the neglect, abuse, or exploitation of children;
- preventing the neglect, abuse, or exploitation of children;
- supporting at-risk families through services which allow children, where appropriate, to remain safely with their families or return to their families in a timely manner;

- promoting the safety, permanence, and well-being of children in foster care and adoptive families; and
- providing training, professional development and support to ensure a well-qualified child welfare workforce.

In terms of accessibility to services, families, partners, and FCM's cited waiting lists for some as a problem. This seemed to be especially true of those that offer substance abuse assessment and treatment services. There is reportedly an acute shortage of intensive in-patient substance abuse treatment for any adults and particularly ones that serve parents with their children. Treatment and other addiction needs were largely identified as the "biggest gap" in the service array. More details about services for substance use disorder follow in the focused narrative below.

Currently, DCS has just under 300 contracted community-based service providers. Any residential provider or licensed child placing agency that becomes licensed is eligible to have a contract if it pursues one and meets the minimum qualifications.

Indiana also contracts for residential services for CHINS in foster care, group care, or treatment, including, in severe instances, psychiatric hospitalization. As of June 2018 there are 128 active residential treatment licenses. As of May 18, 2018, Indiana had a total of 6,312 licensed (relative and non-relative) resource family homes. Of these homes, 2,392 are managed by Licensed Child Placing Agencies (CPA). There are 72 private licensed child placing agencies (LCPA) in Indiana. They are licensed through the DCS Central Office Residential Licensing Unit. LCPAs provide training and recommend individuals for special needs and therapeutic foster home licenses. LCPAs also conduct adoption home studies and make recommendations regarding the readiness of the child(ren) and adoptive family in the preparation for adoption. As of May 27, 2018, there were 5,897 CHINS Children with Case Plan Goals of Adoption. It is critical that the LCPA's support the study and approval process in an effort to find permanent homes for these CHINS. Between October 2017 and the March 2018, 143 CHINS were adopted, but 1,492 remained without permanency. Some providers recommended a "think tank" of public-private partners to address this issue. Some CHINS are sent out of state to receive necessary psychiatric treatment because what is needed is not available within Indiana. There are currently 1,056 CHINS and 733 youth on probation receiving psychiatric or other treatment in Indiana and 17 in out-of-state facilities. Further, reviewers learned that CHINS and adjudicated delinquents may live in the same facilities which is counter to requirements that they be placed separately.

It remains a challenge to understand why some FCM's think they cannot or should not request services, as central office explained that there have been no budget cuts and no instructions that would be counter to the child's best interests. When asked about resources in one region, FCM's, the judiciary and others said "We don't have any" and that they felt over-scrutinized by central office. Another group of FCM's expressed concern that home-based services are "not allowed anymore". Yet we talked with providers who clearly serve families in their homes. Many FCM's were repeatedly uneasy about requesting or approving services. Reviewers heard that this wariness was rooted in a lack of autonomy perceived by the FCM's coupled with heightened scrutiny around local spending in particular.

Recruitment and Retention of Resource Families

Recruitment and retention are linked to and impacted by relationships between all child welfare system stakeholders and fellow foster or adoptive parents. Some foster and adoptive parents indicated that their experiences from recruitment to placement(s) were positive. One foster parent said: “In all of my placements, I have been treated as a team member. They have opened my eyes to other perspectives, and enabled me to have good relationships with biological parents even after reunification, and my team has always worked with my schedule. There is give and take both ways but I'm treated as a person.”

FCM's often reported that foster parents (FP) were excellent partners. They count on their willingness to assist in caring for children and youth with challenging behaviors, and they see them as allies in recruitment and training activities. There were instances of innovative and meaningful roles developed for foster parents as coaches and advocates for birth parents. One birth mother described how she at first resented the foster mother, excluding her from the CFTM process and not viewing her as a partner. She emphasized that – as it became clear to her that the foster parents wanted her child to return to her – she began to see them as part of her support system. However, there were other examples of poor relationships between foster parents and DCS and of the frustrations each had with the other. These contribute to recruitment challenges. One foster parent said that they could not in good conscience recruit any longer for DCS, having been “embarrassed one too many times” as FCM turnover and other issues grew into significant barriers preventing foster parents from getting the support they needed.

Kinship and foster caregivers are essential partners in Indiana's child welfare system. It is also important to have adoptive homes for those children whose parental rights have been terminated. The national rate of child placed in kinship care was 32% in 2016; Indiana is currently a leader in the nation with 49%. The state is now exploring the possibility of implementing different processes for licensure, which could lead to greater efficiency and even greater numbers of relative homes.

Although Indiana has an impressive number of relative homes, over half of CHINS live in other care settings such as an unrelated foster family home or in congregate care. Indiana has the Guardianship Assistance Program (GAP), which is designed to support guardianship as a permanency option for children in foster care that have been placed with a licensed relative or kinship caregiver for at least six months. This program provides financial support and, in most cases, Medicaid for the child. To further assist families in pursuit of guardianship, it is possible for legal fees to be paid up front by DCS (with approval from the Regional Manager where the case is located). In addition, if the guardian's attorney is a vendor with the state, the attorney will submit documentation to be reimbursed for their services up to \$2,000.

A widespread issue that FCM's and relatives raised was child care and the rates and policies for relative caregivers. The relative child care allowance for relatives who work or attend school is up to \$18 per day (\$90 per week) per child for licensed child care. This funding is available for six months only. If the relative becomes licensed or begins receiving Child Care Development Fund (CCDF) prior to six months the funding will end.

The CCDF is a federal program that assists low-income families, families receiving temporary public assistance, and those transitioning from public assistance in obtaining childcare so they can work, attend training, or continue education. CHINS may be eligible for CCDF. Some relatives explained that they could not afford child care after the six month time frame and struggled to meet financial obligations. When relatives cannot afford to care for children it can increase the number of foster homes needed.

Child care was also of immense concern to foster parents and many FCM's. DCS foster parents do not receive a separate/specific child care allotment. DCS daily per Diem for CHINS is:

Table 13: Per Diem Rates Paid to Foster Families

| Per Diem | Ages 0-4 | Ages 5-13 | Age 14-18 |
|---------------------------|----------|-----------|-----------|
| Foster Care | \$20.53 | \$22.29 | \$25.72 |
| Foster Care with Services | \$28.30 | \$30.06 | \$33.49 |

Per Diem rates from other states are captured below:

Table 14: Illinois Per Diem Rates Basic Foster Care

| Per Diem | Birth – 11 Months | 1 year – 4 years | 5 years – 8 years | 9 years – 11 years | 12 years and over |
|----------|-------------------|------------------|-------------------|--------------------|-------------------|
| | \$13.36 | \$13.63 | \$14.23 | \$15.10 | \$16.36 |

Table 15: Kentucky Basic and Treatment Foster Care Per Diems

| Per Diem | Birth - 11 years | 12 years and over | |
|-------------------|-------------------|-------------------|--|
| Regular Care | \$19.70 - \$21.90 | \$21.70 - \$23.90 | Rate lies within this range and is determined based on needs of child* |
| Emergency | \$30.00 | \$30.00 | |
| Treatment Home | \$37.00 - \$42.00 | \$37.00 - \$42.00 | *See above |
| Medically Fragile | \$37.00 - \$42.00 | \$37.00 - \$42.00 | *See above |

Ohio Rate Information

Based on their county administered model, each county sets its own minimum and maximum per Diem (day) rates. They range from \$10.00 to \$100.00. Of 88 counties, information was available for 70. Of the 70, the current average minimum is \$23.00/maximum \$38.00. Fewer than half or less have extra per diem for special/exceptional/intensive. Around 85% of the counties used their maximum daily rate as their emergency placement rate:

Table 16: Michigan Basic Foster Care Per Diem (Daily Rates Paid Biweekly)

| Age Group | Room and Board | Personal Incidentals and Allowance | Clothing | Daily Total | Biweekly Total | Semi-annual Clothing |
|---------------------|----------------|------------------------------------|----------|-------------|----------------|----------------------|
| Birth – 12 years | \$13.08 | \$2.84 | \$1.32 | \$17.24 | \$241.35 | \$107.00 |
| 13 years – 18 years | \$15.57 | \$3.54 | \$1.48 | \$20.59 | \$288.26 | \$122.00 |
| Independent Living | n/a | n/a | n/a | \$21.27 | \$297.78 | None |

Table 17: Minnesota Basic Foster Care Per Diem

| Age Group | Daily Basic Rate | Ongoing clothing and personal needs | Initial clothing allowance |
|---------------------|------------------|-------------------------------------|----------------------------|
| Birth – 5 years | \$21.37 | \$132.49 | \$650.00 (\$325.00/Year) |
| 6 years – 12 years | \$25.32 | \$156.99 | \$770.00 (\$385.00/Year) |
| 13 years – 20 years | \$29.92 | \$185.50 | \$910.00 (\$455.00/Year) |

Table 18: Missouri Monthly Rates Basic and Treatment Foster Care

| Age Group | Monthly Minimum |
|-----------------------------------|-----------------------------|
| Birth – 5 years | \$300.00 |
| 6 years – 12 years | \$356.00 |
| 13 years and over | \$396.00 |
| Level A Treatment or Medical Home | \$777.00 (monthly all ages) |
| Level B Treatment | \$15.49 (monthly all ages) |

Therapeutic Foster Family Homes provide care for a wide variety of children and adolescents, usually those with significant emotional or behavioral problems. These foster parents receive special training in order to serve these children and youth. The Therapeutic foster home per diem is paid by DCS. (Those children may receive some Medicaid services, but Medicaid dollars do not pay per diem.) The needs presented by these children are typically more challenging to assess and serve and costs are usually greater than for regular foster homes. Indiana has a total of 1352 homes with a therapeutic certificate, which includes DCS and LCPA relative and non-relative homes.

Table 19: Therapeutic Foster Care Per Diems

| Per Diem | Ages 0-4 | Ages 5-13 | Age 14-18 |
|-------------------------|----------|-----------|-----------|
| Therapeutic Foster Care | \$40.44 | \$42.20 | \$45.63 |
| Therapeutic Plus | \$64.19 | 65.95 | \$69.38 |

In Pennsylvania, child care expenses are provided to foster parents. In Iowa, children in foster care can be placed in an approved child care setting if the foster parents work, the child is not in school, and the need for child care is documented in the child's case permanency plan. The

Iowa foster parent receives the payment for the child care and is responsible for paying the child care provider directly. Foster parents in Washington D.C. (D.C.) have two options around subsidized child care. If they choose a D.C.-based provider that accepts a child care voucher from the Office of the State Superintendent of Education, then child care is completely subsidized. If they choose another D.C.-based provider or one outside of D.C., then foster parents can receive a subsidy partially cover the cost of child care.

On January 5, 2018, there were 530 children in foster care waitlisted for the Child Care Development Fund. That program is administered by Family and Social Services Administration (FSSA). Eight different foster parents from across the state shared the following statements relative to child care:

1. "We refuse placement almost daily because of it"
2. "It definitely means lots of out of pocket costs as our per diem pretty much only covers daycare; we are left with about \$30 per month per child."
3. "Daycare takes 100% of the per diem and then some and everything else is out of pocket. We can't take any more placements because of this"
4. "Being a single foster parent means I can't afford childcare, so all children I take in have had to be school aged."
5. "I would love to have another child but can't afford daycare cost for another one"
6. "I can't afford to take any placements as childcare cost would leave me bringing home only \$60 a paycheck".
7. "I can't switch to daytime hours because it would cost more money in childcare to earn less"
8. "I had to stop working if I wanted to take more than one child".

The state's data system cannot capture total foster care home capacity, as the number fluctuates depending on the needs level of the children placed at any given time. There are also homes that are licensed for up to five children but, for example, are only willing to care for two children at the time. As of May 31, 2018, 74 foster homes were over capacity. It is important to mention that some foster parents spoke to "never being asked" for placement, asserting that there were probably enough homes statewide to serve more children, but FCM's did not explore well before the need became urgent.

Reviewers heard in most counties that there were shortages of foster homes which had led to some children being placed three to five hours away from their family, school, and community. In addition to relative, foster, and adoptive home placements, there are needs for residential treatment for some children or youth. As an illustration of the importance of immediately accessible placement, the lack of available or willing foster parents or other providers has contributed to some children and youth spending one or more nights in the local office while FCM's and others search for placement resources. Any occurrences where children are in the office after 5:00 p.m. are tracked and monitored hourly.

DCS staff, private providers, and foster and adoptive parents offered many opinions as reviewers facilitated discussions about recruitment and retention, but the issues of trust and communication were common. There was consistent mention of a lack of trust from wary

foster parents who had not been given enough details to make informed decisions about requests. For example, one foster parent said she had not been told of any of the destructive behaviors of the teen placed quickly with her. She said that the FCM “literally begged” her to accept him, describing him as “a good kid”. She blamed DCS for the placement not being successful and stated she would not foster again. Among foster parents who are identified as emergency resources, policy calls for placements to be limited to seven days. Some of these foster parents said, however, that children are frequently left with them longer which also contributes to a lack of trust. One emergency foster parent, whose home is approved for placements of up to seven days, described a placement that had extended beyond 90 days.

FCMs in some counties felt that foster parents had been trained to work with children who had been traumatized and had made a commitment to the children but the foster parents did not communicate concerns until it was too late to provide supports that might have preserved the placement. Diminished trust and inconsistent communication were key concerns identified as reasons foster parents are opting out or are not agreeing to have certain children placed in their homes. Some foster parents said they feared sharing concerns or complaints, as they claimed to have seen children removed in retaliation. Others related having had children for whom they had provided care for years, in some instances since the children were infants or toddlers, removed from them abruptly with no preparation or transition when decisions were made to return them home or place them with another parent or relative. Over the past 24 months, 1,791 foster families voluntarily withdrew their license for various reasons. In April, 2018 alone, 18 foster families withdrew.

Some FCM’s were discouraged, indicating that there were those fostering “in name only” when their true goal was adoption. This issue was of concern to some foster parents as well. One foster parent even recommended that families who want to adopt should not be allowed to foster any child whose plan is reunification. This foster parent had allegedly observed foster parents succeed at “sabotaging” reunification plans and being disrespectful of birth families in the CFTM. The foster parent encouraged DCS central office to shift training and expectations so that teaming with the family becomes an important focus for the foster parent, adding that this should be a component of recruitment so that potential applicants better understand this model. That foster parent also suggested that birth and foster families give input to policy development. One veteran provider expressed discouragement as well, noting a “significant reduction in the maturity and flexibility” of foster parents, stating they had experienced increasing numbers of foster parents who “don’t seem to expect to actually fulfill a parenting role – going to the school, going to treatment, attending Individualized Educational Plan conferences at school, or being involved in therapy”.

There were also foster parents who expressed the belief that too much time and money are being spent on birth families who have demonstrated little to no progress with the goals of their plan. There was a collective sense of need for a more clearly defined role for foster parents in the planning process. Foster families may participate in the CFTM if parents approve, and the FCM is to encourage families to see them as partners in the process. Many foster parents felt that the FCM may not have presented them to the family as partners, stating that they had valuable information to contribute to the planning process but were excluded.

DCS Central office staff advised that the agency had always been diligent about sharing their rights with foster parents, but many foster parents disagreed.

Foster parents felt they needed a formal “Foster Parent Bill of Rights”, which Governor Holcomb signed on April 3, 2018.

(<https://iga.in.gov/legislative/2018/bills/senate/233#document-03c2f28e>). It requires that DCS collaborate with current foster parents, child placing agencies, and other individuals and organizations with expertise in foster care services to develop and update a statement of the rights of a foster parent. The new law further requires the department to distribute and publish on the department's website the statement of the rights of a foster parent. In the course of statewide interviews, there were FCM's, birth families, and others who were concerned that foster parents “already had too many rights” and wielded too much power over decision-making. Importantly, other foster parents suggested a refreshed focus on foster care as “a calling” stating that some appeared “more interested in their payment rate than in children.”

There is currently a gap in resources for CHINS who demonstrate challenging or dangerous behaviors as well as for older teens. FCM's said that there are not enough resources “between” foster homes and residential treatment centers and once a youth has multiple placements they may be hard to stabilize. To address these gaps and others, Indiana is planning to launch “targeted recruitment” efforts. Targeted recruitment is a process that focuses recruitment efforts strategically in neighborhoods and communities where families can be found that are most likely to be a resource for the children and youth in their care. DCS has made a commitment to finalize a plan for targeted recruitment initiatives. Further details can be found in Indiana's federal Program Improvement Plan (PIP). However, as of the date of this report, the design for the targeted plan is still underway.

Reviewers heard that some barriers to maintaining an adequate number of homes were administrative. An example is the length of time spent by foster parents waiting for licensure approval. A foster parent said that one county is actively telling people “it will be a year” because they don't have the staff to do the licensing work. Reviewers heard from other foster parents who said that DCS in another county is “wholesale referring people to LCPA's”. However, DCS data show improvements in timely licensure and continued recruiting efforts, as DCS added over 500 foster homes in 2016. One foster parent – echoing several – communicated “I'm trying to remain positive and patient but the process to get my license has been less than swift. I started the process 275 days ago...” Some clarification discussions have occurred at central office, as there were differences between regions around documentation of, among other things, “time to licensure”. Other problem-solving around consistency in the regions is occurring, as, for example, it has been suggested that a second look be given to “start time” relative to capturing licensure in MaGIK. FCM's noted further that the “Matching Tool” used to identify potential placements for a particular child or sibling group is somewhat limited in applicability and staff still have to access assistance from central office to get more information. DCS is examining the efficiency and utility of the tool is being examined. The licensing process for DCS and private providers is different, and some think this is confusing to prospective foster parents.

Prospective foster parents and relative caregivers are required to complete 10 hours of training in three separate deliveries. Curriculum includes trauma and other important information about attachment and discipline. It is helpful that the availability of foster care specialists to provide the training on the first introductory module permits applicants to begin the training immediately. This lessens the time to training completion. Prospective adoptive parents must complete an additional six hours of training. Licensed caregivers must complete 15 hours of in-service training annually, which can consist of a combination of classroom training, books and conference attendance, for example.

Indiana's PIP*, developed in response to areas identified in the federal Child and Family Service Review (CFSR) as needing improvement, gives valuable insight into status and next steps around recruitment. It contains measurable steps toward increasing the number of foster homes and is – by design – a fundamental starting point. The plan calls for DCS to improve the data and reports currently available to staff to better leverage its use for enhanced targeted recruitment efforts. DCS will focus on the enhancement of foster parent recruitment data to accurately identify characteristics proven to improve matches and implement activities that strengthen the relationship with current foster parents as they are the most effective tool in foster parent recruitment.

The state also plans to monitor, via contract audits, the new requirements for licensed child placing agency contracts. This will require the development and implementation of diligent recruitment plans utilizing available data, including data provided by DCS. Recruitment planning occurs regionally at this time but was previously county-specific. Some found the county plans more useful toward increasing their foster and adoptive resources; some felt that not enough time had passed to see which method got better results. Some foster parents recommended a “recognizable” statewide campaign that would shore up local efforts, emphasizing the immediate appreciation people have when they see, for example, “pink or yellow ribbons”. Foster care appreciation dollars are available on a limited basis, and staff advised that the money is used “ad hoc at best”.

Indiana further received grant funding to implement and evaluate the “All Pro Dad” initiative with the intention to continue it moving forward if found to be successful. The All Pro Dad activities will include such things as a media campaign/celebrity involvement, foster/resource parent hotline, and on-field events with football programs that bring kids and dads together and talk about what it means to be family and foster/adoptive parents. The initiative will focus on increasing the number of therapeutic licensed foster homes in Indiana, a license that requires an advanced skill set that is in high demand in Indiana. The state anticipates that this initiative will lead to a more highly trained resource parent population, stabilized placements, and more acceptance of placements of youth with high level behavioral needs.

