**RESPONSE TO**

**REQUEST FOR PROPOSAL**

**CRFP 0506 HHR2000000001**

**Department of Health and Human Resources**

**DOJ Subject Matter Services**

**Vendor:**

The Child Welfare Policy and Practice Group
428 East Jefferson Street
Montgomery, Alabama 36104
Telephone: 334-264-8300
Cell:334-451-0314

**Contact Person**: Freida S. Baker, Executive Director
fbaker@childwelfaregroup.org

Freida S Baker
Vendor Signature

9-12-19
Date

# REQUEST FOR PROPOSAL
# CRFP 0506 HHR2000000001
## Department of Health and Human Resources
## DOJ Subject Matter Expert Services

| |
|---|
| **The Child Welfare Policy and Practice Group** |
| 428 East Jefferson Street<br>Montgomery, Ala 36104 |
| 428 East Jefferson Street<br>Montgomery, Ala 36104<br>334-264-8300 |
| Fax: 334-264-8310 |
| fbaker@childwelfaregroup.org |
| Contact Person: Freida S. Baker |
| |
| **Signature:** Freida S Baker |
| Date: 9-12-2019 |

Table of Contents

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

**State of West Virginia**
**Request for Proposal**
**10 — Consulting**

**Proc Folder:** 612158

**Doc Description:** RFP - DOJ Subject Matter Expert Services

**Proc Type:** Central Master Agreement

| Date Issued | Solicitation Closes | Solicitation No | Version |
|---|---|---|---|
| 2019-08-08 | 2019-09-13 13:30:00 | CRFP 0506 HHR2000000001 | 1 |

**BID RECEIVING LOCATION**

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

**VENDOR**

**Vendor Name, Address and Telephone Number:**

The Child Welfare Policy and Practice Group
428 East Jefferson Street
Montgomery, AL 36104
334-264-8300

**FOR INFORMATION CONTACT THE BUYER**

Mark A Atkins
(304) 558-2307
mark.a.atkins@wv.gov

**Signature X** Fred J Baker **FEIN #** 72-1364474 **DATE** 9/12/19

**All offers subject to all terms and conditions contained in this solicitation**

**ADDITIONAL INFORMATION:**

The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the "Purchasing Division") is issuing this solicitation as a request for proposal ("RFP"), as authorized by W. Va. Code 5A-3-10b, for the Department of Health and Human Resources (hereinafter referred to as the "Agency") to provide Subject Matter Expert (SME) services in the design and delivery of children's mental health services and to provide technical assistance to the Agency to reach compliance with the Memorandum of Understanding between the United States Department of Justice and the state of West Virginia, dated May 14, 2019 (hereinafter referred to as the "Agreement") per the attached documents.

Note: Online response to this RFP is prohibited. Please refer to the "Instructions to Bidders" and the RFP Document Section 5.3 "Proposal Format" for instructions on submitting a proposal response.

| INVOICE TO | SHIP TO |
|---|---|
| BUYER - 304-957-0209<br>HEALTH AND HUMAN RESOURCES<br>OFFICE OF THE SECRETARY<br>ONE DAVIS SQUARE, FIRST FLOOR, EAST<br>CHARLESTON WV25301<br>US | BUYER - 304-957-0209<br>HEALTH AND HUMAN RESOURCES<br>OFFICE OF THE SECRETARY<br>ONE DAVIS SQUARE, FIRST FLOOR, EAST<br>CHARLESTON WV 25301<br>US |

| Line | Comm Ln Desc | Qty | Unit Issue | Unit Price | Total Price |
|---|---|---|---|---|---|
| 1 | Project Monitoring & Evaluation (submit Attachment_A) | 0.00000 | HOUR | | |

| Comm Code | Manufacturer | Specification | Model # |
|---|---|---|---|
| 80101606 | | | |

**Extended Description :**

Note: Vendors must submit Attachment_A Cost Sheet for bid pricing.

The per hour rate is an all-inclusive hourly rate for general and administrative expenses, including travel, training and supplies necessary to provide the services required in this solicitation.

**SCHEDULE OF EVENTS**

| Line | Event | Event Date |
|---|---|---|
| 1 | Mandatory Pre-Bid Conference 1:30pm EDT | 2019-08-22 |
| 2 | Technical Questiond due by 10:00am EDT: | 2019-08-29 |

West Virginia Ethics Commission

# Disclosure of Interested Parties to Contracts

(Required by *W. Va. Code* § 6D-1-2)

**Name of Contracting Business Entity:** The Child Welfare Policy and Practice Group **Address:** 428 East Jefferson Street Montgomery, AL 36104

**Name of Authorized Agent:** Freida S. Baker **Address:** 428 East Jefferson

**Contract Number:** CRFP 0506 HHR2000000001 **Contract Description:** DOJ Subject Matter Expert Services

**Governmental agency awarding contract:** West Virginia Division of Health

☑ **Check here if this is a Supplemental Disclosure**

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below *(attach additional pages if necessary)*:

1. **Subcontractors or other entities performing work or service under the Contract**
   ☐ Check here if none, otherwise list entity/individual names below.

2. **Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)**
   ☑ Check here if none, otherwise list entity/individual names below.

3. **Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)**
   ☑ Check here if none, otherwise list entity/individual names below.

Signature: Freida S. Baker Date Signed: 9-12-2019

## *Notary Verification*

State of Alabama, County of Montgomery:

I, Freida S. Baker, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 12th day of September, 2019.

Nina Vickrey-Kinard
Notary Public's Signature

***To be completed by State Agency:***

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

*Revised June 8, 2018*

# Disclosure of Interested Parties to Contracts

**Subcontractors**

Sue Steib

Beatrice Salazar

Paul Vincent

STATE OF WEST VIRGINIA
Purchasing Division

# PURCHASING AFFIDAVIT

**CONSTRUCTION CONTRACTS:** Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

**ALL CONTRACTS:** Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

**EXCEPTION:** The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

**DEFINITIONS:**

**"Debt"** means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

**"Employer default"** means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

**"Related party"** means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

**AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.**

**WITNESS THE FOLLOWING SIGNATURE:**

Vendor's Name: The Child Welfare Policy and Practice Group

Authorized Signature: Freida S. Bahr Date: _____

State of Alabama

County of Montgomery, to-wit:

Taken, subscribed, and sworn to before me this 12 day of September, 2019.