Communication between DCS and foster and adoptive parents has been recognized as a need by all. DCS is committed to using data to inform recruitment and has expressed a great interest in transparency. Despite current data, FCM's, foster parents, judges, and others seem to differ relative to availability of foster home placements. Reviewers spoke with many who concurred that relationships must be strengthened, as one foster parent said there had been many years ago a “line drawn in the sand” with the agency and providers unwilling to concede.

Recruitment and retention efforts will likely remain a challenge, but the recent initiatives underway are encouraging and should strengthen this process.

Services for Substance Use Disorder

Substance Use Disorder, often called addiction, is a presenting or secondary issue in well over half of the families served, yet according to many stakeholders, it remains significantly under-resourced. Reviewers learned from leaders of state agencies and other organizations that there have been many robust and successful statewide and local initiatives in the past or currently underway to address the opioid crisis. Reviewers spoke with numerous people in state leadership, including representatives of the Division of Mental Health and Addiction in FSSA and members of the Mental Health and Substance Abuse Task Force housed in the Commission on Improving the Status of Children in Indiana. Reviewers heard a continued theme of partnership and willingness to support any discussion and ongoing strategy relative to addiction and child welfare. In addition, the governor's commitment to combating Indiana's opioid crisis was mentioned by several FCM's. Governor Holcomb announced that finding solutions to combat the opioid drug epidemic is one of the "five pillars" of his administration's agenda. Four new laws were signed by the governor earlier this year, all designed to address addiction through regulation and development of more services as described below. DCS' PIP includes actions required to address this need, and one key activity will be a statewide assessment of client needs for substance use disorder treatment, with a commitment to working with local providers to build capacity in underserved areas. Governor Holcomb also assigned an Executive Director for Drug Prevention, Treatment, and Enforcement to coordinate work at the state level aimed at combating addiction.

The recent House Enrolled Act 1007 will have a positive impact on children and families. There are currently 18 opioid treatment facilities in Indiana; over the next three years that number will increase to 27. One feature of this act is that no citizen will be more than an hour's drive from a drug treatment center. Access to prompt and nearby treatment was cited as crucial for families by FCM's, families, providers, the judiciary and others. For example, other new laws call for more health professionals to be required to check a state database before prescribing any potentially addictive drug. Further, county coroners will now gather more information about suspected drug overdose deaths and report it to the state. Reviewers heard also from leaders about The Community Health Network Neonatal Opioid Addiction Project, which has a focus on screenings and care for pregnant mothers and children born positive to substances. According to Data which were analyzed and prepared by Indiana's Management and Performance Hub ([MPH](#)), opioid prescription rates in Indiana have been dropping since 2012. As has been the case in other states, Indiana has had successes; it appears that the challenge has been agreement around next steps and who is responsible by for sustaining progress.

Even with excellent work having been accomplished to address substance use disorders (e.g. task forces, initiatives, new DCS policies, etc.), there is not a sense of unified direction experienced by the FCM's vis-à-vis addiction. It appears that many FCM's may not understand the state's collaborative efforts, and it is clear that they are discouraged and frustrated with the lack of quickly-accessible resources and the challenge of working with people with addictions.

Reviewers heard in some communities that services are nearby but waiting lists months-long. Reviewers heard in others that it was at least 90 minutes one way to receive specialized outpatient treatment for addiction. FCMs repeatedly related that it takes weeks to complete inpatient referrals, with lengthy waiting lists. Reviewers heard of successes and concerns, but one thing was obvious: the FCMs do not have a clear sense of what treatment is and isn't available; whether it can be paid for by DCS; and what is occurring at the leadership level to combat addiction. One FCM said "Addiction is killing us, too" referring to the challenges and lack of success with many families. Of the 83,063 children born in Indiana in 2016, 2,517 were drug-exposed. In 2017, 3,129 were born drug-exposed and, thus far in 2018, 1,181 children have been. The majority of these were from other substances besides alcohol and crystal methamphetamines.

FCMs and providers recognized that Indiana is certainly not alone in this challenge, and asked that they (line FCMs) be included in future planning, policy development, or other activities.

In October, 2017, Governor Holcomb introduced Indiana's Next Level Recovery website (IN.gov/Recovery) as the online entry point for all state resources on the opioid crisis. The website states "*The facts are simple: Opioid use disorder is a disease; there is treatment; and recovery is possible*". Despite this model, FCM's, birth and foster families, providers, and others shared with reviewers that families are disrespected and misunderstood in many ways. Reviewers heard of families being "screamed at" by judges in court because they were not progressing in their sobriety. Further, FCM's and others related that addicted parents and teens are too often arrested and jailed without supervised withdrawal. Reviewers heard of law enforcement officers telling detainees that "a weekend in jail" would solve the problem. Some judges believe in "forced sobriety", and if a parent is jailed for substances, law enforcement will call an ambulance if the withdrawal appears too painful/disorienting.

Use of drug testing was described as frequent and repeated, with results themselves sometimes being the basis for decisions about removal, family visits, and permanency decisions. FCMs may also be expected to administer drug tests, a duty that raises serious concerns for reviewers regarding family engagement and blurring of roles.

Indiana will soon again receive \$10.9 million to address the state's opioid crisis through the 21ST Century Cures Act. The grants will be provided through the Opioid State Targeted Response Grants administered by the Substance Abuse and Mental Health Services Administration. HHS has prioritized five specific strategies: strengthening public health surveillance, advancing the practice of pain management, improving access to treatment and recovery services, targeting availability and distribution of overdose-reversing drugs, and supporting cutting-edge research. Reviewers learned that, of the \$10.9 million received last year, approximately \$4 million remained; thus with the second allocation, approximately \$15 million is available to the state. FCMs were hopeful that DCS' central office would be included in discussions about resource needs.

The current opioid crisis is severe, but FCMs, law enforcement officials, and others throughout the state are quick to point out that families also struggle with addiction to alcohol,

methamphetamines, cocaine and other substances. Between just March 9, 2018 and April 20, 2018, 26 CHINS entered foster care statewide because of crystal methamphetamines in the home. DCS placed eight of these CHINS with relatives; the other 18 went into group homes or foster homes. According to the Parent Drug/Alcohol Indicator removal questionnaire, in FF2017, 12,384 CHINS came into foster care because of indications of maltreatment due to parent alcohol or drug addiction/misuse. One county conducted 11 removals just the day before interviews due to methamphetamines in two separate homes.

Some FCMs, attorneys, and others identified what they viewed as the increased prevalence of the assumption that a parent who uses any type of substance, particularly any that is illegal, is a “bad person” and unsuitable as a parent. Many point particularly to what they see as an aggressive approach in the case of parental marijuana use and wonder if it is warranted especially since the same level of rigor does not seem to be applied in instances of parental alcohol abuse. In several instances, legal professionals related efforts by DCS to create a legal argument for court intervention when they did not believe one actually existed. Reviewers heard frequent references from DCS staff regarding a substance’s illegality, rather the extent of parental impairment or child endangerment resulting from its use, as the area of focus.

Treatment and other addiction needs were largely identified as the “biggest gap” in the service array. In 2015, the need for substance use disorder treatment was ranked as the highest (4.31 of 5) need for services by a group of FCM’s completing an assessment survey. The FCM’s statements to CWG reviewers resonate with this same observation of need today.

Services currently under contract for Substance Use Disorder include:

- Drug testing and supplies
- Random drug testing
- Detoxification services
- Residential substance use treatment
- Substance use disorder assessment
- Substance use outpatient treatment
- Partners

FY 2017 Total Drug Testing/Screening = \$24,933,487.06

FY 2017 Total SUD Treatment* = \$4,538,182.21

FY 2018 YTD Drug Testing/Screening = \$23,425,843.20

FY 2018 YTD SUD Treatment* = \$3,738,119.55

**The DCS total dollars paid for SUD Treatment does not represent the full scope of treatment as some providers bill directly to Medicaid or other insurances*

Reviewers learned that, in Monroe County, Indiana was utilizing the Sobriety Treatment and Recovery Team (START) model. See: <http://www.aecf.org/resources/start-a-child-welfare-model-for-drug-affected-families/>. Neighboring Kentucky is utilizing this model in at least five counties and outcomes have been positive according to recent data. DCS plans to identify scalable START practices that can be implemented in communities outside the START

innovation counties and apply lessons learned from START locations by expanding principles of the START Model across Indiana. More information about this model may be found in Appendix B.

One provider shared that 50% to 60% of their organization's cases indicate addiction. This person had seen great success in utilization of drug court when connected to child welfare, and recommended that DCS work closely with the Indiana Judicial Branch to compare sobriety and safety data. Several providers have experienced drug court as a successful venue for planning and support of families struggling with addiction. A number of providers described seeing FCMs, law enforcement, and judges give "sobriety instructions" to families with no success, leading to greater frustration from all parties. A representative of the judiciary stated that "immediate, accessible, affordable" treatment is what families in the courtroom need, and was emphatic that DCS needs to do more to obtain monies to combat addiction as the serious child welfare issue it is. This person was concerned that whatever efforts have been successful have not become practice in the field, and asked whether DCS' central office had pursued "Recovery Works" funds. This person added "There's nothing to help people who want to be sober and jail isn't helping." One supervisor lamented lack of access to in-patient services, saying that the out-patient venue doesn't support a safe withdrawal, calling this a "built-in deterrent to sobriety."

According to information gathered from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), there are 206 resources inside the state to assist with addiction. Fifteen of those resources specifically offer opioid treatment programs. The other resources include substance abuse treatment; mental health treatment; health care centers; and buprenorphine physicians. Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access.

Two parent interviews revealed the challenge of addiction and the potential of the system to succeed. In one region, a parent was addicted to alprazolam (Xanax). This parent was incarcerated in 2015 due to drugs, and DCS received custody of the child during that time. The parent reported that DCS exerted little effort, adding that no FCM or any other DCS staff ever came to the jail to talk about the case or include the parent in planning. Like others, this parent related that, "As an addict I had to wait too long for services." The parent mentioned the difficulties of transportation to screening, and things needed such as food, diapers, and clothing, and said "DCS gave me expectations but no service to support me." This parent is currently sober and has had the child returned by the court.

Another parent a reviewer spoke with reported an addiction to methamphetamines, and has been sober for nine months. The parent expressed confidence in the FCM, saying that she "made it happen" through her support, referrals, and positive feedback. This parent's child had been removed in early 2017, and was returned in November, 2017. The parent praised DCS and the providers for "having faith". Parent's own mother was addicted to substances and lost custody of her children as well. This parent has had successful experience with Drug Court

helping pay for treatment, and suggests DCS should have more contracts with more narcotic treatment resources, adding that would help many families.

The majority of families who become known to DCS experience addiction as an issue contributing to the safety of their children. States everywhere are struggling to discuss – much less agree on – the dynamics of treatment or selection of a model. There are great examples of progress in Indiana: Opioid prescription rates are down, more facilities being built to address treatment, greater public awareness, and reviewers learned that crisis response teams will soon serve some rural families. The challenge now is for leaders and others to ensure that the enormity of addiction as a primary child welfare issue remains at the forefront of future discussions and that families, FCMs and others participate as important partners in this work whenever possible.

In addition to DCS, CWG recommends FSSA and the Indiana State Department of Health examine services available for parents struggling with substance abuse, developmental disabilities, and mental health needs that will allow them to receive effective treatment and support while keeping their children safely at home. Such an array of services would necessarily include high quality and therapeutic child care as well as home visiting programs for families identified as being at high risk for relapse. Over reliance on a reactive system that uses child removal as the primary approach to addressing parental addiction will not serve Indiana or its citizens well over time.

F. Case Reviews

CWG conducted a small case file review using a total of 46 cases comprising cases randomly selected from each of the five regions which were the focus of this assessment. The sample was stratified to include three assessment cases, three in-home cases, and four out-of-home cases from each of the regions. For child protective services assessment cases, the time period under review included those with a disposition within the past three months. The in-home cases were selected from those that are currently open and have been open for at least three months. For the out-of-home cases, the selection criteria included currently open cases that had been open for at least six months. Documents requested for review included copies of the most recent safety assessment, case narrative, and any court orders for the assessments. For in-home and out-of-home cases, copies of any formal written assessments such as mental health and substance abuse evaluations for the child and family along with the most recent court order, and the DCS case plan were requested.

After sorting through the case files and eliminating any duplication, a total of 46 cases as shown below was included in the final review:

- 14 CPS investigations (i.e., Assessments)
- 13 in-home cases (i.e., CHINS or IA)
- 19 out-of-home cases (i.e., CHINS)

A review instrument was developed that focused on the degree to which the DCS practice model is reflected in the documentation of key case activities across critical junctures of the case. This was considered along with related information that was obtained during CWG's assessment, in particular some of the data indicators as well as input and feedback from

stakeholder interviews. As a whole, the following were found to be relevant to the overall scope of the assessment:

- As has been stated by numerous sources in the stakeholder interviews and also evident in the data reports, parental substance abuse was either a primary reason or contributing factor to DCS involvement in the majority of the cases reviewed. The three major substances that were prevalent in these particular families included opiates, methamphetamine/amphetamine, and THC/synthetic marijuana.
- In nearly all of the CPS investigations and a majority of the open in-home and out-of-home cases, the families had been previously known to DCS through prior reports of abuse/neglect although a number of these were unsubstantiated. There were also those that were documented as having been screened out.
- Pertinent to family engagement, reviewers noted documentation in many cases of FCMs' efforts to establish rapport, demonstrate respect, and carry out case planning with sensitivity towards parents, caregivers, and children. Some cases contained evidence of FCM's active involvement with legal and alleged fathers of children and with relative caregivers.
- With very few exceptions, there was documentation or references to Child and Family Team Meetings occurring in open in-home and out-of-home cases that we reviewed.
- A majority of children and families were offered and/or had participated in the following interventions which were sometimes provided in combination or as standalone service: 1) substance abuse screening and treatment along with random drug testing, 2) home-based family therapy and wraparound, 3) individual counseling, including trauma-based, dialectical or cognitive behavioral therapies, 4) anger management, and 5) parent aide assistance. Additionally, parents of children in out-of-home care were frequently referred for parenting and family functioning assessments, domestic violence screenings, and psychological or psychiatric evaluations to further inform case planning. In many instances, the Court included the FCM's recommendation for service provision in its orders.

This case review found a number of examples of effective casework which conforms to the practice model and mirrors the strengths that have been described in various stakeholder interviews, specific performance indicators, and components of the training curricula as well as in the policy framework. Several of these are highlighted below:

- Assessments were initiated swiftly to ensure child safety.
- The majority of children in out-of-home care were placed with relatives, and siblings were most often placed together.
- There was documentation of identified strengths and needs for children, parents, and caregivers in the notes from Child and Family Team Meetings. These notes generally included goals and action steps that reflected the family's input and choices.
- Providers and caregivers were included and present for CFTM's in some of the cases that were reviewed.
- Visits between parents and children in out of home care appeared to be occurring frequently and regularly in most of the sample cases. When a determination was made that

visits needed to be supervised, this level of monitoring appeared to be appropriate to ensure safety and/or provide parent coaching to enhance the quality of visitation.

- Court reports were very thorough and contained pertinent information concerning the children and parents, encompassing significant background information along with the current status of case implementation.

Although strengths were noted in the specific examples cited above, there were also several instances in which practice was incongruent with the values and principles that are foundational to the practice model. These are outlined in further detail below:

- In the cases reviewed, there was no indication that FCMs conducting a comprehensive family functional assessment at any point in the case planning process. The Structured Decision-Making Risk Assessment is more limited in its design, scope, and purpose. Reviewers inquired about this and learned that an assessment form was used at one time but was discontinued as it added yet, another form or document to be completed and for which FCMs did not have time. A thorough assessment of the individual strengths, capacities, and needs of all family members is essential to gaining an understanding of the family and the underlying conditions that necessitate child welfare intervention. Furthermore, it serves as an effective and powerful process for engaging families and facilitates the formulation of an individualized case plan. Over time, an assessment reflects changes occurring within the family including those which may have resulted from the provision of services. In the absence of this practice, those formal assessments and evaluations from other professionals proved to be essential during this review to gain a clear understanding of basic information such as family composition, education, work history, health, and marital relationships in addition to the complexities of family dynamics, past traumas, and levels of functioning.
- Despite the importance of teaming as a core component of Indiana's practice model framework, notes in most of the cases showed that relatives, providers, community resources, informal supports, and educators were not involved in the CFTMs. In a number of cases, it was not clear what efforts were underway to include alleged or legal fathers and other paternal relatives in case planning and the CFTMs if they were not living in the household or actively involved when intervention with the family first began. It could not be ascertained whether these stakeholders had been encouraged to become a part of the team and invited to the meetings although input from the providers during the interviews indicated a strong desire for inclusion.
- References to the inclusion of informal supports in the CFTM's were not found nor was use of this type of assistance apparent in the majority of plans reviewed. Reviewer did not see any indication of involvement of friends, relatives, or the faith community, for example. In addition to accessing or purchasing a range of services to meet the individual needs of children, parents, and caregivers, the utilization of natural helping systems brings additional supports to the family, often sustaining their capacity to function effectively when the agency is no longer involved. Moreover, accessing "free" services is a practical approach for the careful use of financial resources.

- The review of CPS investigations and in-home cases found that FCM's engaged in the development of safety plans with substance-abusing parents and caregivers where the primary means for controlling risks involved the parents' indicating that they would refrain from using drugs in the presence of their children. In several of these cases, there were young children involved with a higher degree of vulnerability and the parents and other adult household members were abusing opiates and methamphetamines. Exacting a promise of sobriety from such parents is not considered to constitute sound safety planning since their use of substances may well be beyond their control.
- An additional finding that relates to working with substance-abusing parents and caregivers is the frequency of continued positive drug screens that did not necessarily result in changes in the approach to case implementation and service delivery. It is well understood that the challenges in substance abuse treatment and recovery including the likelihood of relapse. However, evidence of the continued use of drugs would be expected to be reflected in some alteration in the direction of case planning and service provisions. This was not evidenced in the cases reviewed.

G. DCS Training and Professional Development

Training is provided for DCS staff and foster and adoptive parents primarily through a partnership between DCS and Indiana University. Through this training partnership, the following training is provided:

- New Family Case Manager training (referred to as Cohort Training)
- Foster and adoptive parents (Resource and Adoptive Parent Training – RAPT)
- New supervisors and quarterly supervisory workshops
- County directors
- Staff (In-service and ongoing training)

Cohort training lasts for a period of twelve weeks, involving a combination of classroom training provided in Indianapolis, computer-assisted learning activities employed in participant's home-county, hands-on practice experience with a small caseload and practice coaching of participants, provided by local office mentors. New staff are intended to assume cases gradually, to provide time for learning before being assigned a full caseload. In addition to classroom trainers, the Training Partnership includes nine (and soon to be 10) Peer Coach Consultants, who support the development of peer coaches.

Cohort Training Content (Revised 2015)

- Getting to Know DCS
- Laptop & Introduction to MaGIK
- Worker Safety
- Overview of Legal Concepts
- Culture & Diversity I
- Engagement & Interviewing

- Facilitation Orientation
- Self-Care
- Culture & Diversity II
- The Effects of Abuse & Neglect on Children and Families
- MaGIK Training
- Assessing Child Maltreatment
- Case Planning and Intervening for Permanence
- Legal Roles and Responsibilities

Participants spend 25 days in classroom training and 33 days in office-based learning.

Supervisory Core Curriculum Content

- Agency Overview
- Transition to Supervisor
- Self-Awareness
- Culture
- DISC
- Leadership
- Clinical Supervision
- Critical Thinking
- Data Analyst
- Performance Monitor
- Power
- Change
- Change Agent
- Collaboration
- Conflict Management
- Team Management
- Learning Process
- Coaching Questions
- Feedback
- Stages of Worker Development
- Mentoring
- Understanding Psychological Responses
- Coaching Practice
- Leadership
- Work Culture
- Team Formation
- Team Functioning
- Stress Management
- Resiliency
- Retention

- Motivation
- Legacy Statement

Resource and Adoptive Parent Training (RAPT)

RAPT is delivered regionally by nine DCS trainers and local foster care specialists. Prospective foster parents and relative caregivers are required to complete 10 hours of training in three separate deliveries, one of which is computer-based. RAPT 1 is introductory, RAPT 2 is computer-based and addresses trauma (child abuse and neglect) and RAPT 3 addresses child and caregiver issues such as attachment and discipline. The foster care specialists provide the training on the first introductory module, RAPT 1, which permits applicants to begin training immediately. This lessens the lag time to training completion. Prospective adoptive parents are required to complete an additional six hours of training. Though desirable, modules are not necessarily required to be completed in order.

Licensed caregivers must annually complete 15 hours of in-service training which can consist of a combination of classroom training, books and conference attendance, for example. In addition to training prospective and licensed caregivers, DCS trainers also train the trainers of licensed child placing agencies (LCPAs).

Ongoing In-Service Training

Family case managers are required to have 24 in-service training hours per year. The training partnership provides an array of classroom and computer-assisted options for staff. These include, for FCMs, content areas in topics such as forensic interviewing, substance user and meaningful contacts. Supervisors, for example, are provided options that include communication skills and recruiting and retaining the right staff, for example. FCM Supervisors, LOD's, Division Managers, and Regional Managers must complete no less than 32 hours of internal training annually. The partnership is continuously updating in-service options. The Preparing for Success initiative was led by Staff Development in January 2018 to provide additional support to new Family Case managers during their first two years at the agency. These additional trainings are facilitated by Staff Development and are conducted via interactive webinars.

Content areas for Preparing for Success are:

1. Self-Care
2. Secondary Traumatic Stress
3. Building Resilience
4. Career Planning

The evaluation plan includes:

1. DCS will monitor turnover rates
2. An Institutional Review Board request is being finalized for a formal evaluation being managed by IU. This evaluation will measure employee assessments of the Preparing for Success program and its effectiveness
3. DCS is currently developing a process for feedback on specific Preparing for Success content

4. DCS is informally asking for feedback from participants about their perceptions of work readiness, things they wish they'd known earlier, and feedback to pass on to new employees.

Peer Coach Consultants

DCS has peer coach consultants, based regionally, who provide consultation and coaching at the county level. This is an important resource in supporting practice model fidelity. However, some consultants are assigned to serve three regions. This significantly affects their ability to assist meaningful numbers of staff.

Stakeholder Feedback

Some of the feedback from DCS staff addressed issues that are noted by field staff and especially supervisors and managers in all systems, which is that new FCM training is too long. Given what staff describe as high caseloads and pressures to meet compliance metrics, county staff can be impatient for new staff to be back in the office full time, assuming a larger caseload. Some staff felt that the classroom training was too theoretical, with little time available for observing trainers model practice skills and for participants to practice new skills. Because the Cohort training is delivered in Indianapolis, a number of staff wished for regional training that would be in closer proximity to their home and office. Training Partnership staff interviewed were aware of the concerns expressed and report that, where feasible, they try to respond to them.

DCS local staff expressed a strong desire for in-service training to provide external experts in critical areas such as trauma responsive practice and forensic interviewing as a major part of ongoing training. They also wish for more opportunities for conference attendance and other professional development events that would strengthen their practice.

Strengths of the Training System

The Training Partnership itself is a strength. It contains some trainers and coaches who were involved in the intense developmental process staff experienced when the practice model was first introduced. These staff have maintained a high degree of fidelity to the practice model principles. Training staff that joined the Partnership later share that commitment to the practice model. Administratively, the DCS partnership with IU has fiscal advantages for DCS, as university indirect costs can be used as part of the state matching requirement necessary for use of federal IV-E training dollars.

The Partnership makes use of computer-assisted learning to enable participants to master training content in their offices. It also permits curriculum developers to reserve classroom training time for content that necessitates the classroom environment. A simple design step taken by the Partnership in the past is to permit new staff to spend a week prior to training mostly in their office, familiarizing themselves with the work environment by observing other FCM's, learning basic local office procedures, and interacting with their peers. At one time, participants reported to training almost immediately after hiring and had little context for the actual work environment.

One of the most admirable elements of the training structure is the existence of Peer Coach Consultants. The Partnership recognizes that classroom and computer-assisted training are not sufficient for the necessary transfer of learning and have included peer coach consultants to coach local mentors and others at the local level.

The Partnership gets regular feedback from the field and regularly revises content to try to respond to front line input. In some areas, such as the request to regionalize training, Partnership staff do not believe that they can successfully manage the scheduling logistics, given the unpredictability of hiring volume and the location of new hires.

Training Challenges and Vulnerabilities

Training Content

One of the greatest challenges for any child welfare training system is managing the tension between effectively delivering content essential to good practice and the workload demands which insist that new staff be available to the field as soon as possible. Such tension leads to training compromises, which some trainers and local staff noted as present in the current training design. According to some key stakeholders, in trying to achieve some balance between participant skills mastery and local workloads, it appears that Cohort classroom content has become more predominantly lecture rather than permitting modeling activities (trainers demonstrating skills) and practice opportunities for participants (demonstrating skills and receiving feedback). Graduates may be aware of certain interviewing skills, for example, but not fully capable of performing them.

A major contributor to limits on practice skill development is class size. Because of turnover rates, DCS is continuously hiring new staff at a high rate, causing cohort class size to range from 35 participants to 45. In recent years, the Partnership training workforce has only grown from 18 to 21, a number insufficient to keep up with the hiring rate. Class sizes this large make it impossible to provide the kind of hands-on classroom modeling and coaching that would ground new staff in the basic practice model skills.

DCS has attempted to address this challenge by relying heavily on its mentoring structure and process and providing management training to supervisors (2017) to help new staff master the core practice model skills that include child and family engagement, teaming, assessment and planning. The number of local mentors can range from one peer coach serving two adjacent small counties to one peer coach serving dozens in the largest counties. Supervisor Core Training was enhanced to include content on clinical supervision, which included coaching on mentoring and providing feedback to staff. The Partnership provides a day of preparatory training to new mentors and mentors and peer coaches receive up to an additional \$300 per year as an incentive. A day of mentor training is a very modest level of preparation. Many mentors also carry a caseload, which is likely to be a higher priority than coaching new staff. Some stakeholders have advised that local mentors may or may not be able to model and mentor practice model skills with the fidelity necessary to develop new staff appropriately. Many FCMs mentioned that the modest payment provided was not sufficient for them to add mentoring to their already substantial workload. Several newer staff who had experienced

mentoring said that their experience had not been particularly helpful and questioned the basis for selection of mentors.

Training Logistics

Perhaps the most frequent concern expressed by front-line staff about cohort training was the personal impact of participants having to travel to and remain in Indianapolis for the classroom portion. Many asked why the training couldn't be provided regionally. Regional training would lessen time away from home, which is a convenience for families and others with caregiving responsibilities. Some staff thought it would be more cost effective, although that potential benefit has not been analyzed as part of this report.

Supervisors and managers frequently commented about the length of cohort training, feeling that it was too long and limited the ability to assign a larger caseload to new staff sooner. This concern is related to what are described as high staff caseloads and turnover rates in some counties. Others expressed concern that the training did not provide staff enough practical skills in the performance of their case manager role.

In regard to these concerns, trainers point out that one challenge to regionalization is knowing sufficiently in advance when there will be enough new hires and in what numbers and from what counties to create a regional delivery made up of enough participants to merit its scheduling. To some extent, the problem is one of accurate forecasting. And, although no one mentioned it, it appears that few of the classroom trainers are based regionally.

In regard to concerns about cohort training not teaching the mechanics of local procedures, this complaint is nearly universal nationally. Supervisors often believe that that new staff should become procedurally competent in training so they can quickly assume larger caseloads. A challenge pointed out by trainers is that office procedures can differ greatly county by county and individual courts even more so, making training on processes very challenging. In the view of CWG, initial conceptually and theoretically oriented preparation is important. Unless they have prior direct child welfare experience, most new staff begin their child welfare career with little practice experience. Successful practice requires the ability to engage youth and families, create a sustainable child and family team with the family, assess underlying child and family needs, and individualize planning. Mastering these skills requires a conceptual understanding of their value and merit, the opportunity to observe them practiced skillfully and the opportunity to receive feedback on performance from skilled teachers and mentors. The fact that these opportunities are not available to many caseworker candidates in the nation is one reason that many child welfare systems perform poorly. The best opportunity to build this foundation is to begin it in the classroom. If introductory training is primarily focused on policy and procedures, there is little time for skill development. And given the hectic demands of the front-line environment, there is little time to devote to skill development by supervisors managing a unit of six to eleven workers or a few part-time mentors who also carry a caseload.

Fidelity to the Practice Model

When DCS implemented its practice model, it undertook implementation by providing intensive training and coaching in family engagement, teaming, assessment, planning and meaningful visits statewide, in groups of counties serially. As attrition has diminished the number of staff

exposed to this intense development, staff added more recently have had less intensive development, which inevitably affects practice fidelity.

H. Special Populations

Older Youth

DCS currently serves older youth who are 16-18 and are still in DCS legal custody and a smaller number of youth age 19-21, who have opted to remain in care until age 21. DCS staff and advocates spoke of the expectations of federal funders to focus on enrolling youth in post-secondary education in some form and in getting them to graduation. Staff and DCS partners expressed concern that this is often interpreted to mean college rather than perhaps a technical school or helping youth to explore opportunities for an apprenticeship-type employment setting that might be best suited to their strengths and interests. They asserted that many of these youth are not prepared to succeed in a traditional college curriculum and not only become discouraged, but may also incur debt from student loans and/or credit cards. Specialists in serving this population argue that goals for youth should be more individualized. They report that the field is becoming aware of this need, including federal funders.

Older youth professionals interviewed worried about youth who approach age 18 and because of their immaturity and their experiences in care, can't wait to exit the system. They all wished that discussions about their life, education and work plans could begin earlier and be more continuous.

Children Placed Out of State

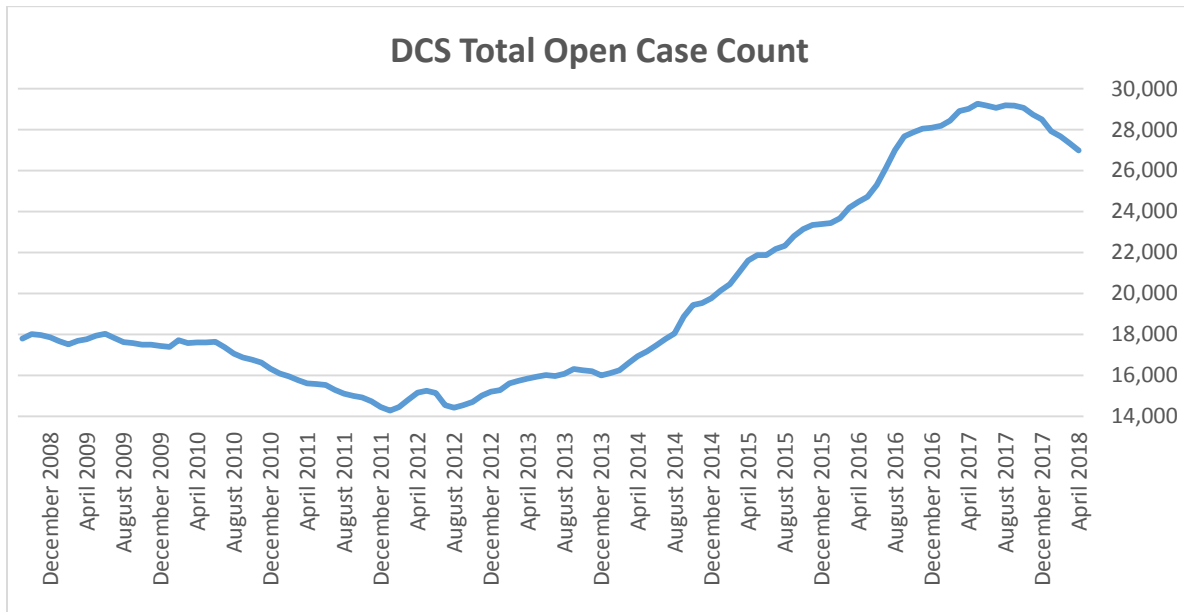
As of the most recent data provided, there are 17 children in DCS custody placed in out-of-state residential treatment facilities because Indiana community-based treatment agencies and residential treatment providers cannot serve them. Being at such distances from their home and community means that their families cannot easily visit them, nor can their FCM. It is also more difficult to plan for children placed at such considerable distances, further limiting their potential for permanency. DCS staff state that the Department always tries to locate in-state resources for challenging children and youth before placing children out-of-state.

Administration and Management

DCS Budget and Finance

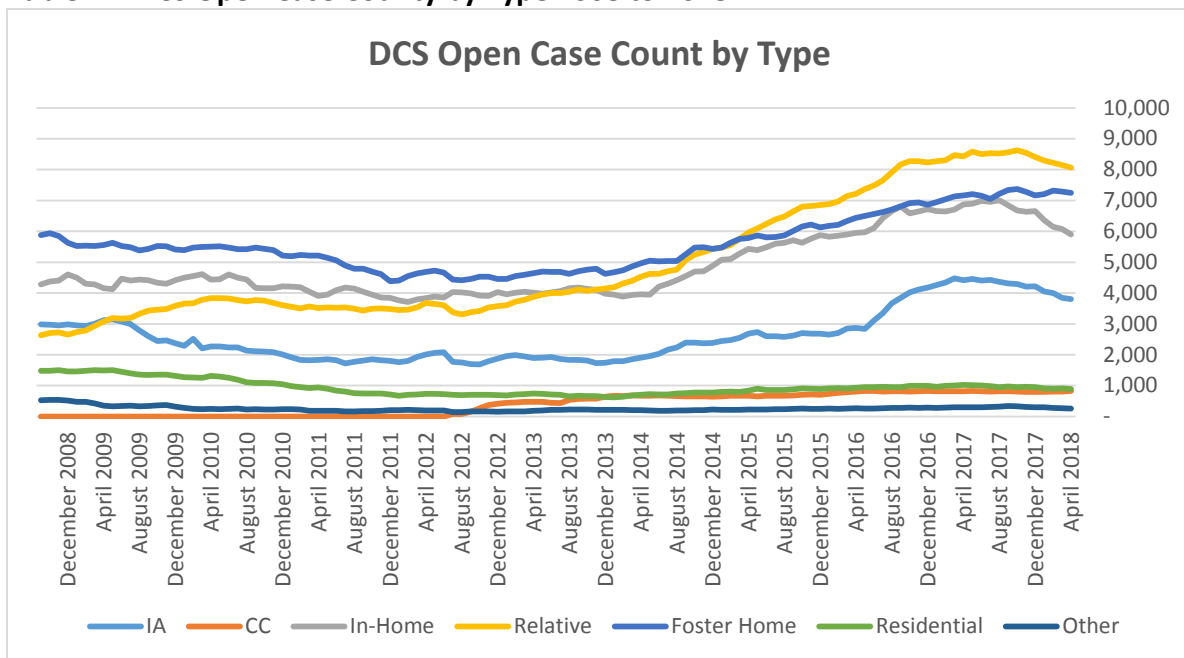
The following data provides an overview of the DCS budget and expenditure trends for recent years.

Table20: DCS Case Count 2008 to 2018



The DCS total open case count, consisting of CHINS (in-home and out-of-home), Informal Adjustments and Collaborative care plateaued in the past year and has now started to decline.

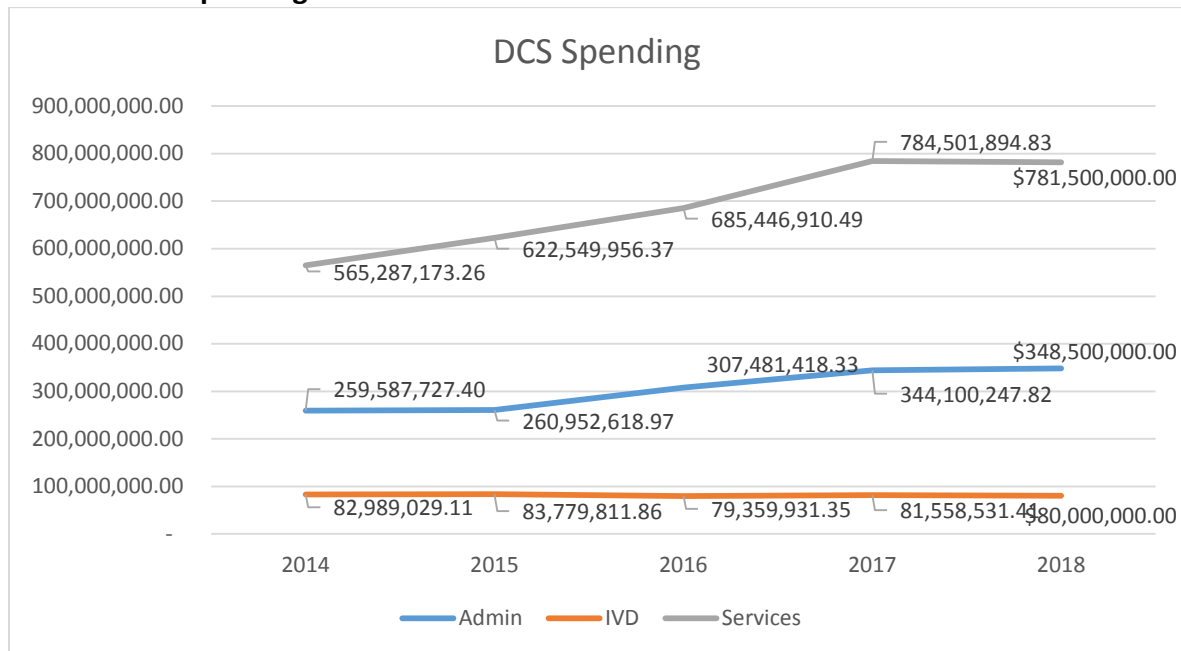
Table 21: DCS Open Case County by Type 2008 to 2018



This chart above shows case trends by case type. Relative care has declined modestly, foster care has leveled off, and in-home services have declined by approximately 1,000. IA is declining

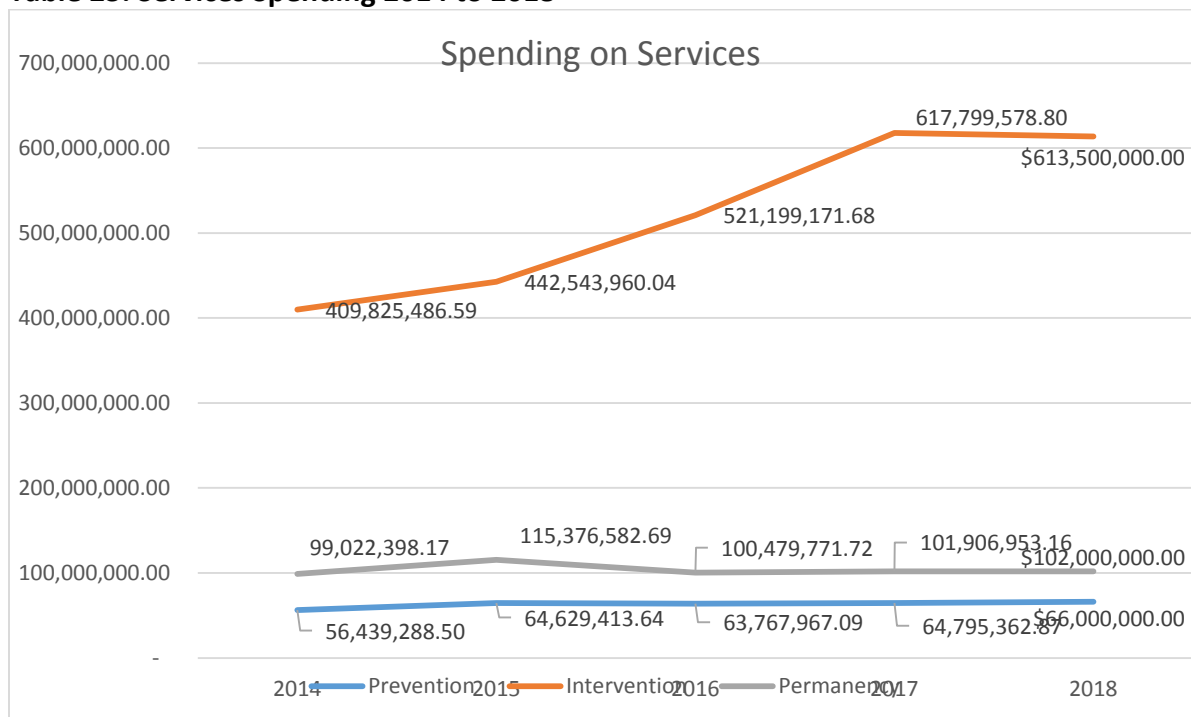
and collaborative care cases has been unchanged for multiple years. DCS reports that residential placements are down from last year by 13%, from 1,011 in May 2017 to 883 in May 2018.