My Commission expires May 2, 2020.

**AFFIX SEAL HERE**

**NOTARY PUBLIC** Nina Vickrey Kynard

# REQUEST FOR PROPOSAL
# CRFP 0506 HHR2000000001
## Department of Health and Human Resources
## DOJ Subject Matter Expert Services

**6.8. Availability of Information:** Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d.

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

The Child Welfare Policy and Practice Group
(Company)

Freida S. Baker
Freida S. Baker, Executive Director
(Representative Name, Title)

334-264-8300
(Contact Phone/Fax Number)

September 12, 2019
(Date)

**DESIGNATED CONTACT:** Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

Freida S. Baker
(Name, Title)

Executive Director
**(Printed Name and Title)**

428 East Jefferson Street, Montgomery, AL 36104
(Address)

334-264-8300/334-264-8310
(Phone Number) / (Fax Number)

fbaker@childwelfaregroup.org
(email address)

**CERTIFICATION AND SIGNATURE:** By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

The Child Welfare Policy and Practice Group
(Company)

Freida S. Baker
(Authorized Signature) (Representative Name, Title)

Freida S. Baker, Executive Director
(Printed Name and Title of Authorized Representative)

September 12, 2019
(Date)

334/264-8300/264-8310
(Phone Number) (Fax Number)

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

**State of West Virginia**
**Request for Proposal**
**10 — Consulting**

**Proc Folder:** 612158

**Doc Description:** ADDENDUM #1: RFP - DOJ Subject Matter Expert Services

**Proc Type:** Central Master Agreement

| Date Issued | Solicitation Closes | Solicitation No | Version |
|---|---|---|---|
| 2019-09-05 | 2019-09-13 13:30:00 | CRFP 0506 HHR2000000001 | 2 |

**BID RECEIVING LOCATION**

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

**VENDOR**

**The Child Welfare Policy and Practice Group 428 East Jefferson Street, Montgomery, Alabama 36104**

**FOR INFORMATION CONTACT THE BUYER**

Mark A Atkins
(304) 558-2307
mark.a.atkins@wv.gov

Signature X Fredrick A. Bahn FEIN # 72-1364474 DATE September 12, 2019

All offers subject to all terms and conditions contained in this solicitation

## ADDITIONAL INFORMATION

ADDENDUM No. 01: Is issued for the following:

1. To publish the Agency's response to the questions submitted by Vendors during the Technical Questioning period.

2. To publish the mandatory Pre-Bid attendance sheets.

No other changes made.

The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the "Purchasing Division") is issuing this solicitation as a request for proposal ("RFP"), as authorized by W. Va. Code 5A-3-10b, for the Department of Health and Human Resources (hereinafter referred to as the "Agency") to provide Subject Matter Expert (SME) services in the design and delivery of children's mental health services and to provide technical assistance to the Agency to reach compliance with the Memorandum of Understanding between the United States Department of Justice and the state of West Virginia, dated May 14, 2019 (hereinafter referred to as the "Agreement") per the attached documents.

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| BUYER - 304-957-0209<br>HEALTH AND HUMAN RESOURCES<br>OFFICE OF THE SECRETARY<br>ONE DAVIS SQUARE, FIRST FLOOR, EAST<br>CHARLESTON WV25301<br>US | BUYER - 304-957-0209<br>HEALTH AND HUMAN RESOURCES<br>OFFICE OF THE SECRETARY<br>ONE DAVIS SQUARE, FIRST FLOOR, EAST<br>CHARLESTON WV 25301<br>US |

| Line | Comm Ln Desc | Qty | Unit Issue | Unit Price | Total Price |
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| 1 | Project Monitoring & Evaluation (submit Attachment_A) | 0.00000 | HOUR | | |

| Comm Code | Manufacturer | Specification | Model # |
|---|---|---|---|
| 80101606 | | | |

**Extended Description :**

Note: Vendors must submit Attachment_A Cost Sheet for bid pricing.

The per hour rate is an all-inclusive hourly rate for general and administrative expenses, including travel, training and supplies necessary to provide the services required in this solicitation.

## SCHEDULE OF EVENTS

| Line | Event | Event Date |
|---|---|---|
| 1 | Mandatory Pre-Bid Conference 1:30pm EDT | 2019-08-22 |
| 2 | Technical Questiond due by 10:00am EDT: | 2019-08-29 |

**ADDENDUM ACKNOWLEDGEMENT FORM**
**SOLICITATION NO.:** CRFP 0506 HHR2000000001

**Instructions:** Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

**Acknowledgment:** I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

**Addendum Numbers Received:**
(Check the box next to each addendum received)

| | | | |
|---|---|---|---|
| [ x ] | Addendum No. 1 | [ ] | Addendum No. 6 |
| [ ] | Addendum No. 2 | [ ] | Addendum No. 7 |
| [ ] | Addendum No. 3 | [ ] | Addendum No. 8 |
| [ ] | Addendum No. 4 | [ ] | Addendum No. 9 |
| [ ] | Addendum No. 5 | [ ] | Addendum No. 10 |

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

The Child Welfare Policy and Practice Group
Company

Authorized Signature

September 12, 2019
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

# Proposal of the Child Welfare Policy and Practice Group in Response to West Virginia Request for Proposal CRFP 0506 HHR2000000001

## I. Project Overview

### A. Background

The West Virginia Department of Health and Human Resources (DHHR) has entered into an agreement with the United States Department of Justice to ensure compliance with the Americans with Disabilities Act (ADA) in the provision of mental health services for the target population described below:

"All children under the age of 21 who (a) have a serious emotional or behavioral disorder or disturbance that results in a functional impairment, and (i) who are placed in a residential mental health treatment facility or (ii) who reasonably may be expected to be placed in a residential mental health treatment in the near future; and (b) meet the eligibility requirements for mental health services provided or paid for by the Department of Health and Human Resources."[1]

The referenced agreement provides that DHHR will contract with a subject matter expert (SME) to offer technical assistance to DHHR in its efforts to comply with the terms of the agreement in the implementation of trauma-informed, community-based mental health services to the target population. This document outlines the experience, qualifications, and methodology that the Child Welfare Policy and Practice Group (CWG) will bring to this work.

### B. Project Goals and Mandatory Requirements

The RFP sets forth specific goals and mandatory requirements that pertain to them. The designated Subject Matter Expert (SME) will be expected to fulfill the following goals and objectives:

- Provide technical assistance to help the Agency reach compliance with the Agreement. Specifically, the Agreement requires the Agency to (i) increase the availability and quality of in-home and community based mental health services; (ii) decrease the unnecessary use of residential mental health treatment facilities; and (iii) develop a quality assurance and performance improvement system.
- Provide a semi-annual assessment of the Agency's compliance with the Agreement, including the implementation plan and all supplements and schedules.
- Provide any recommendations to facilitate the Agency's compliance.
- Prepare a comprehensive report on the Agency's compliance including recommendations to facilitate or sustain compliance.

Mandatory requirements associated with the above goals and objectives are as follows:

- Provide a baseline report with preliminary observations and recommendations by November 14, 2019.
- Provide a semi-annual (every six months) comprehensive report on the Agency's compliance with the Agreement, including recommendations to facilitate compliance.

- Provide technical assistance to the Agency on the development and delivery of statewide children's mental health services.

II. Qualifications and Experience of the CWG and Project Team

A. CWG

The Child Welfare Policy and Practice Group is a non-profit technical assistance organization, created in 1996. Its focus has been on system change through provision of strategic planning, curriculum development, direct staff training and training of trainers, front line supervision and practice coaching, and system evaluation. Technical assistance has primarily involved child welfare systems, but CWG has also assisted children's mental health systems both as a provider of technical assistance and as a court monitor. CWG's evaluation work has a unique feature which assesses practice quality though use of the Quality Service Review© (QSR). Since 1996, CWG has provided some level of assistance and support in thirty-one states. CWG's existence grew out of a class action lawsuit against the Alabama child welfare system, R.C. vs. Hornsby brought by the Bazelon Center for Mental Health Law on behalf of a plaintiff class consisting of children with mental health needs in the child welfare system. The former CWG Director, Paul Vincent, was the recently appointed child welfare director in Alabama when the case was settled and led the reform through its first six years. That reform achieved significant improvements in child and family outcomes and created a number of successful strategies that have since been adopted around the country. The QSR, the Family Team Conferencing approach, use of Medicaid Targeted Case Management in child welfare, and the extensive use of local flexible funds for service tailoring all grew out of that reform.

CWG is committed to working with agencies to improve outcomes for children, youth and families in ways that are effective and sustainable. Like many child serving agencies within behavioral health and child welfare systems, CWG embraces the philosophy, principles, and core values applicable to systems of care. The Substance Abuse Mental Health Service Agency (SAMHSA) defines system care as, "A coordinated network of community-based services and supports organized to meet the challenges of children and youth and their families." The core components and principles of care embraced by CWG mirror those reflected in the memorandum of understanding between WVDHHR and the USDoJ.

Hallmarks and features of CWG work include:

- Systems assessments and strategic planning, oversight, and support.
- Practice model and or curriculum development.
- Quality Service Reviews© conducted and coached in real time with staff, partners, and families.
- Child and Family Team Meetings design, coaching, and mentoring
- Well-developed knowledge of federal child welfare laws, policies, and procedures and their implications for local systems.
- Demonstrated success in working across child welfare system to improve outcomes.

CWG's evaluation and technical assistance experience is extensive and has involved the following child welfare and/or child and adolescent mental health systems: Alabama, Arkansas,

District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Los Angeles County, Louisiana, Michigan, Missouri, New Jersey, New York, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Wisconsin, and Wyoming.

The assessment and quality assurance processes used by CWG are designed to identify and understand key factors that affect system outcomes. Such understanding is required as a basis for designing effective and reasonable pathways to improved performance in maintaining children safely in their own homes and enabling necessary out of home placements at the least restrictive level possible. Projects that illustrate CWG's approach are discussed below as they pertain to the specific areas of SME called for in the RFP: It is important to note that CWG's work in many jurisdictions has been multifaceted, encompassing several or all of the areas of experience outlined in the RFP.

**RFP 4.3.1.1.**The delivery, design, and implementation of children's mental health services was entailed in particular in CWG's work in Arizona and Los Angeles County, California.

- **Arizona.** In Arizona, CWG assisted the state to develop a greater service array for children with mental and behavioral health needs. The child and family teaming planning model (CFTM) was introduced and integrated into daily practice, and became a vehicle for families and professionals to identify and craft individualized in-home or community-based services. Partnerships with local mental health, child welfare, education and other entities were strengthened through greater transparency and by widening the circle of input and participation through the teaming process.. Many providers quickly expressed interest in diversifying services, largely driven by the CFTM process' greater transparency and inclusion. At the time this work began, 300 Arizona children were placed in residential treatment outside of the state. All of those were ultimately returned to the state for reunification and the focus on meeting their needs contributed to the development of in-home and community-based treatment and other services. Child and family team meetings were conducted onsite for those children and youth, and were facilitated by CWG for direct planning purposes, as well as for teaching the principles of family-focused planning to the professionals and informal team members involved in each case. Planning focused on avoiding step-down congregate care placements in order to return children to their communities.
- **Escambia County, Florida.** CWG worked with Families First in Escambia County, Florida to design children's behavioral health and case management services. This included the programming for children in both therapeutic foster care and residential settings.
- **Los Angeles County, California**. CWG has supported the implementation of the Katie A. Settlement Agreement (a mental health agreement) in Los Angeles for over 15 years. The shared goal of the mental health and child welfare agencies and private providers there is a comprehensive, interagency, community-based system of services and supports in which agencies, providers, relatives, foster families and informal caregivers work together collaboratively to meet children's needs to prevent them from entering foster care and to experience better outcomes while they are in foster care. Many CWG consultant and leadership staff have supported the work there, coaching and conducting Quality Service Reviews, congregate care studies, and evaluation of other important components of the

system. As noted above, proposed West Virginia CWG team member Paul Vincent continues to serve on the Katie A. Panel and brings rich experience and current context to any child and adolescent mental health systems assessment or discussion. Freida Baker, another member of the CWG team in this proposal, has also worked in Los Angeles.