Table 22: DCS Spending 2014 to 2018



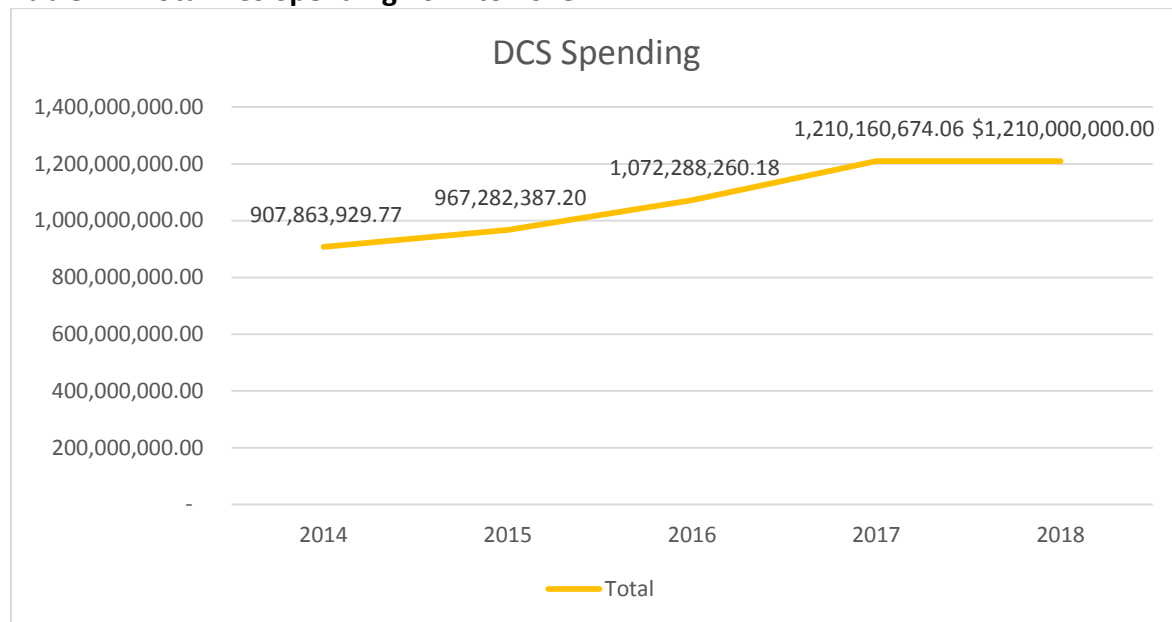
Administrative costs, which consist mostly of staff costs, rose from approximately \$260 million in 2014 to approximately \$350 million currently. Services for the same period rose from \$565 million to \$781 million. Child support costs (IV-D) have been essentially unchanged.

Table 23: Services Spending 2014 to 2018



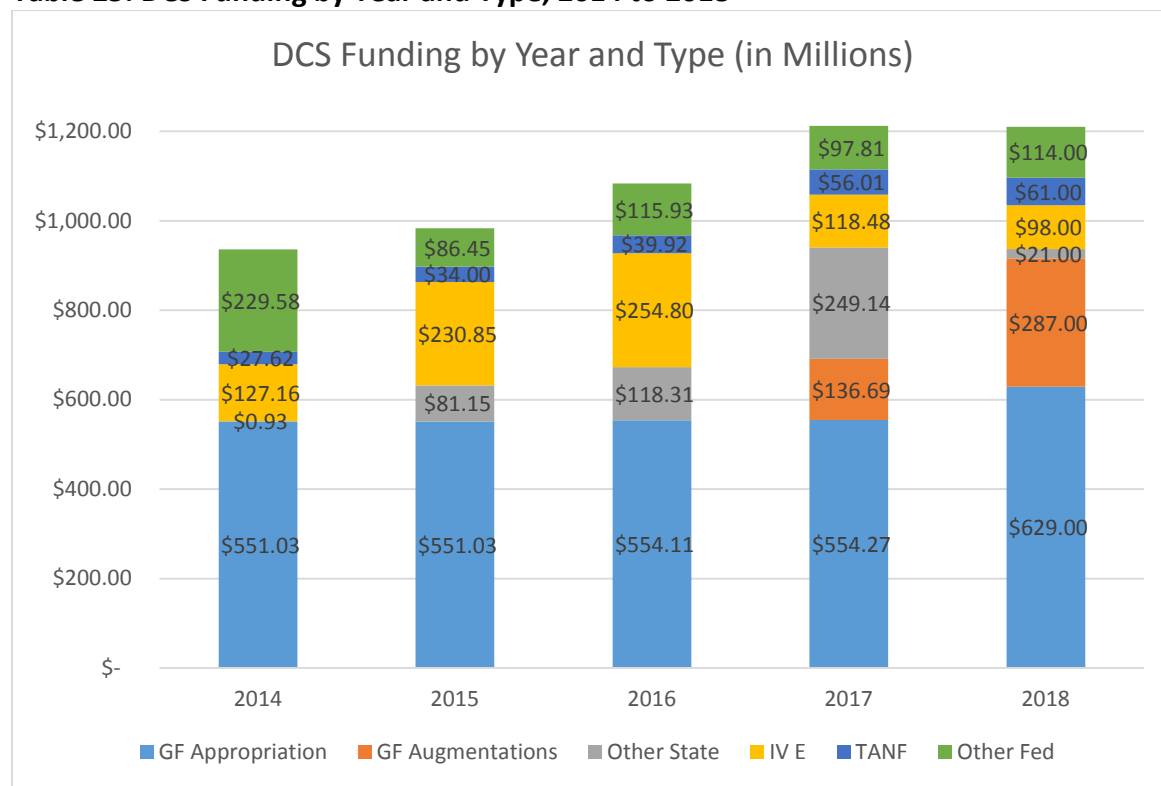
Service expenditures have plateaued since 2017. In the graph above Permanency references post adoptive and guardianship payments. Intervention costs include services related to foster care, IA and older youth (FY 2018 costs are projections).

Table 24: Total DCS Spending 2014 to 2018



Total DCS spending has risen from \$907 million in 2014 to an estimated \$1.21 Billion in 2018.

Table 25: DCS Funding by Year and Type, 2014 to 2018



This chart reflects the amount of annual funding by source. GF Augmentation reflects funds provided from the State Budget Agency to supplement the DCS general funds appropriation. Most noteworthy in the chart are the amount of General Fund Augmentation for 2017 and 2018 and the reduction in Title IV-E claiming. IV-E revenues have declined because under its federal IV-E capped allocation waiver, DCS expended more IV-E funds early in the waiver period. This left less revenue available in 2017 and 2018. The DCS General Fund appropriation for FY2019 is \$679 million, \$50 million more than for FY 2018.

Some front-line DCS staff and providers spoke of funding cuts in the past few years as additional challenges that affect their work. DCS staff spoke most frequently about limitations in training opportunities and reductions in regional meetings. DCS budget staff explain that there have not been budget cuts in the overall DCS budget, but that because costs continue to rise, there may have been some administrative limitation applied.

DCS states that it is unable to accurately forecast expenditures for the upcoming fiscal year, as it is waiting until the results and recommendations of this study are available. Once DCS knows The Child Welfare Group's recommendations which involve additional costs, the Department should be able to project costs and make decisions about Department-wide allocations.

Medicaid Revenue

It is also noteworthy that no Medicaid reimbursement for services are reported, as Medicaid covered services are not directly billed to DCS. The status of Medicaid claiming is described as follows. In May of 2017, DCS and FSSA initiated a number of work groups to explore opportunities for DCS to maximize Medicaid and other federal funds to increase available revenue. In September 2017, DCS compiled the findings of these workgroups in a paper that identified possible strategies for increasing the recovery of Medicaid funds. In a nationwide survey conducted in Federal Fiscal Year 2014 by Case Trends, DCS ranked 41 of 52 states, including Washington, DC and Puerto Rico, in expenditures from federal sources (Child Trends (Updated 2016). *Child Welfare Financing SFY 2014: A survey of federal, state, and local expenditures*. Available at: <https://childtrends-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2016/10/2016-53ChildWelfareFinancingSFY2014-1.pdf>.)

A monthly data exchange between DCS and FSSA showed that only 7.5 percent of CHINS were not enrolled in Medicaid; 1,238 of those CHINS were in the home. This suggests that a high number of CHINS would be eligible for Medicaid participation in some services that are now being supported exclusively with state funds. In many states, the cost of mental health services for this population, for example, would be substantially borne by Medicaid. The same monthly data match also returned that 33.67 percent of parents and adults involved with DCS were enrolled in Medicaid. For these adults and children with substance abuse conditions, for example, Medicaid could cover a portion of their treatment costs.

Based on the findings of these workgroups, achieving the following objectives could leverage Medicaid and improve outcomes for children and families served by DCS.

1. Leverage Medicaid covered residential treatment
2. Improve coordination of health care services for DCS Medicaid beneficiaries
3. Increase eligibility determinations for parents and adults involved with DCS
4. Modify DCS provider invoicing procedures
5. Enhance data integration and reporting between DCS and FSSA

The examination of Medicaid resources slowed somewhat at the end of 2017 due to the pending guidance of the Child Welfare Group, but recently staff have given renewed attention to Medicaid maximization opportunities. Specifically, there has been a revision to the State Medicaid Plan that facilitates greater recovery of Medicaid funds for DCS children placed in Psychiatric Residential Treatment Facilities (PRTF). No revenue forecast is available at this time; however, based on the experience of other systems, the initiative could free up state funds for investment elsewhere.

J. The Child Welfare Workforce, Workload, and Supports

Family Case Managers: Role and Qualifications

DCS defines the role of frontline service delivery staff as one of case management rather than direct service provision. This means that Family Case Managers (FCMs) are charged with assessing individual and family needs with regard to child safety and well-being, working with families to identifying services and develop a plan of action to meet those needs, making

referrals for appropriate services, working with the family and service providers to assess progress, and providing a clear and concise summary of information to the court as a basis for decision making. In addition, FCMs have multiple duties associated with documentation and service coordination.

FCMs are required to have at least a baccalaureate degree from an accredited college or university. A social work degree is not required; rather, applicants must have 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. There is no requirement for prior work experience.

DCS does work in partnership with the Indiana University School of Social Work to recruit Bachelor of Social Work (BSW) graduates. The BSW Scholars Program provides stipends and DCS internships for students interested in a career in child welfare. Graduates of the program are able to forego the pre-service training requirement and enter into agreements to work for DCS for at least two years. The partnership also provides opportunities for employees to obtain the Master of Social Work (MSW) degree.

Despite the existence of the partnership with the IU School of Social Work, the emphasis on the need for social work education among DCS service delivery personnel does not appear to be strong. Reviewers were unable to determine how many FCMs and FCM Supervisors currently have social work degrees as these data are not kept. It was also learned that there is no difference in compensation or assignments for staff with social work degrees or for graduate over bachelor's degrees. Several FCMs interviewed mentioned this as not providing any incentive for staff to develop social work knowledge and skills through specialized or advanced education. Some commented that they had been interested in getting an MSW, but given the stress associated with their workloads and the fact that there was no promise of increased salary, they had decided against it.

A recommendation of the Alvarez and Marsal 2017 Operations Assessment was to expand the BSW Scholars Program as a means of reducing turnover. That report noted that more than half of FCMs who leave employment do so within the first two years; BSW Scholar graduates, on the other hand, have a two year commitment to the agency. That report also noted that the job performance metrics of BSW scholarship recipients were generally higher than those trained through the "cohort" pre-service training program for other employees. Reviewers were told that budgetary limitations have prevented follow-through with the expansion of the program as recommended. However, it was also learned that there have been problems in the past recruiting students for this program.

Staff Stability

High levels of turnover, especially among FCMs, was among the most commonly cited themes in the interviews conducted over the course of this review. Service providers, foster parents, youth, legal professionals, and DCS personnel themselves all pointed to frequent changes in FCMs as a factor creating discontinuity in services for children and families and adversely affecting interactions with other professionals. Vacant caseloads created when FCMs leave also add to workloads and stress for those remaining and for their supervisors who must fulfill

responsibilities related to these cases in addition to their regular assignments. This concern is supported by the most recent turnover report available from DCS (March 2018) which showed statewide FCM turnover at 12 months to be 30.4 per cent. Staff interviewed cite high workloads, the lack of both support and positive regard experienced in some units and offices, the amount of on-call and overtime work required, and pay that is incommensurate with the demands of the job as factors leading to high rates of turnover.

Compensation

Both FCMs and FCM Supervisors interviewed felt that their salaries were not commensurate with the high levels of stress, legal liability, and expectations of overtime and on-call work that characterize their jobs. Overtime and on call work were pointed to most frequently as factors justifying higher salaries. This was particularly an issue for FCM Supervisors who receive no compensation other than accrued compensatory leave for being on call. FCMs themselves can claim overtime for actual on call work, but even they asserted that this does not compensate them adequately for the adjustments they must make in the personal lives to be available after-hours since they receive no compensation unless they are actually call out. FCMs spoke, for example, of having to make plans for child care and restrict their after-hours activities when on-call. Several did comment, however, that they would not consider becoming supervisors because it would mean loss of over-time pay and thus a significant reduction in their overall incomes.

Additional concerns related to compensation were what some viewed as the inadequacy of the .38 per mile reimbursement for use of their own cars in their work and the fact that their medical insurance has a \$5,000 deductible, which many said was difficult to manage on their salaries. Several also referenced what they considered their inequitable treatment relative to the Indiana State Police which recently received a ten percent increase.

The current salary ranges for the FCM 2 (the position level of all FCMs who have successfully completed pre-service training and competency assessment) and FCM Supervisors are shown below. As a reference point, U.S. Census data show the median household income in Indiana to be \$50,433 per year for 2016. Reviewers were unable to obtain information to show at what point in an individual's career he or she could expect to reach the midpoint or maximum salary.

Table 26: DCS Salaries for FCMs and FCM Supervisors

| Job Title | Annual Minimum | Annual Midpoint | Annual Maximum |
|------------------|----------------|-----------------|----------------|
| FCM 2 | \$35,776.00 | \$46,631.00 | \$57,486.00 |
| FCM Supervisor 4 | \$37,778.00 | \$51,376.00 | \$64,974.00 |

State salary and turnover data in child welfare positions are not publicly available in a number of states and many states are reputed to have high rates of turnover in front line child welfare staff. CWG reviewers thus looked to Iowa as a Midwestern state known to have a relatively low rate of turnover averaging between 8 and 9 per cent for ongoing service workers and between 4 and 5 per cent for those conducting assessments. Iowa attributes this degree of staff stability primarily to the competitive rate of compensation provided for child welfare staff. Although

staff in Iowa are called social workers, they are not required to have social work degrees but only a baccalaureate. Thus the employment pool in the two states should be roughly comparable. In Iowa, the current annual salary range for Iowa Social Worker 2s who are front line case managers in ongoing services ranges from \$42,702.40 to \$63,502.40. For Social Worker 3s who perform child abuse and neglect assessments, the annual salary range is \$46,217.60 to \$69,721.60. Both classifications are eligible for premium overtime which is at the one and one-half time rate for hours worked in excess of 40 per week.

Both DCS FCMs and FCM Supervisors may receive an annual increase in pay based on their performance appraisals. This is determined on a year to year basis, however, and increases are not awarded in all years. On December 29, 2017, Governor Holcomb authorized performance-based salary increases for the services that employees provided during 2017, as shown in the following table. When available, raises are awarded based on performance appraisal. The following table shows the salary increase scale for 2017:

Table 27: Performance Appraisal Salary Increases for 2017

| Rating | Percent increase over current salary |
|----------------------------|--------------------------------------|
| Does not meet expectations | 0% |
| Meets expectations | 2% |
| Exceeds expectations | 3% |
| Outstanding | 4% |

Reviewers were told by a number of FCMs that their supervisors are cautioned against awarding too many ratings of “exceeds expectations” or “outstanding” due to the associated cost of raises. Whether that is the case is unknown. However, a breakdown of the most recent performance ratings available shows that only 9% were assigned a rating of “exceeds expectations” or “outstanding.”

Table 28: Most Recent Employee Ratings Total

| Rating | # Employees | Percent |
|----------------------------|-------------|---------|
| Does not meet expectations | 53 | 3% |
| Meets expectations | 1858 | 88% |
| Exceeds expectations | 195 | 9% |
| Outstanding | 2 | <1% |
| Total | 2108 | 100% |

FCMs called for their having a voice in future discussions about salaries as well as regulations concerning compensatory and “flex” time. For example, court activities take priority over any adjusted or alternate work schedule. If a court appearance is required on a planned flex day, the FCM must adjust his or her schedule to attend court unless the supervisor approves an alternative. When a family needs to meet with the FCM outside of scheduled work hours, the FCM has to obtain approval from their immediate supervisor before they can proceed or confirm with the family. The perceived lack of DCS central office commitment to soliciting input and feedback from FCM’s was universally noted as contributing to low morale. A few veteran staff spoke to initiatives in the past that included a strong FCM voice, for example, the development of Indiana’s CFTM policies, the practice model, and early training curriculum development. They felt that this had been largely absent recently.