The Katie A. agreement requires the state to develop three types of previously unavailable community-based mental health services for child welfare-involved youth. Foster youth and children at risk of out-of-home placement became entitled by law to *Katie A.* services. As a result, thousands of youth became eligible for services that are intended to reduce institutionalization and criminalization of children and youth. *Katie A.* has served as a model for other states seeking to expand the array of legally required services provided to youth with mental health challenges. CWG brings a unique set of skills, experience, and perspective to any assessment of a child and adolescent mental health system based on the participation of panel member Paul Vincent and a global CWG presence there for many years.

**RFP 4.3.1.2.** In addition to the work outlined above in Arizona, CWG and individual team members designated for this project have extensive experience in the design and implementation of services to reduce reliance on restrictive care for children with serious emotional and behavioral needs.

- **Allegheny County, Pennsylvania.** The Allegheny County Department of Human Services is responsible for a wide range of services including behavioral health, child welfare, juvenile justice and intellectual disabilities in children, youth, and adults. CWG assisted DHS in implementation of a teaming practice model to serve families which addresses the natural crossover of many children and families between systems, and supports a community-based model for treatment
- **Prescott and Flagstaff Arizona.** CWG supported the work of Child and Family Support Service, Inc. to provide a full array of therapeutic, direct support, and case management services to children and youth with behavioral health needs with a focus on community-based care.
- **Escambia County, Florida.** CWG supported the Families First Network in Escambia County in developing children's behavioral and case management services. These included services for children and youth placed in treatment foster care and residential settings.
- **Illinois.** CWG helped prepare the residential monitors in Illinois relative to facilitation of Child and Family Team Meetings. The CFTM process was used as a planning tool to engage the youth, family, residential staff and case workers, and to plan and develop individualized courses of action and methods to build concrete supports and direction for youth coming out of residential care and/or treatment back into the community. CWG also helped to develop two of the monitors as master coaches so that they could train and coach the entire residential monitoring team
- **Los Angeles County**. The former CWG Director (Paul Vincent), who will be a member of this project team, helped the child welfare and mental health agencies develop a shared model of practice, implement a system-wide use of the child and family team process, employ the

Quality Service Review process to assess practice fidelity and current outcomes, and create a highly individualized intensive home-based mental health capacity for serving children with high mental health needs. CWG staff served as reviewers in assessing practice quality and conducting special reviews of home-based mental health services and group care.

- **Louisiana.** Another member of the project team designated in this proposal (Sue Steib) served as Child Welfare Program Director in Louisiana where rates of congregate placement were maintained consistently below the national average through the development of therapeutic foster care, individualized supports for relative and fictive kin placements, and widespread use of certified clinicians as in-home therapists. Her experience in this area continued in her work with Casey Family Programs in Louisiana as well as in Oklahoma which also maintained a low rate of placement in residential treatment.

**RFP 4.3.1.3.** Experience in providing SME related to continuous quality improvement and quantitative and qualitative data analysis is incorporated in almost all of CWGs work with states and counties. In states where CWG has supported quality improvement and qualitative data analysis, systems improvements have ranged from the establishment of flexible dollars and the creation of more individualized services, to expanded attention to trauma. Some selected exampies are discussed below.

- **Indiana.** In June, 2018 CWG completed a review of Indiana's Department of Child Services which entailed extensive collection and analysis of quantitative and qualitative data as a basis for developing detailed recommendations for system reform. DCS immediately began follow-up to implement these recommendations with significant success. By June 2019, the number of children in out of home care had dropped by 14.4% and the total caseload by 17.3%. Staff turnover overall had dropped by 18.7% and turnover for case managers by 18.7% and DCS had moved from a deficit of 618 family case managers to a deficit of only 19. The Indiana work was led by three of the four CWG team members designated in this proposal (Baker, Steib, and Vincent).

- **New Jersey:** The New Jersey Department of Children and Families maintains an Office of Quality at the state level that is grounded in the principles and QSR model learned from CWG. The QSR process has evolved over the years since being introduced by CWG, and is now considered a natural and necessary component of New Jersey's system. CWG began working with New Jersey in 2005. By 2015, significant improvements had been demonstrated in their system as indicated by the following findings:[1]
  - 40% fewer children in foster homes in 2015 compared to when DCF entered federal oversight in 2000
  - 85% of children receiving services from the child protection system were in their own homes.
  - Number of available resource families available at nearly twice current need in 2015.
  - Kinship placements increased from 12% in 2000 to nearly 40% in 2015.
  - Child and Family Team Meetings (CFTM) required as fundamental to case planning
  - Improved training curricula
  - Improved collaboration with formal and informal partners

The CWG practice model has become ingrained enough to be identified by the agency as "the cultural norm". Other systems improvements supported by CWG included the development of medical and behavioral services, flexible funding for service provision based on findings and recommendations made by the CFTM, increased rates for resource families, and comprehensive and culturally responsive services which are flexible enough to consider the beliefs, practices, and cultural and linguistic needs of diverse populations. These include, for example, recruitment and approval of more bilingual foster resources and multi-lingual in-home providers of behavioral assistance and counseling.

- **District of Columbia.** CWG evaluated the capacity of the Child and Family Service Administration's Quality Assurance and Quality Improvement process. As part of its efforts to restructure child welfare services, the District of Columbia also asked CWG to support a quality assessment of eight community collaboratives which had been established to develop service delivery and support networks for children and families in their respective target areas. The initial findings were encouraging relative to increased collaboration, greater understanding of the practice model, and commitment to local service delivery. The District used the information from the original collaboratives to support development o f their current policies and practices.
- **Michigan.** The Department of Health and Human Services adopted the QSR model in 2015 and continues to utilize the process. CWG continues to participate in reviews and coaches state staff in real time and through debriefing.

**RFP 4.3.1.4.** Provide experience in providing SME related to community-based services including Wraparound facilitation, behavioral support services, children's mobile crisis response, therapeutic foster care, and Assertive Community Treatment.

- **Arizona.** CWG's work in Arizona was associated with the sweeping J.K. mental health settlement and involved working in partnership with the Maricopa Behavioral Health Authority, where CWG consultants served as trainers and practice coaches, to create a system-wide strength- and needs- based individualized practice model. Much work was focused upon strengthening Wraparound and clinical practice through training and coaching at the front line. In partnership with Maricopa, plans and activities were developed to support the agency and providers to assess and improve their own practice and organizational cultures.
- **Los Angeles County.** CWG's work in Los Angeles County, as referenced in the preceding sections, has addressed the creations, implementation, and ongoing monitoring of a full range of community-based services including behavioral supports, family teaming, and treatment foster care.
- **Iowa.** CWG conducted a review of the Iowa Department of Human Services in late 2017, which included recommendations for improvement relative to planning with families. Facilitation of the "Family Team Decision Meeting" (FTDM) as it is known there, emerged as an important area for assessment. In 2018, CWG was asked by Iowa to conduct a review of a sample of Family Team Decision Meetings. In particular, the state wanted information about the integrity of the process, especially relative to participation, facilitation, service

identification and provision, and outcomes. CWG shadowed team meetings all over the state and gave feedback on facilitation of the meetings, the decisions reached, the clinical strengths and needs of the process, and other findings. Responsibilities for facilitation of meetings and provision of services referenced in 4.3.1.4 are shared among the agency and other resources. Facilitators are responsible for directing the meeting, guiding the discussion toward prevention and local resources, and confirming the plan in writing to all.

In addition, Iowa hosted a series of "Provider Forums" across the state, with particular attention to the upcoming requirements of Family First; the development of a stronger service array; and partnership between the agency and resource communities. Over 120 participants met in 11 venues across the state to address the existing relationships with DHHR and the quantity and quality of services available relative to in-home prevention in particular. Budgetary and legal concerns were discussed as well. The heightened awareness of service availability and accessibility as a result of the Forums and information presented to the state in CWG's report has been, according to the state and providers, very helpful in their decision-making process vis-à-vis funding, recruitment, compliance, and other provider concerns relative to diversification, transportation, etc.

- **New Jersey**. CWG worked with the Managed Care and Behavioral Health Authority in New Jersey in the integration of teaming methods in services to children and youth dually enrolled in child welfare and children's behavioral health
- **Oklahoma.** A member of the proposed CWG team (Steib) worked closely with child welfare agency personnel and mental health consultants in planning the use of children's mobile crisis and behavioral support services response as adjuncts to the design of the state's Intensive Safety Services under its Title IV-E waiver demonstration grant.
- **Tennessee**, Wilder Youth Development Center: In this secure facility for juvenile offenders, CWG introduced the teaming process for case planning, and supported development and provision of wraparound services with youth in transition.
- **Washington, D.C**.CWG supported the development of therapeutic and case management services in DC and surrounding communities.
- **Wyoming**, Wyoming Girls School. CWG introduced the family team model and supported individual approaches to improve behavioral health and educational success, including wraparound and child-specific services.

**RFP 4.3.1.5.** Experience in providing SME in the provision of preventive services. CWG has had a wide range of influence in the design of preventive services. As far back as 1996, CWG partnered with the Edna McConnell Clark Foundation to launch a prevention approach called "The Community Partnership for Protecting Children" (CPPC). The initiative was introduced in Missouri, Iowa, Florida, and Kentucky. Through work with CPPC and child welfare agencies, partnerships were created or strengthened between neighborhoods, parents, law enforcement, schools, faith communities, and social service providers. The initiative called for the community to support families before they faced crises, and to intervene more rapidly and effectively when

abuse or neglect were suspected. Consultation also included work to improve child protection policy and practice in ways that more reliably strengthened families and safeguarded children. The project was guided by four practice principles: 1. Family-centered Practice; 1. Neighborhood Networks; 3. Shared Decision-making, and 4. Policy and Practice Change.

CWG's more current work in system reviews typically focuses heavily on opportunities to safely prevent entry into out of home placement by assessing opportunities to develop and expand community-based services. Examples include the following states and cities:

- **Arizona.** CWG facilitated a capacity-development process which resulted in a greater commitment to collaboration and helped the system develop child and family team meetings in Maricopa County (Phoenix) as the foundation for planning with families. Local agencies were given a voice in planning, which led to greater interest in a collaborative approach. This framework created an excellent opportunity to share successes and lessons learned, and informed the planning processes across the system. Local initiatives were creative and family-focused, and the process of inclusion was endorsed by top-level agency leaders. With our coaching and support, for example, one agency designed an internal process which emphasized coaching and supervision of out-of-home placements and unique plans for reducing/eliminating use of residential treatment through development of a community-based focus. Another developed approaches to organizing/reorganizing their workforce. Another restructured its entire model and moved from a "solo approach" to an integrated system, utilizing three internal teams to provide more effective services. CWG presented concepts, strategies, and coaching and modeling which resulted in successful implementation of the settlement.
- **Foundations First Home Care Inc, District of Columbia.** CWG worked with this provider to develop therapeutic and case management services for children and youth in the District of Columbia and adjoining communities.
- **Indiana.** CWG's assessment of the Department of Child Services produced detailed recommendations calling for serving children and families at an earlier point than child protection intervention by examining current statutes prescribing child welfare involvement and joining with other public and private sector service providers and advocates to strengthen community-based services, especially in the area of parental substance use.
- **Philadelphia.** CWG's evaluation of the Improving Outcomes for Children system reform in Philadelphia provided detailed guidance for developing school and community based services outside of the child welfare system for children and youth referred to child welfare and often placed out of home for reasons associated with truancy and other behaviors not constituting threats to child safety.

**RFP 4.1.3.6.** CWG leaders have extensive experience in working with jurisdictions involved in consent decrees or other agreements involving class action litigation as detailed below. It is important to emphasize, however, that consent decrees have never been the only reason CWG works with a system. The objective of CWG's work is attainment of the goals of improved practice and outcomes established by leaders and administrators who invited CWG's support

- **Alabama**. The senior staff of CWG led Alabama's ground-breaking child welfare reform in the R.C. vs Hornsby case, which produced better child and family outcomes, a child and family team meeting process tailored for child welfare, a needs-based approach to practice, a statewide process of "money following the child", and the Quality Service Review process. These reforms led to a functional and successful child welfare system of care. Alabama exited court oversight.