Workload/Caseload

Many FCMs reported higher-than-standard caseloads. It was not uncommon to hear about caseloads of 25-35 children who, by policy, must be seen at least once a month. Cases in DCS are defined as Assessment, indicating the work conducted to assess the validity of reports of suspected child abuse or neglect, and Ongoing (Ongoing CHINS In-Home, Informal Adjustment In-Home, or CHINS Out-of-Home). Indiana statutes define a standard of 12 cases for assessment of reports of abuse and/or neglect and 17 for ongoing cases whether involving services to children placed in out of home care and their families or to families where children remain in the custody of their parents. Assessment cases are based on families. All of those that are ongoing, however, are defined based on children. This makes case counts for ongoing services to children who remain with their families different than the Child Welfare League of America (CWLA) standards on which many agencies and these reviewers typically rely to gauge whether caseloads are reasonable. CWLA standards recommend the following:

- No more than 12 cases (i.e., families) per month for caseworkers conducting child protection assessments
- No more than 17 family cases for caseworkers providing ongoing support to families involved in child protective services; 12 cases if caseworkers are conducting family-centered casework.
- No more than 12 to 15 children in out of home care. These caseworkers are also expected to provide services to the parents and/or permanency resource for these children as well as for their substitute caregivers.

Both the Caseload and Workload Analysis conducted by Deloitte in 2015 and the Alvarez and Marsal Operations Report of 2017 recommended reconsidering the method of counting cases in Indiana to bring it into greater alignment with national standards. The Deloitte report recommended standards aligning with those of CWLA which call for measuring out of home care cases by child and in-home cases by family, while Alvarez and Marsal suggested counting out of home care cases by the number of placements in which members of a family sibling group are involved. According to that approach, a family of four children in out of home care in which three children were in one placement and one child in another would be counted as two cases. Although counted by child, CWLA standards also assume that services to the parents of the children are included in the workload of the assigned caseworker.

By way of illustration, the table below shows the difference in staff need if the 1:17 child standard currently in use for ongoing cases in DCS is applied to the average number of ongoing in-home cases served per month over the past year (April 2017 to March 2018), versus the application of a 1:17 per family standard as per the CWLA standards. The calculation converts per child case counts to family case counts using a figure of an average of 1.9 children per family provided by DCS.

Table 29: Difference in Staff Need Applying Per Family Standard

| Average monthly count of ongoing in-home cases (IA + CHINS In-Home)* | # FCMs required applying 1:17 standard to Child Count | # FCMs required applying 1:17 standard to Family Count Per CWLA standards | Difference in FCMs required |
|--|---|---|---------------------------------|
| 10,925 | $10,925/17=643$ | $10,925/1.9/17=338$ | $643-338=305$ or 47% fewer FCMs |

There are several additional factors that complicate the assessment of optimal caseloads in DCS. One is that many FCMs, particularly those in smaller counties, carrying mixed caseloads consisting of some ongoing cases and some assessments. A breakdown of caseload sizes conducted using a single day's data and not differentiating between assessment and ongoing cases, found that, on that day, 15% of FCMs had caseloads of ten or less (i.e., below the standard for either case type). However, 38% of FCMs had caseloads that ranged from 21 to 31 and over, well over the current standard for either assessment or ongoing services cases. The largest group (47%) were carrying caseloads ranging from 11 to 20 with the majority of those (29%) having 16 to 20. Because this was a count taken on a single day and near of the end of the month (May 2018), it is possible that many of these FCMs had had more cases assigned during the month, had closed them, and not yet received new assignments. However, the most recent weighted caseload report which shows about 9% of FCMs still in pre-service training suggests that this portion of filled FCM positions was not yet available for case assignment. Currently, although it is recommended that new FCMs be given cases more slowly immediately after they complete the 12 week pre-service training, there is not standard that prescribes the rate of assignment as exists in some other agencies with which reviewers are familiar.

Policy also has strong implications for workload. For example, Chapter 5, Section 12 in discussing the process of closing a CHINS case says "During critical case junctures involving the child or resource parent(s) (e.g., Trial Home Visits [THV], potential placement disruptions, new child abuse and/or neglect [CA/N] allegations, potential runaway situations, pregnancy of the child, and/or lack of parental contact), face-to-face contact with the child; parent, guardian, or custodian; and resource parent(s) must be made weekly by the assigned Family Case Manager (FCM). DCS will monitor and evaluate the situation and may convene a Child and Family Team (CFT) Meeting and/or a case conference, to assess whether the situation warrants continued weekly face-to-face contacts." In addition, there are other provisions for frequency of visits in in-home cases is determined by the level of assessed risk with cases determined to be at moderate and high risk requiring visits of three to four time per month. Such requirements for

increased visitation can add significantly to workload given time required for travel, the visit itself, and documentation.

Finally, the portion of a caseload that is court-involved also affects workload and should be a consideration in Indiana since all cases have at least minimal court involvement and, as reviewers understand it, hearings are held on informal adjustment cases in some counties.

These factors make projecting caseloads difficult and suggest that, optimally, there should be some flexibility based on assessment of actual workload. However, the following methodology provides an approach that, in the opinion of reviewers would more closely approximate alignment with CWLA standards and the actual workload represented by cases in DCS. Because the total caseload in DCS has changed markedly over the past year, this illustration applies the case counts shown in the monthly case summary from May 2018, the most current available at the time of this report. The monthly total of assessments was 11,806. At an assessment caseload of 12, this calls for 984 FCMs assuming each is carrying a full caseload of assessments only. The calculation for ongoing cases is more complex since, currently in DCS, those are counted by child.

Table 30: Ongoing Cases Caseload Calculation

| Est. OOHC CHINS* | # OOHC FCMs applying standard of 15 children | Est. In-Home (CHINS +IA) families: 9206 child total/1.9=4845 families, applying standard of 17 families | Collaborative Care total of 819/15 child standard | FCM Totals based on each position having full caseload |
|------------------|--|---|---|--|
| 16,570 | 1105 FCMs | 285 FCMs | 55 FCMs | 2,429 |

*Out-of-home care CHINS calculation applies .75 to total CHINS child count of 22092

The DCS weighted caseload management report for May 2018 shows a total of 2,101 filled positions against an estimated need based on application of the current 12/17 standard of an additional 421.27 positions for a total of approximately 2,522. A final calculation of the number of positions required must take into consideration the average number of positions filled at any given time, but not yet available for caseload assignment. Further, it would be optimal to build in some factor to allow for overfilling as many agencies have done to account for staff who are unavailable and to allow for more timely filling of vacancies when they occur. Based on the calculation applying CWLA standards as shown in the table above, it is clear that DCS is in need of additional FCMs to manage its current workload. Whether or not that number is as high as the 421 currently projected will require additional analysis of average vacancy rates and numbers of positions either unfilled or unable to handle a full caseload. In addition, in counties in which there are high rates of court involvement, court time may need to be measured separately and factored into the caseload analysis. This is likewise true for cases that require

additional home visits each month based on policy requirements. Some workload studies done in other states have measured the actual time required for each additional visit including travel and documentation so that that can be included in estimating workload beyond application of the CWLA or other broad standard. In one such study known to reviewers, each additional home visit added about three and one-half hours of work per month. However, many examples of workload studies are publicly available in the national Child Welfare Information Gateway Workload Study Compendium.

Supervision

Supervisors interviewed during this review indicated that they had as many as 11 FCMs in their units. Almost all, unless largely assigned to a function other than case supervision, had at least six and the norm was 8 or 9. The latest data provided in May 2018 showed that there are a total of 2,920 FCMs in DCS and 382 supervisors. This yields a ratio of one supervisor to 7.66 FCMs. It was learned, however, that some supervisors are assigned other tasks and thus have limited supervision workloads resulting in other supervisors being assigned more FCMs. CWLA standards call for a supervisor to caseworker/case manager ratio of no more than one to five. This limited ratio recognizes the demonstrated importance of the supervisory role in promoting and supporting optimal practice and outcomes. Further, both supervisory competence and supervisory support have been strongly linked in child welfare workforce research to staff stability and, when absent, to turnover.

Services that Support Effective Case Management

DCS, at the central office level, provides specialty teams to provide consultation to local offices in specialized areas. This capacity includes licensed clinicians who are available to provide consultation with treatment plans for children in residential facilities and who can also make recommendations regarding placements if their consultation is requested; masters level educators who serve as advocates for foster children in public schools; a medical review panel through Indiana University for children on medication and with special medical needs; and investigators who locate kin for placement and permanent connections. An additional support is the Health Services Specialist, a nurse who serves as the agency's liaison with the PEDS (Pediatric Evaluation and Diagnostic Service) center at Riley Hospital for Children.

Interviews with personnel from local schools and the Indiana Department of Education made it clear that the educational liaisons are highly valued. Overall, relationships between DCS and public schools appeared to be fairly strong, a strength that reviewers often do not find in jurisdictions and a fact that was largely attributed to the availability and intervention of educational liaisons.

Despite the provision of PEDS and the Health Service Specialist, a consistent theme heard by reviewers was that, up until this year, DCS had a team of nurses to provide individual consultation in cases involving children with special medical needs. Those positions were eliminated this past year. FCMs cited, for example, that nurses would participate in CFTMs, coach parents and foster parents in providing specialized care, and assist in staffing medically involved cases. DCS staff interviewed were unanimous in expressing how keenly the loss of this resource is felt.

Organizational Culture and Climate

Findings regarding organizational culture and climate are inferred from interviews with front line and middle management personnel in the DCS offices that were a focus of this review. Although no formal measure of these variables were used, recurring themes regarding the work norms and values referenced by staff, the degree to which they experience rewards in their work, feel supported by their superiors and the organization over all were interpreted as evidence of culture and climate. Such findings were mixed: Some counties reported high levels of adherence to practice model norms as well as strong workplace collegiality and support even as they expressed dissatisfaction with workload, compensation, or particular aspects of policy or resources. In others, frontline staff expressed feeling that their lives were ruled by “dashboards” that announced overdue case process deadlines, that expectations were unclear and in persistent flux, and that there was no recognition of accomplishments but rather constant threats of “fact files”, the colloquial term for negative comments or letters in their personnel files. A case manager in one county office said “I don’t dare ask my supervisor a question because, if I should already have known the answer, I will get a negative fact file.” Many case managers felt that they experienced a lack of recognition for good work, ready punishment for shortcomings, and little to no hope for advancement and/or professional development.

A prevailing culture of fear was a consistent theme, even in offices where case managers expressed feeling greater support from their immediate leadership. Fear was a word mentioned over and over again in interviews with DCS staff and often recognized by their partners in provider or state partner agencies. Several of those interviewed outside of DCS said “Case managers feel that no one has their backs.”

Overall, comments suggested more positive culture and climate in smaller counties. In Marion County, the largest office, the recent “localization” effort which involves dividing staff into four geographic sector offices with separate directors and middle management, seems to have had a somewhat positive effect on morale, staff retention and, in the opinion of staff, community engagement.

K. Courts and Legal System

Based on federal reporting of 2016, the most current available, Indiana has the highest rate of court involved maltreatment victims of any state of the 41 states reporting. Just over 72% percent of child victims have court cases in Indiana compared with an average 29% nationally.

Each county in Indiana has courts of juvenile jurisdiction that are responsible for overseeing the cases of families served by DCS. For the most part, it appears that Indiana courts use a “one judge, one family” model, indicating that the same judge maintains oversight of the CHINS or IA throughout the life of the case. This is generally considered to be best judicial practice in child welfare legal proceedings as it provides optimal continuity for all parties involved. One court among the focus counties was described as using a rotational system of judicial assignment, but this appears to be an exception.

Agency-Court Relationships

Most of the judges, Local Office Directors (LOD), DCS supervisors, and case managers reported that they enjoy positive working relationships in their respective counties. Some reported regular meetings between judges and the LOD, and have developed innovative practices in partnership with DCS. One judge has for years collaborated with DCS and others to plan and host child welfare conferences in their region. Judges expressed concern around FCM caseloads and indicated an understanding of the broad issue of turnover and the implications it can have for children and families. All partners in the judicial process were eager to talk about ways to improve outcomes for children and families and were encouraged by the review.

Of concern is that, in some counties, both court and DCS representatives reported less than ideal interaction and, in a few, DCS staff consistently reported experiencing treatment in the court room that they viewed as disrespectful and, in some instances, severely so. They also expressed concern that such treatment occurs in the presence of the families who are reliant upon the FCM for service coordination and ultimate resolution of their CHINS case.

Rate of Court Involvement in Child Welfare Cases

Based on federal reporting of 2016, the most current available, Indiana has the highest rate of court involved maltreatment victims of any state of the 41 states reporting. Just over 72% of child victims have court cases in Indiana compared with an average of 29% nationally. Only Nebraska at 62.3% of its cases being court involved comes within even 10% of that volume.

In Indiana, cases carried by DCS are either adjudicated as a Child in Need of Services (CHINS) or as Informal Adjustments (IA). IA cases, reviewers were told, may have very minimal court involvement with judges simply signing off on the IA authorization, or greater court oversight involving periodic hearings based on the preferences of the local judge. Reviewers were unable to identify any category of cases that are served on a strictly voluntary basis, with only the family and agency agreeing on the provision of services as exists in most other jurisdictions with which reviewers are familiar.

In addition, reviewers were told repeatedly that many cases remain open far beyond a need for services simply because the parent with whom a child is placed has not, for whatever reason, been able to file for and receive custody of the child. These cases continue to require case management and periodic court hearings absent any identified need for continued oversight or services to the family. Unfortunately, this report is only anecdotal since such cases are not identified in the automated data system.

Agency Legal Representation

DCS has its own legal division staffed with attorneys who provide representation for the agency in case-related child welfare legal proceedings. Most judges and other partners are pleased with this organizational design. Prior to the division hiring in-house attorneys for county work, counties had contracts with local attorneys. While some veteran judges and DCS staff had positive experiences with that model, most saw the current design as helpful and were encouraged by current activity around hiring and training new attorney staff. Attorneys are assigned to county offices to work with FCMs on legal aspects of cases and to represent DCS in

court. Their oversight is through the structure of the Legal Operations Division headed by the DCS General Counsel in the agency's central office. As of May 2018, DCS had 184 attorney positions filled, the number having grown from 123 positions in January 2014, the earliest date for which data were provided.

Turnover and lack of experience in the DCS legal workforce was an issue consistently raised in this review. For some judges, DCS Local Office Directors, supervisors, and case managers, it was considered the most critical need in the agency. A number of DCS staff in county offices as well as judges and attorneys and others knowledgeable about the legal aspects of child welfare pointed to inadequate pay and training as well as unreasonable workloads as issues contributing to high rates of turnover and persistent vacancies in the legal division. High rates of attorney turnover and vacant positions result in the inconsistent availability of consistent and good quality legal consultation to case managers and are responsible for continuances of scheduled court hearings as well as delayed filings for termination of parental rights when reunification efforts have been unsuccessful. These shortcomings all have the potential to contribute to delays in the attainment of important permanency and well-being outcomes for children and families. The broad nature of what a serious concern this is became even more evident when foster parents cited it as an issue.

Agency attorneys interviewed typically expressed high levels of commitment to child welfare work, but pointed to overwhelming workloads, constant changes in assignment, lack of clerical and paralegal support, and unclear delineation of roles between FCMs and attorneys as factors negatively affecting their work and performance. Almost all indicated that they are required to work many hours of uncompensated over-time in order to have any hope of meeting the demands of their jobs.

DCS has been trying to address the need for additional legal support by adding attorney positions. However, personnel data reports show that, although 54 positions have been added over the past year, the net gain in actual filled positions has been only 9 as vacancies are constantly occurring. The salary paid to attorneys with 0-8 years of legal experience is \$52,000. Some of those interviewed commented either that this seemed too low or that eight years was too long before providing a salary increase. A number of interviewees within the legal profession expressed their opinion that this salary is below those for most other public sector attorney positions in Indiana, even those requiring fewer work hours and less responsibility. Many of these informants also expressed the opinion that DCS attorneys need better training and oversight, particularly as it relates to their performance in evidentiary hearings.

DCS has no written standard for attorney caseloads. Currently, caseloads are monitored by Chief Counsels who supervise county attorneys, and adjustments are made to try to keep caseloads to about 100 cases per attorney.

Representation of Children and Parents in CHINS Proceedings

A detailed analysis of parent and child legal representation practices across counties was beyond the scope of this assessment. However, interviews with child advocates and public defenders were sought and conducted in the focus regions and judges, DCS personnel, foster parents, parents, youth, Guardians-ad Litem, and CASA's were questioned about their

experiences with legal and advocate representation. The information obtained indicates that children involved in CHINS proceedings are consistently represented by either non-attorney advocates or attorneys and that indigent parents are offered representation by public defenders or attorneys contracted through the local public defender. Capacity for such representation does vary across counties. Most judges interviewed indicated that they observed representation for parents and children in court hearings to be at least adequate but reports of whether parents and children experienced out-of-court contact with their legal representatives varied. Most public defenders interviewed reported having heavy workloads and struggling to provide the level of service that they believe their clients deserve.

Overall, it appears that Indiana courts are cognizant of the need for all parties to have competent legal representation in CHINS proceedings. There remains, however, some question as to whether there is capacity for optimal representation in many areas of the state. Only one of the focus regions included in this review provided parent representation that included social work support for attorneys, a service included in some models achieving good outcomes for families involved in child welfare in other jurisdictions.

H. Review of Indiana Statutes and DCS Policies and Comparison to Other States

The statute and policy review and comparison to neighboring states conducted in this assessment highlights relevant differences and, in some cases, raises questions for consideration by policymakers.

The following states were selected for comparison to Indiana: Illinois, Kentucky, Michigan, Ohio and West Virginia. With the exception of West Virginia, these states border Indiana. West Virginia was selected based on its proximity to Indiana, the severity of the opioid crisis in that state, and the fact that that state has also experienced a large growth in the population of children in out of home care.

Laws and agency policies in the following categories were identified, compiled, analyzed and compared:

- Definitions of child abuse and neglect, with particular emphasis on definitions of neglect;
- Reporting/Intake/Investigation
 - Mandatory reporters of child abuse and neglect;
 - Prioritization of reports of child abuse and neglect;
 - Alternative response;
 - Classification of investigation findings and level of evidence;
- Removal of children from home;
- Substance-exposed newborns.

In addition to the foregoing, laws prescribing penalties for illegal possession of narcotic drugs were also examined.

It is important to note that this review did not examine laws and policies regarding other aspects of the child welfare system, such as foster care, permanency planning, court process and the like. Summaries of laws and policies reviewed as well as citations to source material can be found in Appendix A.

Definitions of Child Abuse and Neglect

Nationally, neglect is by far the most common form of child maltreatment reported to child welfare agencies. In 2016, 89 percent of child victims of maltreatment in Indiana experienced neglect. Nationally, that figure was about 75 percent.¹

Indiana's definitions of abuse and neglect are atypical in that they are located in the statute that defines a Child in Need of Services (CHINS), who, in addition to being a victim of maltreatment, requires the coercive intervention of the court in order to receive needed care, treatment, or rehabilitation. Elsewhere in the statutes, the definition of "child abuse and neglect" incorporates by reference the CHINS definitions but, for purposes of reporting and investigating child maltreatment, is not limited to cases that require court intervention. Thus, CHINS are a subset of abused and neglected children, i.e., those who are the subject of CHINS judicial proceedings.

The CHINS definitions include the following: "The child's physical or mental condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent, guardian, or custodian to supply the child with necessary food, clothing, shelter, medical care, education, or supervision." This is not an unusual definition of basic neglect. Some of the comparison states, however, have adopted definitions that appear to qualify or limit cases of neglect to exclude poverty or occasional inattention/lapses in judgment.

- **Illinois:** The definition of "neglected child" includes the following language: "who is subjected to an environment which is injurious insofar as (i) the child's environment creates a likelihood of harm to the child's health, physical well-being, or welfare and (ii) the likely harm to the child is the result of a *blatant disregard* of parent, caretaker, or agency responsibilities;
- **Kentucky:** "*continuously or repeatedly* fails or refuses to provide essential parental care and protection for the child, considering the age of the child." Also: "Engages in a *pattern of conduct that renders the parent incapable* of caring for the immediate and ongoing needs of the child including, but not limited to, *parental incapacity* due to alcohol and other drug abuse;
- **Michigan:** "Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care, *though financially able to do so*, or by the *failure to seek financial or other reasonable means* to provide adequate food, clothing, shelter or medical care.
- **West Virginia:** "Whose physical or mental health is harmed or threatened by a present refusal, failure or inability of the child's parent, guardian or custodian to supply the child with necessary food, clothing, shelter, supervision, medical care or education, *when that refusal, failure or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian.*"

¹ U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*. Available from <https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>.

DCS' definition of neglect is more broad and unqualified than those of comparison states. The way in which Indiana defines the class of caregivers subject to its child welfare laws is similarly broad. Indiana uses the terms "parent, guardian or custodian." "Custodian" is defined broadly and means "a person with whom a child resides" and also includes individuals who own, operate, are employed by or who volunteer at foster homes, child care facilities and child care centers, certain paid caregivers, a member of the household of the child's noncustodial parent, and "an individual who has or intends to have direct contact, on a regular and continuing basis, with a child for whom the individual provides care and supervision."

Two of the other states under review, Ohio and West Virginia, also use the term "parent, guardian or custodian." However, these states are more restrictive in their definitions of "custodian:"

- **Ohio:** "a person who has legal custody of a child or a public children services agency or private child placing agency that has permanent, temporary, or legal custody of a child."
- **West Virginia:** "a person who has or shares actual physical possession or care and custody of a child, regardless of whether such person has been granted custody of the child by any contract, agreement or legal proceedings"

Perhaps because "guardian" and "custodian" have precise legal meanings, the other states have adopted broader terms to describe individuals within the scope of the child welfare laws:

- **Illinois:** "person responsible for the child's welfare"
- **Kentucky:** "person in a position of authority or special trust"
- **Michigan:** "person responsible for the child's health or welfare"

Reporting/Intake/Investigation

- A. Mandatory Reporters:** Indiana and Kentucky are the two states included in this review in which everyone is a mandatory reporter of child abuse and neglect. Laws in the other states limit mandatory reporters to a list of professionals and others who are likely to come into contact with children, such as law enforcement, teachers, social workers, health care providers, attorneys, child care providers and the like. Interestingly, referral rates per 1,000 children in both Indiana (108.2) and Kentucky (101.9) were almost twice the national average of 55.1 in 2016.²
- B. Centralized Intake:** Indiana has a centralized intake system, as do all the other states with the exception of Ohio, which has a state-supervised, county-administered child welfare system.
- C. Prioritization of Reports:** In 2016, Indiana screened in 66 percent of abuse and neglect referrals, which is slightly higher than the national average of 58 percent and higher than Kentucky (50.4), Michigan (61.2), Ohio (45.5) and West Virginia (60) (no data from

² U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*. Available from <https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>.

Illinois).³ Indiana is unique among the comparison states in that there are least two categories of reports that are automatically screened in: 1) reports from a judge or prosecutor, and, 2) all reports involving children under age 3 (unless a Regional Manager approves screening them out. (This latter policy is not in statute or the policy manual). Once a report is screened in, the timing of a response depends on the level of risk to the child. Indiana does not differ significantly from the comparison states in terms of how it characterizes the highest priority reports:

- **Indiana:** imminent danger of serious bodily harm;
- **Illinois:** immediate danger of physical harm;
- **Kentucky:** fatality or near fatality or child under age 4 at high risk;
- **Michigan:** immediate danger of harm;
- **Ohio:** emergency report;
- **West Virginia:** present danger.

Court Involvement

Indiana has a statute that authorizes DCS to implement a program of “informal adjustment” with a family if DCS has probable cause to believe that the child is a child in need of services. DCS is required to seek approval from the juvenile court before it may implement a program of informal adjustment. The court may deny such request if it finds that 1) there is no probable cause to believe that the child is need of services, or 2) the coercive intervention of the court is required. The program of informal adjustment is deemed approved if the court does not act on the request within a specified time.

Requiring court approval to provide services to a family before a dependency and neglect proceeding is initiated is highly unusual. In most states, the child welfare agency may, in appropriate circumstances, open a case and work with a family without prior court involvement. The Indiana statute raises several questions: How often does the court deny a request for informal adjustment on the basis that coercive intervention of the court is required? What might be the effect of this statute on the number of CHINS proceedings opened and the number of children entering care? How does the requirement for court involvement affect engagement with families? What is the impact of this requirement on court and other resources?

Classification of Investigation Findings and Level of Evidence

The level of evidence required to support a child abuse and neglect finding can affect the substantiation rate and, by extension, the rate of foster care entries. In Indiana, investigated reports of child maltreatment are either “substantiated” (based on a preponderance of the evidence) or “unsubstantiated” (based on credible evidence). Three of the comparison states (Kentucky, Michigan and West Virginia) and the vast majority of other states in the U.S. also use the preponderance standard. Thus, Indiana’s level of required evidence does not differ from the norm.

Classification and levels of evidence in the comparison states are as follows:

³ Ibid.

- **Illinois:** unfounded (no credible evidence); indicated (credible evidence of child abuse or neglect); undetermined (cannot initiate or complete investigation).
- **Kentucky:** unsubstantiated (insufficient evidence); substantiated (admission, judicial finding or preponderance of the evidence); child fatality/near fatality; unable to locate child; services needed for child or family.
- **Michigan:** Category V: services not needed; Category IV: services recommended (no preponderance of evidence); Category III: services needed (preponderance); Category II: child protective services needed; Category I: court petition required.
- **Ohio:** substantiated (admission, adjudication or other confirmation); indicated (circumstantial or other isolated indicators); unsubstantiated (no child abuse or neglect found); family moved; unable to locate.
- **West Virginia:** maltreatment occurred (preponderance of credible evidence); maltreatment did not occur (preponderance of credible evidence).

Removal of Children from Their Families

Law and policy governing the circumstances under which a removal of a child from home is warranted clearly affect the number of children entering foster care. In Indiana, the majority of children in CHINS proceedings have been removed from home

The DCS policy manual contains the following provision:

“The Indiana Department of Child Services (DCS) will remove a child from his or her parent, guardian, or custodian if:

1. A reasonable person would believe that the child’s physical or mental condition is seriously impaired or seriously endangered due to injury by the act or omission of the child’s parent, guardian or custodian; or
2. The child’s physical or mental condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child’s parent, guardian or custodian to supply the child with necessary food, clothing, shelter, medical care, education or supervision; and
3. The coercive intervention of the court is needed (taken) to protect the child.”

The circumstances described above under which DCS will remove a child mirror the two CHINS definitions of general abuse and neglect. This policy is puzzling because it implies that any child who meets one or both of these definitions will be removed from home. Actual practice, however, is that at least a minority of CHINS are served in-home. This raises the question of what distinguishes out-of-home versus in-home CHINS, since both must meet definitions of abuse or neglect requiring the coercive intervention of the court.

Although Indiana and federal law require DCS to make reasonable efforts to prevent the need for removal of a child from home, the policy manual is mostly silent on this point except to

reiterate the need for a judicial finding of reasonable efforts in order to qualify for federal funding.

In contrast, Illinois law and policy makes clear that removal is only warranted when a child “cannot be cared for at home or in the custody of the person responsible for the child's welfare without endangering the child's health or safety.” Similarly, Ohio’s regulations state: “If the public children services agency (PCSA) or private child placing agency (PCPA) has determined a child cannot be maintained safely through the implementation of voluntary safety planning, the PCSA or PCPA shall pursue removal of the child from the home.”

Substance-Exposed Newborns

Laws and policies in this category were included because of the increasing prevalence of prenatal substance exposure in the context of the opioid epidemic. All of the states under review have some policy in this area. Indiana calls out prenatal substance exposure in its CHINS definitions, as does Illinois. Kentucky and Michigan require reporting of newborns affected by maternal substance use. Ohio and West Virginia have adopted policies that govern intake of reports of prenatal substance exposure.

The Child Abuse Prevention and Treatment Act (CAPTA) requires a state that receives part of the \$26 million in state CAPTA grants to have policies and procedures to address the needs of infants affected by prenatal substance exposure, including a requirement to report such infants to child welfare agencies and the development of a plan of safe care for each such infant that addresses the treatment needs of the infant and affected family or caregiver.

Only one state, Ohio, mentions the plan of safe care in the policies reviewed. Ohio’s regulations spell out in detail the information regarding the plan of safe care that is to be collected when a report of a substance-exposed infant is received. The regulations prohibit screening out a referral if the plan of safe care information is not obtained, the plan of safe care has not been developed, or the plan of safe care is not adequate to address the safety of the infant.

Criminal Penalties for Drug Possession

In the course of CWG’s assessment, the question was raised whether a recent reduction in Indiana’s criminal penalties for drug possession may be affecting rates of child maltreatment because perpetrators are spending less time in prison and thus more time with their children. This report cannot answer that question, but it does summarize criminal penalties for illegal drug possession across the six states under review. The summaries in Appendix A are based on the following parameters:

- They focus on penalties for illegal possession for personal use, as opposed to manufacture, transport, distribution, trafficking, sale, etc.

- They are intended to be limited to Schedule I or II controlled substances identified as opiates or narcotics, such as heroin, oxycodone, fentanyl, etc., as opposed to hallucinogens, stimulants, etc.

Comparing penalties across states is challenging because prison terms and fines are calculated differently based on quantity, type of drug, unit of measurement, etc. The penalty structure is quite complex in some states (e.g., Ohio) and simple in others (e.g., West Virginia). By way of illustration, the following example compares potential prison terms for possession of 15 grams of heroin:

- Illinois: 4 – 15 years
- Indiana: 2 – 12 years, 6 years advised
- Kentucky: 3 years maximum
- Michigan: 4 years maximum
- Ohio: mandatory term of 2-8 years
- West Virginia: 90 days to six months

Based on this example, Indiana’s penalties appear to be within the “normal” range represented by the states under review.

This analysis of state statutes makes clear that some of Indiana’s “front end” policies are similar to those of surrounding states, but that there are also differences that may be significant in terms of their effect on the increase in the number of children entering foster care.

IV. Recommendations

Treatment and Supports for Parental Substance Abuse and Mental Health Needs

1. Intervention by DCS should not be the first resource for families struggling with substance abuse and mental health needs. Treatment and support must be available for direct self-referral with outreach to be sure parents and other community groups that might be in contact with parents know about those resources and understand clearly that no report to law enforcement or DCS will be made based solely on their seeking or referring for treatment. Further, treatment approaches should be designed to include adjunctive services that allow parents to maintain custody of their children whenever it is possible for them to safely do so. Some children will always require placement out of their homes to ensure their safety, but over-reliance on this approach will create far reaching problems for Indiana as children sustain developmental and emotional harm in the foster care system and reunited families struggle to address issues of disrupted attachment. The array of services should also include adjunctive supports for families such as basic and therapeutic child care, parent support partners, in-patient programs that allow children to enter with the parent, and specialized long-term out-patient support models designed for parents and children. This work will require the

involvement of FSSA, the Department of Education, the Department of Health, private providers, and other community and faith-based groups. It is also important that the courts be included and particularly that there be collaboration with drug courts as decisions are made about treatment approaches to ensure coordinated development and funding.

2. Developing this network of supports for families will, of course, require some time. Meanwhile, DCS should strengthen and expand across the state the Sobriety Treatment and Recovery Teams (START) model which has been begun in one county (Monroe). Other models such as the Parent-Child Assistance Program (PCAP) developed by the University of Washington (<http://depts.washington.edu/pcapuw/>) should be considered.

DCS Policy

Intake and Assessment

3. Indiana receives a higher than average rate of referrals and accepts about two-thirds of them for investigation. Reports and assessments have steadily grown over the past several years. It is recommended that Indiana re-examine its broad definitions of neglect and “custodian” against those of neighboring and other states that more narrowly define these terms to either (1) exclude neglect which is based solely on poverty or limited, one-time lapses in parental judgment; (2) limit the definition of custodian to one who is assigned consistent caregiving responsibility (e.g., a day care provider) by the child’s legal parent; (3) redefine sexual abuse assessments under the purview of DCS as those in which a legally defined caregiver is the alleged perpetrator; and (4) require that the statutory elements of a report be met for DCS to conduct an assessment, regardless of the age of the children involved.

4. The provision for a one-hour response for assessments should be reconsidered. In many states the most immediate referrals are assigned a 24 hour response time. Within that, child welfare agencies prioritize reports to respond as quickly as possible to certain situations such as those in which law enforcement is requesting immediate child protection assistance, those in which a child is disclosing maltreatment while at school and afraid to return home, and those in which children are in medical facilities that are requesting immediate intervention. Immediate may be necessary in situations such as these, but such circumstances defy precise definition in policy and law and should be assigned to the discretion of the child welfare agency within the limits of a 24 hour response priority. Such immediate response is not without risk since it deprives child protection professionals of the time needed to review prior records and develop a well-considered investigation plan that maximizes the likelihood of accomplishing an accurate and thorough assessment. When important historical information is unknown or when children must be interviewed in situations in they find frightening or threatening, assessments can have the unintended consequence of leaving children in greater danger than they were prior to the report.

5. The thirty day assessment time limit, although adequate in some instances, may provide inadequate time in others for fully engaging family members and their support networks in assessment and safety planning. An upper limit of 60 days would be preferable and allow assessors to take additional time where it is needed to achieve a better outcome. Supervisors should be responsible for ensuring that decisions are made and services provided at the earliest point consistent with the time required to gather and consider all needed information.

6. Courts are an integral part of the legally constituted child welfare system in the United States. Court oversight is obviously necessary when children cannot be made safe at home and in selected other situations when families cannot be voluntarily engaged to make changes needed to protect their children. There is, however, no evidence that it is required to successfully effect all child welfare intervention. Court involvement consumes vast amounts of resources in terms of court and attorney time; requires large amounts of additional caseworker time devoted to writing reports, appearing in court, and communicating with legal personnel; often intimidates and confuses parents and children, and can slow down case progress since court docket timelines usually trump family timelines. Indiana children and families would likely benefit from lower rates of court involvement in the context of child welfare intervention. DCS should attempt to engage families voluntarily in safety planning for their children and participating in services to support child safety and well-being whenever possible.

DCS Practice

7. DCS should reclaim the family-centered practice model that it adopted shortly after its formation. This will require (1) a return to valuing and consistently soliciting and using the input of families and their support systems in ongoing casework and in regular child and family team meetings, (2) learning to recognize and mobilize family protective factors that promote child safety even when some safety threats exist, (3) understanding harmful effects of child removal and disrupted attachment for children as a counterbalance in considering whether removal is the best course of action, and (4) increasing the number and skill level of peer practice coaches available to staff. The latter requires that the qualifications for selection and ongoing development of practice support staff be designed to ensure that they truly possess the knowledge and skills to help case managers recognize the factors that underlie child maltreatment and to work with families to select services that will meet their unique needs. Additionally, DCS should examine those areas of practice policy cited in this review as being inconsistent with family-centered practice, especially those pertaining to parent engagement and inclusion and take steps to ensure, at a minimum, that case plans are developed with and for parents.

- ***Promoting the Practice Model*** - DCS should formally relaunch its practice model to DCS staff, providers and legal partners using the following strategies: Promoting the practice model through policy, video testimonials by family members and other stakeholders;

providing additional training and coaching; and strengthening the use of child and family team meetings.

- **Classroom Training** – Additional trainers will be needed to enable Cohort classroom training to become more skills-focused. The Training Partnership should be given enough additional trainers to permit class sizes of no more than 25 participants.
- **Mentoring** - Create positions for a full-time or part-time mentor in smaller counties and multiple mentors in larger counties. Mentors should be selected based on their commitment to practice and skills in applying the DCS practice model. In smaller counties, mentors may carry half a standard caseload. Full and part-time mentors should receive additional compensation commensurate with the advanced level of knowledge, skill, and responsibility required to carrying out these duties. If turnover is low, it may be possible for several smaller counties to share a mentor. DCS should enforce the proposed caseload standard for full and part-time mentors and they should receive additional practice model training and coaching as a prerequisite. Local family case manager allocations will need to be assessed for mentors carrying caseloads to ensure that sufficient new positions are allocated.
- **Child and Family Team Meetings** – Cohort training includes an introduction to child and family team meetings. Coaching and mentoring of the process is provided by local mentors who must deal with the time and other constraints mentioned before in this section. A number of seasoned staff who experienced the original teaming implementation process acknowledge that the quality of team meetings has declined generally as the development process has become less intensive and as prior facilitation experts have left the system. New staff may be observing team meetings which have less fidelity to the original model and as a result, will emulate that process. Also, the Qualitative Service Review (QSR), which once provided feedback to staff on practice quality in areas like teaming, is no longer in use. As a result, the front-line has lost a process that identifies needs for practice improvement
- DCS should expand the number of practice coaches focused on strengthening the child and family teaming process by modeling team meeting preparation and facilitation and providing feedback to supervisors, local mentors and family case managers.
- **Regional Training Delivery** – DCS should pilot the regional delivery of Cohort training in a single regional location to test the benefits and cost effectiveness of closer proximity to participants. For this to be successful, DCS human resource personnel must coordinate with the operations and training sections to anticipate hiring numbers and locations. Providing Cohort training regionally will require additional training staff.

Specialized Populations

Older Youth

8. Throughout the country, youth who exit the foster care system without permanency have extremely poor outcomes. DCS already permits youth age 19 to 21 to continue receiving services. It is recommended that DCS consider extending the age in which foster youth can receive services to age 23. Advocates estimate that the number of youth choosing this option will be small, but will likely consist of the most vulnerable older youth. DCS should also facilitate the involvement of its collaborative care staff with youth at age 16 to help those youth begin considering the option of remaining in care past age 18.

Case Management

The model of case management used by DCS, as understood by CWG, is one in which the role of the family case manager is generally only to connect families to services, coordinate services, and report progress to the court. In many instances, families are even assigned a contracted case manager in addition to their DCS family case manager. Families and children do need specialized interventions beyond generalized casework, and Indiana is fortunate to have at least a moderately sufficient array of private sector service providers, but the caseworker-family relationship is critically important in supporting families in the often hard work of making the changes necessary to keep their children safe. Parents and children who are subjected to a succession of disconnected referred service providers may be left without anyone whom they trust and with whom they can speak frankly about their service needs and what it will take to meet them. Some family case managers and providers as well expressed concern to reviewers about the number of different people involved in working with some families. The case manager should serve as the “hub of the wheel” who coordinates services, ensures that they make sense and are useful to children and families, and determines, with input from other service providers, to what extent real change directed toward child safety and well-being has taken place. This takes time and requires that caseworkers truly engage with families. Both policy and workload requirements in DCS need some adjustment to fully support this function.

9. It is recommended that DCS:

(a) Establish a caseload standard of no more than 17 families (not children) for in-home services and no more than 15 children for out of home care caseloads. Both caseload standards and policy should make it clear that family case managers carrying cases of children placed out of home also have an equal responsibility for permanency planning and engaging children’s parents in an individualized plan of services designed to remedy the safety threats that brought their children into care.

(b) Once caseloads approach the caseload target, require that case managers visit with parents in their own homes at least once per month.

The Data System and Use of Data in DCS

DCS lacks any significant capacity to analyze data for practice/outcome associations, key data variables, predictive factors and causation. Current data staff are fully occupied in ongoing operational duties.