- **Illinois vs. Smith**: In 2016, Paul Vincent, along with Marci White and Mark Testa, were asked by the parties to serve as "court experts" tasked with studying the system over a four-month period and making recommendations to the court. The court appointed these professionals and the report became the basis for a specific implementation plan approved by the court. Many of these recommendations were primarily directed at class members with significant mental health needs.

  In 2017, CWG was asked by the Illinois Department of Children and Family Services to support the development of "immersion sites" for in-state facilitators and coaches relative to Child and Family Team Meetings as the newly adopted practice model there. The court also assigned CWG the responsibility of training and coaching the QSR process in order to develop and maintain the internal capacity of the agency to manage ongoing assessment of their system. While CWG is not a party to implementation, its work in Illinois is directly tied to their decree, and continues to provide support in identification of strengths, barriers, and lessons learned as the process proceeds.

- **Los Angeles County.** The CWG director served as Chair of the Katie. A. Monitoring Panel and helped the child welfare and mental health agencies develop a shared model of practice, implement a system-wide use of the child and family team process, employ the Quality Service Review process to assess practice fidelity and current outcomes and provide recommendations for improvement.

- **New Jersey.** CWG assisted New Jersey in implementing its Nadine H. child welfare settlement agreement by assisting in the development of the practice model implementation plan, trained its trainers and staff in family engagement skills, child and family teaming, assessment, planning and making visits effective. CWG also helped the system develop and implement its Quality Service Review process.

- **New York City.** The CWG director served as a member of the Marisol Monitoring Panel, overseeing the City's implementation of its implementation plan. The Administration for Children's Services, the City's child welfare agency, exited court oversight.

- **Oklahoma.** Following the state's DG vs. Yarbrough settlement, CWG conducted a review of child welfare system operations, provided training and coaching in practice skills to agency staff, and developed curricula to support the agency practice model. CWG's work was conducted collaboratively with support from Casey Family Programs in an initiative that ultimately led to marked increase in the number of children able to remain safely at home with their families. Over the approximately two years of CWG's involvement, Oklahoma experienced a drop of approximately 2000 children in out of home care. A member of the

CWG team proposed for the work in West Virginia (Steib) was the Casey consultant in Oklahoma during that time.

- **Tennessee**. CWG was represented as a member of the court advisory panel which served as court monitor and consultant to implementation in the Brian A. settlement. CWG work included an assessment of system operations, participation in crafting and modifying implementation plans, ongoing compliance monitoring, mentoring the implementation of Tennessee's Quality Service Review Process, and preparing court reports. The Tennessee system has exited court oversight.
- **Utah.** CWG served as court monitor in the David C. settlement agreement, conducting system evaluation, providing compliance monitoring, providing curriculum development, assisting in the introduction of the Quality Service Review process, and preparing court reports. CWG also assisted the parties in crafting an agreement which led to exit.
- **Washington, DC.** CWG assisted the court monitor by participating in Quality Service Reviews and evaluating the capacity of CFSA's Quality Assurance/and Quality process.
- **South Carolina.** The former CWG Director serves as a co-monitor in the DSS Michelle H. settlement agreement. That role includes evaluating system operations and compliance, preparing court reports, advising the agency on implementation strategies and moderating discussions between the parties, among other duties. Another member of the proposed CWG team for West Virginia (Steib) serves as the child welfare workforce expert for the court monitors.

B. Project Team

The brief professional biographies of the proposed CWG project team are listed below. The full resumes of each may be found in Appendix B.

CWG intends to bring to this work an exceptionally experienced and well-qualified group of consultants, clearly exceeding the minimum requirements outlined in the RFP. Not only does this team have the educational credentials and far in excess of the basic experience called for, but each has served in a senior administrative capacity in a public child welfare or mental health system.

**Freida Baker, MSW**

Freida Baker is the Executive Director of the Child Welfare Policy and Practice Group (CWG) in Montgomery, Alabama, a nonprofit technical assistance organization created in 1996. She was previously Deputy Director of Family Services with the Alabama State Department of Human Resources (DHR). She has over thirty-six years of child welfare experience. She participated closely in the implementation of Alabama's landmark R.C. Consent Decree and has expertise in systems and change management. The current advisory panel for the groundbreaking Katie A. settlement in Los Angeles, California recently invited Mrs. Baker to conduct an assessment of congregate care facilities there, with focus upon the status and well-being of youth residing in congregational (treatment) care, especially relative to their mental health and well-being.

In addition to supporting recent comprehensive reviews in Indiana and Iowa, she has participated in statewide Quality Service Reviews in Iowa, Utah, and Florida and directs management of a current large-scale training initiative in Illinois. She is a certified Federal State Reviewer and has participated in the federal Child and Family Service Reviews and QSR reviews nationally. She is also LAMM certified through the National Child Welfare Workforce Institute. Ms. Baker has engaged social workers, the judiciary, behavioral health experts, educators, foster parents, physicians, and other partners across the nation.

Mrs. Baker is an adjunct professor for the School of Social Work at the University of Alabama, and has served as adjunct in Sociology in other college settings. She received her BA from Auburn University and the MSW from the University of Alabama.

**Beatrice Salazar, BSW, MA (Counseling Psychology)**

Bea Salazar is a committed human services professional who has over twenty-five years of experience in the areas of child welfare, juvenile probation, behavioral/mental health, and holistic community health and wellness. She has worked in various capacities from caseworker to director of children's behavioral services and director of an integrated community health and wellness department. Ms. Salazar has developed, managed, and provided oversight for over twenty federal, state, and community grant funded programs. As director of a behavioral agency she developed and implemented a system of care that incorporated the child and family team process. That program grew from seven employees to sixty-two employees who served over 900 children and families annually. System of Care philosophy, strength-based family-driven care, individual child and family teaming, cultural responsiveness, and quality assessment have been the foundations that have guided Ms. Salazar's work.