10. DCS should create a small unit made up of data professionals which can take responsibility for analyzing the voluminous data currently being collected and identifying new opportunities to assess the effects of system interventions in the lives of children and families. These professionals should work closely with child welfare program leadership to identify a limited set of key outcome and process measures that can be displayed in regular management reports and disaggregated by region and county so that staff at all levels of the organization can regularly assess their performance and use data to develop and test questions about practices that improve safety and permanency outcomes for children and families.

Quality Assurance/Quality Improvement QA/QI

11. DCS does have a quality assurance and quality improvement (QA/QI) framework, but it needs to be strengthened and better integrated throughout the organization. The following recommendations are offered as a means of facilitating that work:

- a. QA/QI in child welfare involves both technical skills (data collection and analysis, research methodology, and data presentation) and essential craft knowledge (an understanding of the practice model, essential practice skills and the exigencies of front-line practice). It is critical that those involved in structuring and leading QA/QI work have either practice experience or the opportunity to learn in some detail what is involved in front-line child welfare practice and supervision.
- b. Pay attention to the number and importance of things measured and reported. Having many data points dilutes attention to those most relate to outcomes. Further, it add to the burden of those entering data and thus likely reduces its timeliness and quality.
- c. Add or reassign resources to build on DCS' QSR expertise, experience and baseline data to revive the QSR: Indiana has invested considerable time and energy in the development of QSR and has a valuable baseline of information connecting practice with outcomes at the case level. QSR was recently discontinued, however, due to resource demands and increasing competition for staff time to conduct and use the system. Currently, DCS does not have a substitute for QRS' ability to provide feedback on what is working and what is not. Without regular systemic

feedback, validated at the case level, systems tend to bog down in competing subjective explanations about why things are the way they are, and what to do to improve. The federal review, done only every three to five years, is not an adequate substitute.

d. Improve the child death review process by adding voices to the conversation. Indiana, like all states, aims to eliminate child deaths within its child welfare system. The reality is that this is no more immediately achievable than eliminating child deaths in traffic accidents or from hospital acquired infections. DCS should continue the child death review process but also involve sister state agencies, community partners, providers and the public. This process will develop a deeper and more contextualized understanding of the factors contributing to child deaths and promote child safety. Finding a way to focus the conversation on reducing child deaths and building stronger partnerships, is more likely to lead to productive action

e. Look for opportunities to promulgate a shared practice model across the community. Quality assurance and quality improvement work best when everyone has a shared understanding of goals and outcomes, and the practices that contribute to progress. Indiana has made efforts in the past to communicate its practice model to its most frequent partners such as schools and mental health providers. Reinforcing this work but also expanding it to the broader community will add a level of transparency and ultimately improve outcomes for children, youth and families. Quality improvement in child welfare tends to progress when quality assurance information is as widely available as possible. Sharing information and illuminating DCS' strengths and needs will allow the community to play a role in achieving better outcomes for children and youth.

f. Improve the organization and presentation of reports and data related to MaGIK. A review of a sample of reports within MaGIK suggested that the current level of data organization and presentation could be improved in ways that would contribute to its effective utilization. The high volume of reports, combined with pressure to produce information, likely contributes to the shortcomings found in MaGIK. As DCS thinks about how to present QA/QI information to management, field personnel, and the community, it should be mindful that sophisticated organization and presentation of data can greatly increase its usefulness and impact. [See Tufte, Edward: Visual Explanations and Beautiful Evidence, Graphics Press, 1997 and 2006, respectively.]

The Child Welfare Workforce

Supervision

12. Reduce the supervisor to family case manager ratio: The role of the supervisor is critically important in child welfare. Reviewers consistently found that supervisors in DCS have between six and 11 family case managers under their supervision. The CWLA standard for front-line supervisors is one to five. While peer practice coaches are beneficial, the best child welfare systems are those in which supervisors have the time, knowledge, and skill to develop and

support excellent casework practitioners and to recognize complex case situations and oversee them in a way that avoids the oversights or missteps that often lead to families being re-referred or even to tragedy. Currently, DCS does not have such a group of supervisors. Many came to their roles after very short tenure as case managers and almost all have a workload that exceeds what is considered optimal in child welfare practice. In addition, DCS should support high quality supervision by: (a) Ensuring supervisors are always the first to experience training in new skills and practice approaches (i.e. before it is offered to family case managers in pre-service or other training); and (b) developing a structure through which supervisors can have input into decisions that affect policy and practice.

Agency Culture and Climate

13. DCS experiences a high rate of turnover among frontline staff. Morale is low in many offices and reviewers were often told of work environments that are perceived as punitive and compliance driven. In a family case manager focus group in one large county, the following statement was made: “We are afraid to ask our supervisors questions because we will have a ‘fact file’ (negative letter in the personnel file) if it is something we should already have known.” Such a statement reflects the very opposite of a learning culture that leads to staff retention and strong practice outcomes. It is recommended that DCS conduct further inquiry into the extent to which culture and climate are factors that negatively impact recruitment, retention and development of high performing front line staff. This might be accomplished in partnership with national experts such as those in the Center for Behavioral Research at the University of Tennessee or pursued with faculty at the Indiana University School of Social Work. This inquiry should recognize, while there are some factors, such as compensation, that affect climate across the state, many culture and climate factors are localized and thus warrant individual, office by office identification and solutions based on direct input from frontline staff.

14. Both DCS personnel and others who work with DCS spoke frequently to reviewers of the “culture of fear” existing among front line staff. This is, unfortunately, not an unusual finding in child welfare agencies today. However, child welfare staff who are unduly fearful to the extent that they place concern about the consequences of personal liability or sanction above the immediate and long-term well-being of children and families do not produce the best outcomes. In the experience of reviewers, such fear can only be mitigated when top leadership clearly communicates a commitment to support frontline personnel unless they commit fraud or are grossly negligent in performing their duties.

DCS Staff Recruitment and Retention

15. DCS should develop a clear strategy for recruiting and retaining skilled and knowledgeable front line staff including supervisors. Suggested components of such a plan would include:

- a. Selection criteria that state a clear preference for staff with the BSW or MSW.
- b. Consideration of whether pay is commensurate with that of other positions in Indiana requiring similar education and pressures, potential liability, and on call accessibility. Comparisons might also be drawn with other states having similar costs of living and substantially lower turnover rates. One such example is Iowa which starts case managers about \$7,000 per year higher and tops salaries for front line staff about \$6,000 beyond the top range in Indiana. Iowa currently experiences turnover between 8 percent and 9 percent compared to about 30 percent in Indiana.
- c. A career ladder that provides higher pay to staff with social work degrees and that has opportunities for advancement in pay and status based on acquisition of additional certifications in specific practice skills such as
 - Working with families experiencing domestic violence,
 - Assessing and intervening in child sexual abuse,
 - Treating and managing frequently referred families, and
 - Assessing and intervening in families experiencing parental substance abuse.
- d. Ongoing training opportunities for all front line staff and middle managers that provide exposure to cutting edge knowledge in the child welfare field. This would include (1) information about evidence-based models such as those featured on the California Evidence-Based Clearinghouse and developing criteria for approving payment for learning opportunities offered outside of DCS; (2) training of managers, supervisors, and FCMs in (a) the dynamics of substance use and the behaviors often demonstrated by individuals with a substance disorder and (b) the effects of trauma and disrupted attachment associated with children's removal and placement and ways to mitigate these in efforts to keep them safe.
- e. Work in partnership with state university schools of social work to recruit more social work graduates and develop incentives (including higher rates of pay) for staff to pursue the MSW. An effective agency-university partnership would also include some joint planning of elective course offerings for students in child welfare internships and attention to designing and supporting meaningful internship experiences.

Decentralization of Decision-Making

Local DCS staff and many external stakeholders spoke about what they considered the over-centralization of central office decision-making related to both policy and financial issues. Because they are so close to the families and communities, DCS staff expressed their belief that they often know best how resources should be used and case decisions made.

16. DCS should identify opportunities to decentralize decisions that directly affect work with children and families. DCS should form a work group of local family case managers, supervisors, county office directors and selected state office staff to review local decision-making authority and its limits related both to policy and spending. The suggested group should be chaired by a

local office director and have the responsibility to identify areas of policy and spending decision-making now held centrally that can be delegated to the county level. While reviewers do not intend to suggest that this activity be limited to the use of flexible funds available to meet concrete needs of children and families, this is an area that is believed to be under-valued and overly constrained in current policy. Provision of concrete needs can not only be invaluable in safety planning with families but also communicates a helping intent that can lay the foundation for more collaborative and productive work. Policies about utilization of local flexible funds should reflect the following characteristics:

- Uncommitted to existing services
- Free of unnecessary and arbitrary policy restrictions
- Easily accessible to caseworkers and the child and family team
- Minimally limited by multiple levels of approval*
- Routinely perceived as available at the front line
- If financed by categorical funding streams, the categorical origin is invisible to the front line worker (i.e. matching of cost to funding source should be made at levels other than the worker)
- Retain their flexible funds identity even after they have been committed to a provider for a specific service (i.e. not re-categorized for the long term related to the service provided)
- Applicability to recurring costs (such as an ongoing services) as well as to non-recurring costs (rent or automobile repairs)
- Reflect some parity across service/provider types (i.e. formal vs. informal, agency provider vs. individual provider, recurring vs. non-recurring costs)
- Ability to be quickly committed and paid
- Integrally linked to a needs based, individualized practice culture

** Limiting the layers of approval for flexible funds use does not suggest that competent oversight of the use of flexible funds should be eliminated. Supervisory oversight and staff training are essential for the effective and appropriate use of flexible dollars.*

Services to Families In-Home and Permanency for Children in Out of Home Care

17. Critically assess counties that are outliers in the time of involvement in CHINS cases from open to closure to determine what factors contribute to cases remaining open for lengths of time that exceed the state average by 20 percent or more. Longer length of involvement with families than is absolutely necessary to ensure child safety and permanency consumes precious resources that might be better allocated to families in need of intensive intervention and delays resolution for families. Further, longer lengths of stay in out of home care are associated with greater instability and lowered likelihood of children attaining a legally permanent family.

DCS Budget and Finance

18. DCS should hire or contract with a Medicaid expert with experience in working with child welfare and behavioral health systems to assist it in maximizing the use of Medicaid for services.

DCS Legal Representation

19. DCS should critically assess and take steps to resolve factors that contribute to attorney turnover and lack of expertise in planning and participating in evidentiary hearings

a. DCS is already increasing the number of staff attorneys. While there is a need for more attorneys at this particular time, it should be noted that some of the recommendations of this assessment should result in a decrease in the number of judicially involved cases in DCS. Thus, at some point in the future, the need for attorneys may at least stabilize if not decline somewhat.

b. Attorney pay and job responsibility should be examined as it compares to other public sector attorney positions in Indiana and pay adjusted accordingly.

c. DCS should work with the Indiana Office of Court Services, using the American Bar Association (ABA) standards as guidance to determine optimal caseloads and standards of training for DCS attorneys. Staff at the ABA Center for Courts have expertise in this area and their support can be accessed through Indiana's federal regional office of HHS/ACYF.

d. DCS and the Indiana Office of Court Services should also consult ABA national standards for the representation of families and children to determine areas needing improvement and begin longer range planning to that end. Indiana is to be commended for providing at least basic representation to all parties in CHINS proceedings, but reviewers also heard that the capacity of these representatives is limited by high caseloads and that their work with parents and children is often limited only to in-court time.

20. DCS needs to engage providers immediately in a demonstration of partnership, with a focus on what the provider community needs in order to best serve children and families. This may include, for example, assessment of current policies or procedures, including audit requirements, data collection, or strengthening assessment of outcomes for services.

APPENDIX A

Review of Indiana Child Welfare Statutes

Review of Indiana Statutes and DCS Policies and Comparison to Other States

Introduction

This report was prepared in response to a request by the Child Welfare Policy and Practice Group (CWG) to compare certain of Indiana's "front end" child welfare laws and policies to those of neighboring states to identify differences that might be contributing to the large increase in the number of Indiana children entering foster care in the context of the opioid crisis. This review is part of a larger assessment of Indiana's child welfare system undertaken by CWG at the request of the Indiana Governor's office.

Before discussing the substance of the review, some caveats are in order:

While state statutes and agency policy manuals available on the agency's website provide some insights into how these systems function, caution should be exercised in drawing conclusions based on a review of these documents in isolation, for a number of reasons.

- Most important is that the increase in Indiana's foster care population in the context of the opioid crisis is likely the result of a host of factors that include demographics, resources, agency culture, judicial practice and community norms in addition to law and formal agency policy.
- Also, statutes such as definitions of child abuse and neglect are subject to interpretation, which is likely to vary both among and within jurisdictions.
- Finally, this review is limited to review of state statutes, agency policy manuals and, in some cases, administrative regulations available on the web. Policy can often be found in a wide array of other sources in addition to publicly available statutes and policy manuals, such as transmittals, memoranda, newsletters, training materials, practice models and other forms of policy and practice guidance. Policy may also be unwritten and be based on custom and tradition.

For these reasons, this statute and policy review and comparison to neighboring states does not attempt to draw conclusions, but rather to highlight relevant differences and in some cases raise questions for consideration by policymakers. As such, it may provide an opportunity to take a fresh look at the documents that are intended to guide what agency staff are expected to do to protect children from abuse and neglect.

Methodology

The following states were selected for comparison to Indiana: Illinois, Kentucky, Michigan, Ohio and West Virginia. With the exception of West Virginia, these states border Indiana. West

Virginia was selected based on its proximity to Indiana and the severity of the opioid crisis in that state.

Laws and agency policies in the following categories were identified, compiled, analyzed and compared:

- Definitions of child abuse and neglect, with particular emphasis on definitions of neglect;
- Reporting/Intake/Investigation
 - Mandatory reporters of child abuse and neglect;
 - Centralized intake;
 - Prioritization of reports of child abuse and neglect;
 - Alternative response;
 - Classification of investigation findings and level of evidence;
- Removal of children from home;
- Substance-exposed newborns.

In addition to the foregoing, laws in the following categories were examined at the request of the state and/or CWG:

- Criminal penalties for illegal possession of narcotic drugs;
- Central registry of child abuse and neglect.

It is important to note that this review did not examine laws and policies regarding other aspects of the child welfare system, such as foster care, permanency planning, court process and the like.

Summaries of laws and policies reviewed as well as citations to source material can be found in the Appendix.

Findings

I. Definitions of Child Abuse and Neglect

The following discussion focuses primarily on definitions of neglect, as opposed to physical or sexual abuse. Nationally, neglect is by far the most common form of child maltreatment reported to child welfare agencies. In 2016, 89 percent of child victims of maltreatment in Indiana experienced neglect.⁴ Indiana, like some of the other states reviewed, includes in its definitions prenatal substance exposure, which could be considered a form of neglect. These provisions, however, will be discussed in the section on Substance-Exposed Newborns, below.

⁴ U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*. Available from <https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>.

Indiana's definitions of abuse and neglect are somewhat atypical in that they are located in the statute that defines a Child in Need of Services (CHINS), who, in addition to being a victim of maltreatment, requires the coercive intervention of the court in order to receive needed care, treatment or rehabilitation. Elsewhere in the statutes, the definition of "child abuse and neglect" incorporates by reference the CHINS definitions but, for purposes of reporting and investigating child maltreatment, is not limited to cases that require court intervention. Thus, CHINS are a subset of abused and neglected children, i.e., those that are the subject of CHINS judicial proceedings.

The CHINS definitions include the following: "The child's physical or mental condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent, guardian, or custodian to supply the child with necessary food, clothing, shelter, medical care, education, or supervision." This is not an unusual definition of basic neglect. Some of the comparison states, however, have adopted definitions that appear to qualify or limit cases of neglect to exclude poverty or occasional inattention/lapses in judgment.

- **Illinois:** The definition of "neglected child" includes the following language: "who is subjected to an environment which is injurious insofar as (i) the child's environment creates a likelihood of harm to the child's health, physical well-being, or welfare and (ii) the likely harm to the child is the result of a *blatant disregard* of parent, caretaker, or agency responsibilities;
- **Kentucky:** "*continuously or repeatedly* fails or refuses to provide essential parental care and protection for the child, considering the age of the child." Also: "Engages in a *pattern of conduct that renders the parent incapable* of caring for the immediate and ongoing needs of the child including, but not limited to, *parental incapacity* due to alcohol and other drug abuse;
- **Michigan:** "Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care, *though financially able to do so*, or by the *failure to seek financial or other reasonable means* to provide adequate food, clothing, shelter or medical care.
- **West Virginia:** "Whose physical or mental health is harmed or threatened by a present refusal, failure or inability of the child's parent, guardian or custodian to supply the child with necessary food, clothing, shelter, supervision, medical care or education, *when that refusal, failure or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian.*"

DCS may want to consider whether its broad, unqualified definition of neglect may be bringing more children into care than is necessary.

How Indiana defines the class of caregivers subject to its child welfare laws may also affect the number of children coming into care. Indiana uses the term "parent, guardian or custodian." "Custodian" is defined broadly and means "a person with whom a child resides" and also

includes individuals who own, operate, are employed by or who volunteer at foster homes, child care facilities and child care centers, certain paid caregivers, a member of the household of the child's noncustodial parent, and "an individual who has or intends to have direct contact, on a regular and continuing basis, with a child for whom the individual provides care and supervision."

Two of the other states under review, Ohio and West Virginia, also use the term "parent, guardian or custodian." However, these states are more restrictive in their definitions of "custodian:"

- **Ohio:** "a person who has legal custody of a child or a public children services agency or private child placing agency that has permanent, temporary, or legal custody of a child."
- **West Virginia:** "a person who has or shares actual physical possession or care and custody of a child, regardless of whether such person has been granted custody of the child by any contract, agreement or legal proceedings"

Perhaps because "guardian" and "custodian" have precise legal meanings, the other states have adopted broader terms to describe individuals within the scope of the child welfare laws:

- **Illinois:** "person responsible for the child's welfare"
- **Kentucky:** "person in a position of authority or special trust"
- **Michigan:** "person responsible for the child's health or welfare"

II. Reporting/Intake/Investigation

III.

- D. **Mandatory Reporters:** Indiana and Kentucky are the two states under review in which everyone is a mandatory reporter of child abuse and neglect. Laws in the other states limit mandatory reporters to a list of professionals and others who are likely to come into contact with children, such as law enforcement, teachers, social workers, health care providers, attorneys, child care providers and the like. Interestingly, referral rates per 1,000 children in both Indiana (108.2) and Kentucky (101.9) were almost twice the national average of 55.1 in 2016.⁵
- E. **Centralized Intake:** Indiana has a centralized intake system, as do all the other states with the exception of Ohio, which has a state-supervised, county-administered child welfare system.
- F. **Prioritization of Reports:** In 2016, Indiana screened in 66 percent of abuse and neglect referrals, which is slightly higher than the national average of 58 percent and higher

⁵ U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child maltreatment 2016*. Available from <https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>.

than Kentucky (50.4), Michigan (61.2), Ohio (45.5) and West Virginia (60) (no data from Illinois).⁶ Indiana is unique among the comparison states in that there are least two categories of reports that are automatically screened in: 1) reports from a judge or prosecutor, and 2) reports involving children under age 3 (this latter policy is not in statute or the policy manual).

Once a report is screened in, the timing of a response depends on the level of risk to the child. Indiana does not differ significantly from the comparison states in terms of how it characterizes the highest priority reports:

- **Indiana:** imminent danger of serious bodily harm;
- **Illinois:** immediate danger of physical harm;
- **Kentucky:** fatality or near fatality or child under age 4 at high risk;
- **Michigan:** immediate danger of harm;
- **Ohio:** emergency report;
- **West Virginia:** present danger.

- G. **Alternative Response:** Indiana does not have an alternative or differential response system, unlike Kentucky and Ohio. Illinois enacted legislation in 2017 that allows, but does not require, a differential response program.

Indiana does have a statute that authorizes DCS to implement a program of “informal adjustment” with a family if DCS has probable cause to believe that the child is a child in need of services. DCS is required to seek approval from the juvenile court before it may implement a program of informal adjustment. The court may deny such request if it finds that 1) there is no probable cause to believe that the child is need of services, or 2) the coercive intervention of the court is required. The program of informal adjustment is deemed approved if the court does not act on the request within a specified time.

Requiring court approval to provide services to a family before a dependency and neglect proceeding is initiated is unusual. In most states, the child welfare agency may, in appropriate circumstances, open a case and work with a family without prior court involvement. The Indiana statute raises several questions: How often is the statute utilized? How often does the court deny a request for informal adjustment on the basis that coercive intervention of the court is required? What might be the effect of this statute on the number of CHINS proceedings opened and the number of children entering care?

⁶ Ibid.

H. Classification of Investigation Findings and Level of Evidence: The level of evidence required to support a child abuse and neglect finding could affect the substantiation rate and, by extension, the rate of foster care entries. In Indiana, investigated reports of child maltreatment are either “substantiated” (based on a preponderance of the evidence) or “unsubstantiated” (based on credible evidence). Three of the comparison states (Kentucky, Michigan and West Virginia) and the vast majority of other states in the U.S. also use the preponderance standard. Thus, Indiana’s level of required evidence does not differ from the norm.

Classification and levels of evidence in the comparison states are as follows:

- **Illinois:** unfounded (no credible evidence); indicated (credible evidence of child abuse or neglect); undetermined (cannot initiate or complete investigation).
- **Kentucky:** unsubstantiated (insufficient evidence); substantiated (admission, judicial finding or preponderance of the evidence); child fatality/near fatality; unable to locate child; services needed for child or family.
- **Michigan:** Category V: services not needed; Category IV: services recommended (no preponderance of evidence); Category III: services needed (preponderance); Category II: child protective services needed; Category I: court petition required.
- **Ohio:** substantiated (admission, adjudication or other confirmation); indicated (circumstantial or other isolated indicators); unsubstantiated (no child abuse or neglect found); family moved; unable to locate.
- **West Virginia:** maltreatment occurred (preponderance of credible evidence); maltreatment did not occur (preponderance of credible evidence).

IV. Removals

Law and policy governing the circumstances under which a removal of a child from home is warranted clearly affect the number of children entering foster care. In Indiana, the majority of children in CHINS proceedings have been removed from home. Of the 14,763 children in open CHINS cases at the end of SFY 2014, 10,550 (72 percent) were placed in out-of-home care.⁷

The DCS policy manual contains the following provision:

“The Indiana Department of Child Services (DCS) will remove a child from his or her parent, guardian, or custodian if:

4. A reasonable person would believe that the child’s physical or mental condition is seriously impaired or seriously endangered due to injury by the act or omission of the child's parent, guardian or custodian; or

⁷ Department of Child Services, Presentation to the House Family, Children & Human Affairs Committee, January 14, 2015.

5. The child's physical or mental condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent, guardian or custodian to supply the child with necessary food, clothing, shelter, medical care, education or supervision; and
6. The coercive intervention of the court is needed (taken) to protect the child.”

The circumstances described above under which DCS will remove a child, mirror the two CHINS definitions of general abuse and neglect. This policy is puzzling because it implies that any child who meets one or both of these definitions will be removed from home. Actual practice, however, is that at least a minority of CHINS are served in-home. This raises the question: What distinguishes out-of-home versus in-home CHINS, since both must meet definitions of abuse or neglect requiring the coercive intervention of the court?

Although Indiana and federal law require DCS to make reasonable efforts to prevent the need for removal of a child from home, the policy manual is mostly silent on this point except to reiterate the need for a judicial finding of reasonable efforts in order to qualify for federal funding.

In contrast, Illinois law and policy makes clear that removal is only warranted when a child “cannot be cared for at home or in the custody of the person responsible for the child's welfare without endangering the child's health or safety.” Similarly, Ohio’s regulations state: “If the public children services agency (PCSA) or private child placing agency (PCPA) has determined a child cannot be maintained safely through the implementation of voluntary safety planning, the PCSA or PCPA shall pursue removal of the child from the home.”

V. Substance-Exposed Newborns

Laws and policies in this category were included because of the increasing prevalence of prenatal substance exposure in the context of the opioid epidemic. All of the states under review have some policy in this area. Indiana calls out prenatal substance exposure in its CHINS definitions, as does Illinois. Kentucky and Michigan require reporting of newborns affected by maternal substance use. Ohio and West Virginia have adopted policies that govern intake of reports of prenatal substance exposure.

The Child Abuse Prevention and Treatment Act (CAPTA) requires a state that receives part of the \$26 million in state CAPTA grants to have policies and procedures to address the needs of infants affected by prenatal substance exposure, including a requirement to report such infants to child welfare agencies and the development of a plan of safe care for each such infant that addresses the treatment needs of the infant and affected family or caregiver.

Only one state, Ohio, mentions the plan of safe care in the policies reviewed. Ohio’s regulations spell out in detail the information regarding the plan of safe care that is to be collected when a report of a substance-exposed infant is received. The regulations prohibit screening out a referral if the plan of safe care information is not obtained, the plan of safe care has not been developed, or the plan of safe care is not adequate to address the safety of the infant.

VI. Criminal Penalties for Drug Possession

In the course of CWG's assessment, the question was raised whether a recent reduction in Indiana's criminal penalties for drug possession may be affecting rates of child maltreatment because perpetrators are spending less time in prison. This report cannot answer that question, but it does summarize criminal penalties for illegal drug possession across the six states under review. This summaries in the Appendix are based on the following parameters:

- They focus on penalties for illegal possession for personal use, as opposed to manufacture, transport, distribution, trafficking, sale, etc.
- They are intended to be limited to Schedule I or II controlled substances identified as opiates or narcotics, such as heroin, oxycodone, fentanyl, etc., as opposed to hallucinogens, stimulants, etc.

Comparing penalties across states is challenging because prison terms and fines are calculated differently based on quantity, type of drug, unit of measurement, etc. The penalty structure is quite complex in some states (e.g., Ohio) and simple in others (e.g., West Virginia). By way of illustration, the following example compares potential prison terms for possession of 15 grams of heroin:

- Illinois: 4 – 15 years
- Indiana: 2 – 12 years, 6 years advised
- Kentucky: 3 years maximum
- Michigan: 4 years maximum
- Ohio: mandatory term of 2-8 years
- West Virginia: 90 days to six months

Based on this example, Indiana's penalties appear to be within the "normal" range represented by the states under review.

VII. Central Registries

The review of central registry laws and policies focused on 1) the contents of the registries, 2) access to registries for purposes of employment screening, 3) the right to appeal findings, and 4) expunction of records.

- **Illinois:**
 - Central register is to contain all initial, preliminary and final reports regarding all cases of suspected child abuse or neglect.
 - Included among those provided access to child abuse and neglect records: The operator of a licensed child care facility or a facility licensed by the Department of Human Services in which children reside when a current or prospective employee of the facility is the perpetrator in an indicated child abuse and neglect report.

- A perpetrator may request that a record be amended or removed from the register and shall be entitled to a hearing within the Department to determine whether the record should be amended or removed on the grounds that it is inaccurate or it is being maintained in a manner inconsistent with law.
- Unfounded reports are to be expunged forthwith, except as follows:
 - Reports where the subject of the report requests that the record not be expunged because the subject alleges an intentional false report was made;
 - Reports classified as priority 1 or priority 2 in accordance with the department's rules, or the report was made by a mandated reporter;
 - Reports involving the death, sexual abuse, or serious physical injury of a child will be maintained for 3 years;
 - All other unfounded reports for 12 months following the date of the final finding.

If an individual is the subject of a subsequent investigation that is pending, the department shall maintain all prior unfounded reports pertaining to that individual until the pending investigation has been completed or for 12 months, whichever is longest.

- Identifying information on all other records shall be removed from the register no later than 5 years after the report is indicated, with certain exceptions.

- **Indiana:**

- The child protection index contains data regarding substantiated reports of child abuse and neglect.
- A child care provider, upon submission of written consent by an individual who 1) is employed by or who has applied for employment with the provider, 2) has volunteered with the provider in a capacity that would place the individual in direct contact with children on a regular and continuous basis, or 3) is at least 18 years of age and resides in the home of the provider, may have access to any information related to a substantiated report that names the individual as the perpetrator.
- The perpetrator may request an administrative hearing to amend or expunge a substantiated report. At the hearing, DCS must prove by a preponderance of credible evidence that the perpetrator is responsible for the child abuse or neglect. If DCS fails to carry its burden of proof, the report shall be expunged or amended as ordered by the hearing officer. This section does not apply to substantiated reports if a court has determined that the child is a child in need of services.
- An individual identified as a perpetrator may file a petition with a court exercising juvenile jurisdiction to expunge a substantiated report. The court may consider the factors listed in IC 31-39-8-3 and any facts relating to the perpetrator's current status, activities, employment, contacts with children or other relevant circumstances. The court may grant the petition if it determines

that there is little likelihood that the petitioner will be a future perpetrator of child abuse or neglect.

- **Kentucky:**

- The central registry shall include the name of each individual who has been found to have abused or neglected a child and who has waived the right to appeal a substantiated finding or whose substantiated finding was upheld on appeal.
- The cabinet shall conduct a check of the central registry for each individual who applies for licensure, is hired by or volunteers with an entity required by law to obtain information from the registry or an entity that may require a central registry check as a condition for working with children on a regular basis.
- A person who has been found to have abused or neglected a child may appeal the finding through an administrative hearing.
- Each name shall remain on the central registry for 7 years and removed thereafter, with certain exceptions.

- **Michigan:**

- If the department classifies a report of suspected child abuse or neglect as a central registry case, the department shall maintain a record and notify the perpetrator. "Central registry case" means a child protective services case that the department classifies as category I or category II.
- Upon written request, the department may release documentation that a person is not named in the central registry as a perpetrator of child abuse or neglect. The recipient or the department may share the document with whoever is appropriate for the purpose of seeking employment or serving as a volunteer to work with children.
- A person who is the subject of a report may request the department to amend the record from the central registry or request a hearing to expunge the record.
- If the investigation of a report does not show child abuse or neglect by a preponderance of the evidence, the report shall be expunged. Otherwise, the record will be maintained for 10 years or, in the case of certain severe child abuse or neglect, until the perpetrator is dead.

- **Ohio:**

- Ohio's Central Registry is a confidential database that contains allegations of reports of child abuse and neglect and the parties involved.
- Central Registry information may be released only to: (1) the subject of the information, (2) an agency processing foster/adoption applications, or a CSA investigating a report of child abuse and/or neglect. If an employer requires Central Registry search results as a condition of employment, the individual may request the search on their own and provide a copy of the results letter to the employer.
- Information contained in the Central Registry is entered by the public children service agency (PCSA) that investigated the report of child abuse and/or neglect and only the originating PCSA has the ability to adjust any information in the

report. The subject of the search may contact the PCSA for information about their appeal and/or grievance procedures.

- Expunction not addressed in source material.
- **West Virginia:**
 - Establishes a child abuse and neglect registration system to be maintained by the State Police for those convicted of certain crimes against children. Registration is active for 10 years after release from confinement or placement on probation, parole, etc. Information is confidential and may be disclosed to the individual and to law enforcement and government agencies with a need for such information.

Conclusion

The foregoing discussion makes clear that some of Indiana's "front end" policies are similar to those of surrounding states, but that there are also differences that may be significant in terms of their effect on the increase in the number of children entering foster care. Again, this report is not intended to draw conclusions or make recommendations but rather to raise questions and highlight issues for discussion and consideration by agency leadership and other policymakers.

Appendix B



Parent-Child Assistance Program (PCAP)

Parent-Child Assistance Program

The Parent-Child Assistance Program (PCAP) is an evidence-based home visitation case-management model for mothers who abuse alcohol or drugs during pregnancy. Its goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs.

Director: Therese Grant, Ph.D.

Our Background and Vision

In the mid-1980's when cocaine was a popular drug of choice, Dr. Ann Streissguth and her research team at the University of Washington Fetal Alcohol and Drug Unit were awarded a federal grant to study the effects of prenatal cocaine exposure on infants and young children. The research protocol involved enrolling 500 high-risk mothers who had abused cocaine during pregnancy, interviewing them, and bringing their babies into our lab for periodic neuropsychological and other assessment.

Study findings confirmed our hypothesis that prenatal cocaine exposure is not a good thing, but in many ways the most important lessons were those we learned directly from the mothers themselves. We listened carefully as we spent time with them in their cramped apartments listening to stories of family dysfunction that seemed horrific to young researchers, but were "just the way it is" to them. These mothers wanted to be "good mothers" but they were instead giving their babies the same kind of upbringing they had experienced as children. They didn't know any other way.

As the cocaine study came to an end, a compelling challenge that faced our research team was how to work in a meaningful way with the high-risk mothers who delivered these babies. Under Dr. Streissguth's mentorship, the PCAP model was developed in 1991 because we understood that these mothers were themselves the abused, neglected, and deprived children of just a decade or two ago. Turning our backs on them because they are difficult to work with does not make their problems go away. It does ensure that these women will continue to experience a host of problems associated with intergenerational substance abuse, and continue to bear children who suffer in turn. PCAP undertook the challenge to find a way to connect with this population.

PCAP's primary aims are:

- to assist substance-abusing pregnant and parenting mothers in obtaining alcohol and drug treatment, staying in recovery, and resolving myriad complex problems related to their substance abuse;

- to assure that the children are in safe, stable home environments and receiving appropriate health care;
- to link mothers to community resources that will help them build and maintain healthy, independent family lives;
- to prevent the future births of alcohol and drug-affected children.

Sobriety Treatment and Recovery Teams (START)

About This Program

Target Population: Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor

Brief Description

START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. **START** pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into **START** services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each **START** CPS worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.

Program Goals:

The goals of **Sobriety Treatment and Recovery Teams (START)** are:

- Ensure child safety
- Reduce entry into out-of-home care, keeping children in the home with the parent when safe and possible
- Achieve child permanency within the Adoptions and Safe Families Act (ASFA) timeframes, preferably with one or both parents or, if that is not possible, with a relative
- Achieve parental sobriety in time to meet ASFA permanency timeframes
- Improve parental capacity to care for children and to engage in essential life tasks
- Reduce repeat maltreatment and re-entry into out-of-home care
- Expand behavioral health system quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues
- Improve collaboration and the system of service delivery between child welfare and mental health treatment providers

Contact Information

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Appendix C

Source Documents Include:

- Annual Progress and Services Report
- Child and Family Services Review Findings
- Court Improvement Program Website
- DCS Policy Manuals
- DCS Website
- Indiana General Assembly website
- Indiana.gov
- Indiana's Management and Performance Hub ([MPH](#))
- Program Improvement Plan
- Substance Abuse and Mental Health Services Administration

Appendix D

Paul Vincent, MSW, LCSW

Director, The Child Welfare Policy and Practice Group

Paul Vincent is the founder and Director of The Child Welfare Policy and Practice Group, a nonprofit technical assistance organization created in 1996. The Child Welfare Group directs its technical assistance toward improving outcomes for children and families through strengthening front-line practice.

Current work involves child welfare systems in Michigan, Pennsylvania, Illinois, Philadelphia, Los Angeles, California, Oklahoma, Florida and Indiana. Work in these systems includes strategic planning, curriculum development and training, front-line practice coaching and system evaluation.

Mr. Vincent directs the overall work of the organization and represents it and the front-line practice perspective in various national policy forums and foundation initiatives. He also leads the organization's participation in class action litigation, such as in Los Angeles, where he serves as Chair of the Katie A. Advisory Panel in California, and in South Carolina, where he serves as co-monitor in the Michelle H. Settlement Agreement. The Child Welfare group was also court monitor in Utah through its exit from court oversight.

Prior to the creation of The Child Welfare Group, Mr. Vincent was the director of Alabama's child welfare system during a period of class action litigation, from 1989 to 1996. During that period Alabama emerged as a national leader in demonstrating improved outcomes through implementation of a strength and needs-based, individualized model of practice. Mr. Vincent and staff, along with the federal court monitor, also developed the Qualitative Service Review process during the same period. He was awarded NAPCWA's Annual Award for Excellence in Child Welfare Administration in 1994.

Sue D. Steib, PhD, LCSW

Independent Consultant, The Child Welfare Policy and Practice Group

Sue Steib has over 45 years of child welfare experience including direct practice, agency administration, research, and consultation. Prior to joining the Child Welfare Policy and Practice Group as an independent consultant in May 2016, she was a Sr. Director of Strategic Consulting at Casey Family Programs (CFP), a position she held for eight years. During that time, she led CFP's work in two states and served as part of a consulting team providing support to child welfare systems in 15 states. From 2001 to 2008, Dr. Steib was Director of the Research to Practice Initiative at the Child Welfare League of America (CWLA), leading work to synthesize current research in child welfare and related fields while making it accessible to agency leaders and direct practitioners through papers, workshops, and direct consultation. Dr. Steib came to CWLA following a 31-year career in Louisiana's child welfare system where she served in positions ranging from caseworker to supervisor, ultimately serving as the statewide Child Welfare Program Director.

Freida Baker, MSW

Program Coordinator, The Child Welfare Policy and Practice Group

Freida Baker served as the Deputy Director of Family Services for the Alabama State Department of Human Resources. She has 35 years' experience in child welfare beginning her career as a Social

Worker, then Supervisor, and Program Manager prior to her appointment as Deputy. She was instrumental in preparation for two federal Child and Family Services Reviews (CFSR's) in Alabama and is keenly well-versed in current federal policies related to children and families. She is a certified Federal State Reviewer and has participated in the CFSR process nationally. She participated closely as a Program Manager in the implementation of Alabama's landmark R.C. Consent Decree and has expertise in systems and change management. She is also LAMM certified. She has for years conducted trainings and facilitated excellence across the nation for social workers, the judiciary, educators, foster parents, and physicians. Mrs. Baker has taught for the University of Alabama and is a guest lecturer for social work classes across the country.

George Taylor, MA Psychology
Senior Associate, The Child Welfare Policy and Practice Group

George Taylor is one of the founding members of CWG and has been involved in the majority of the group's projects in more than ten states and major jurisdictions. He has been principally involved in the assessment of systems intended to provide child welfare or mental health services to children, youth, and families; the development of strategic plans; training direct practice and assessment skills; and in the analysis of formal and informal evaluation results.

Examples of current and recent work include supporting the monitoring of a statewide child welfare reform in Utah, consulting with the Center for Community Partnerships in Child Welfare in the national rollout of the community partnership initiative supported by the Annie E. Casey Foundation and the Edna McConnell Clark Foundation, as part of an external evaluation of privatized child welfare services in Broward County, Florida, and providing data consultation and analytic support for the Katie A. Advisory Panel, which advises the Los Angeles County Department of Children and Family Services (DCFS) on the implementation of a settlement agreement designed to improve outcomes for children and youth with mental health needs served by the Los Angeles County DCFS.

Taylor retired from the University of Alabama's multi-service training and treatment center that addresses training, research, and services for children and adolescents with complex mental health needs, and for their families. In Alabama, Taylor was active in the statewide provider organization and was its president during the critical years of the Alabama child welfare reform.