In addition to the work described above, Ms. Salazar has provided independent consulting, coaching, mentoring, and training in several states and to Native American tribal communities to include system change planning and implementation of the child and family team process. Her extensive experience working with diverse populations at system, program implementation,

employee, and service participant levels has served to strengthen community engagement and enabled the success of child and family team implementation. Cultural responsiveness, Culturally and Linguistically Appropriate Services (CLAS Standards), and health disparities are areas of specialty trainings in which Ms. Salazar is experienced.

**Sue D. Steib, PhD, LCSW**

Sue Steib has over forty-five years of child welfare experience including direct practice, agency administration, research, and consultation. Prior to joining with the Child Welfare Group in 2016, she was Senior Director of Strategic Consulting at Casey Family Programs (CFP), a Seattle-based foundation dedicated to helping child welfare systems across the United States improve their practice and outcomes. During her eight years at CFP, she led the organization's work in Louisiana and Oklahoma, supporting child welfare leaders there in their efforts to reduce the need for out-of-home care for children and to improve practice outcomes related to safety and permanency. Additionally, she served as part of a consulting team providing support to child welfare systems in fifteen states. From 2001 to 2008, Steib was director of the Research to Practice initiative at the Child Welfare League of America (CWLA) in Washington, DC, leading work to synthesize current research in child welfare, juvenile justice, and children's mental health to make it accessible to agency leaders and practitioners across the nation through papers, workshops, and direct consultation aimed at supporting efforts to apply evidence in planning, program implementation, and evaluation. Steib came to CWLA after a thirty-one year career in Louisiana's child welfare system, where she served in positions ranging from caseworker and casework supervisor to program administrator and statewide Child Welfare Program Director. Particular areas of interest and expertise include the child welfare workforce, agency administration and leadership, evidence-based practice implementation and evaluation, and the use of data to assess performance and guide quality improvement. Most recently Steib played a major role in child welfare system assessments in Philadelphia, Iowa, and Indiana, and in workforce assessment and planning in S. Carolina. She also continues to work under contract with Casey Family Programs and has, over the past three years, supported that organization's work in Broward County, Florida and Oklahoma.
Steib holds both the MSW and PhD in Social Work from Louisiana State University and is a Licensed Clinical Social Worker in Louisiana.

**Paul Vincent, LCSW**
Paul Vincent is the recently retired Director and founder of The Child Welfare Policy and Practice Group (CWG) which directs its technical assistance toward improving outcomes for children and families though strengthening front-line practice. Mr. Vincent's work included system assessments, (child welfare and child and adolescent mental health) strategic planning, curriculum development, training, front-line practice coaching, Continuous Quality Improvement training and practice evaluation.

Mr. Vincent directed the overall work of the organization and represented it and the front-line practice perspective in various national policy forums and foundation initiatives. He led the organization's participation in the provision of technical assistance in systems involved in class action litigation, such as in Los Angeles, where he currently serves on the Katie A. Advisory Panel; in Utah, where the Child Welfare Group was Court Monitor; and in Tennessee, where he served on the Brian A. Technical Assistance Committee.

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.

## III. Project Approach and Methodology

This section describes the approach that CWG views as necessary to achieve the project goals and objectives and fulfill the mandatory requirements outlined in the RFP. Specific tasks, timelines, and the roles assigned to each team member are described in section IV of this proposal.

### A. CWG Perspective and Values

CWG's work is diverse yet consistently grounded in values of family centeredness and family and youth involvement. Whether in training and coaching direct practice or in supporting systems level assessment and reform, our consultants believe that the quality and effectiveness of child welfare, juvenile justice, and mental health services must be viewed from the perspective of the way in which families and children experience them. CWG subject matter experts will thus be concerned, not only with the capacity and distribution of the service array, but also with the consistency with which family and youth driven planning and treatment teams are used in WVDHHR and the degree to which this process enables families to experience services as accessible and useful.

### B. Creating the Baseline Report

The baseline report with preliminary observations and recommendations for fulfillment of the project goals must be completed by November 14, 2019. The agreement between WV DHHR and the U.S. Department of Justice (USDoJ) calls for the implementation of specific community-based models and services as a means of preventing unnecessary out of home and congregate care for the children and youth in the defined target population. These include wraparound facilitation, children's mobile crisis response, therapeutic foster care, family training and support, and Assertive Community Treatment as well as screening, assessment, and behavioral support services. In order to prepare the required baseline report, it will be necessary to assess the extent to which these resources currently exist in West Virginia, their geographic distribution, accessibility, and capacity in relation to the needs of the children and youth they must serve.

Secondarily, it will be important to understand, to the extent evaluative data exist, how successful these services have been in maintaining children and youth with mental health needs

in their homes and/or preventing entry or re-entry into residential treatment. The terms "therapeutic foster care" and "family training and support", for example, may describe an array of models with varying degrees of evidence and effectiveness. Likewise, Safe at Home, which W. Virginia has implemented under the terms of its federal Title IV-E demonstration waiver, has, according to evaluation information reviewed by CWG, been more successful in preventing re-entry into residential treatment than initial placements.[2]

1. Baseline Data Collection

a. Quantitative Indicators

CWG consultants will work with DHHR leaders to examine and interpret quantitative data that reflect the experience of the target population and the capacity of service providers. It is anticipated that this will include, at a minimum, the following:

- The number of children and youth comprising the target population, their current status, and needs (i.e., ages, gender, placement/in-home, identified needs, treatment received, treatment needed)
- The capacity of clinical providers currently existing in WV, the types of services they are able to offer, and their enrollment of the target population
- The geographic distribution of providers (e.g., county, region)
- Provider outcomes (e.g., case closure, placement/in-home status, case closure, re-referral)
- Placement resources including family foster care, therapeutic foster care, supported relative placements, and residential treatment

Understanding of the above data will also require review of the methodology for determining risk of residential placement among the eligible population; review of current screening tools and their administration, and criteria for residential placement.

b. Funding

Funds currently available to support mental health and related services and their sources will be determined and assessed to determine opportunities for maximization of resources available to the state. This has been an important aspect of CWG's work in a number of states and will be handled by a member of the team with extensive experience in this area.

c. Descriptions of Provider Programs and Models

It will be necessary to carefully examine the types of services and models currently existing in the state, the extent to which they comport with the services required in the DHHR-USDoJ agreement, and the evidence that exists related to their effectiveness in serving the target population or other youth with the same or similar needs.

Developing, implementing with fidelity, and sustaining evidence-based and research informed models on a large scale is a complex and multi-faceted endeavor. Typically, greater efficiencies

can be attained by identifying services that may already incorporate the key features of those supported by research and thus may lend themselves to more ready development or adaptation to meet the identified needs. For the most part, the agreement requires services that may be broadly defined. The terms "behavioral support services" and "treatment foster care", for example, may describe a variety of service approaches that have very different components. Thus, it will be important to understand what these services, to the extent that they currently exist, actually look like relative to what is known about effective approaches. In the case of existing evidence-based models (e.g. Multisystemic Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care), planning will address questions of fidelity and barriers to expansion relative to need. When such models do not exist, attention may be more appropriately focused on basic evaluation of current services to determine (a) the extent to which they incorporate the features of evidence-based models most associated with positive outcomes, (b) their current effectiveness in achieving positive outcomes for children, youth, and their families, and (c) barriers to implementation and spread of services that replicate or closely comport with evidence-based models.

d. Policy and Reports

Members of the CWG team will review child welfare and juvenile services policies pertaining to response to children and youth with mental health needs and key reports that provide information on the state's needs and capacity. This aspect of the review is anticipated to include the state's Medicaid plan, the findings of the round three federal Child and Family Services Review, the federal Program Improvement Plan, the implementation plan submitted by WVDHHR in September 2019, and any existing legislative or special committee reports pertaining to the provision of mental health services to the target population.

e. Interviews

CWG has found, through years of systems assessments, that critical information and rich perspectives emerge from interviews with agency personnel at multiple levels (leadership, management/administration, supervision, and direct service), service providers, service recipients, and other system stakeholders such as judges and advocates. While members of the agency's leadership team and selected external partners may be interviewed individually, most interviews are best conducted in a structured focus group format. All interview participants, whether in groups or individuals, are provided with both verbal and written information explaining the purpose of the interviews, that their participation is voluntary, and that individual identities will not be recorded in either notes or reports. The number of participants in each group, copies of questions asked, and summaries of the information elicited are included in the final report as is the method for coding and analysis of interview data. The CWG team anticipates working closely with the DHHR leadership to select individuals and groups whose participation in interviews will provide the most complete and representative information leading to fulfillment of the mandatory requirements.

C. Ongoing Development and Evaluation

The information obtained to complete the baseline report will enable identification of service needs relative to current capacity. Thus this phase of the SMEs' support will focus on facilitating the development of an action plan for achieving full compliance with the WVDHHR-USDoJ memorandum of understanding prior to the end of calendar year 2024. CWG envisions this work being mapped on a time frame to conform to the agreed upon semi-annual program reports with priorities established based on need and resource availability and specific action steps. This work must be grounded in the state's implementation plan and in detailed identification of what will be required to achieve the full array of needed mental health and supportive services at the necessary volume and accessibility. In similar work, CWG has found that this process requires consideration of the following factors:

- Funding – Assessment of funding requires accurate incremental cost projections, determination of what is available, what can reasonably be obtained and within what time frame, sustainability, limitations on utilization, and strategies to maximize funds. An essential consideration as it pertains to the child welfare population or youth who may be candidates for foster care in accordance with federal Title IV-E requirements will be West Virginia's plans for participation in the Family First Preventive Services Act and the requirements of that legislation pertaining to funding of evidence-based practices as federal regulations unfold.
- Foundational requirements – Foundational requirements relate to areas such as the supply of qualified clinicians and the readiness of service providers to revise their business models to create the necessary service array.
- Community involvement and support – This includes the areas of public education and communication and coordination across systems such as health care and education.

CWG anticipates beginning work immediately following submission of the baseline report to engage a defined group of DHHR staff, providers, and other stakeholders to draft a preliminary work plan. From CWG's perspective, it will be important to create a team that offers broad and diverse input. Additionally, CWG would be open to posting work products for public input if this is consistent with time frames and accepted local procedures.

Ongoing work will of necessity focus strongly on the incremental development of service capacity and accessibility along with, in the case of specific models, assessment of fidelity and ongoing quality improvement as outlined in B.1.c. above. It is anticipated that this work, done collaboratively with WVDHHR and the public and private sector members of the system of care in West Virginia, will make up much of the ongoing work following the completion of the baseline report.

IV. Proposed Work Plan

The table below describes the specific actions that will be required to achieve the project goals, fulfill the mandatory requirements, the estimated time frames for their initiation and achievement, and the anticipated roles of the respective CWG team members.

| Work Activity | Est # Days | Team Member(s) |
|---|---|---|
| Phase 1: Preparation of the baseline report | | |
| Meetings and interviews with key WV and USDoJ personnel and summarization | 5 | Baker, Salazar, Steib |
| Review and assessment of policies and reports | 5 | Salazar, Steib |
| Meetings and interviews with providers and other system stakeholders and summarization | 3 | Baker, Salazar, Steib |
| Review and analysis of budgets and funding plans | 2 | Steib, Vincent |
| Review and analysis of quantitative data pertaining to the target population and service capacity | 4 | Steib, Salazar |
| Preparation of the baseline report | 3 | Steib, Salazar |
| Phase 2: Ongoing development, implementation, and preparation of the semi-annual report | | |
| Meetings with key WV and USDoJ personnel, providers, and other stakeholders for ongoing barrier identification and planning | 4 | Steib, Salazar |
| Periodic (at least quarterly) review of quality assurance and administrative data related to service and target population goals | 4 | Steib, Salazar |
| Technical assistance in service design, fidelity assessment, and evaluation | 6 | Steib, Salazar |
| Completion of semi-annual report | 7 | Steib, Salazar, Baker, Vincent |

# The University of Alabama

has conferred upon

## Freida S. Sublett

the degree of

## Master of Social Work

with all the rights and privileges thereunto appertaining.

In Witness Thereof, this diploma duly signed has been issued and the seal of the University affixed.

Issued by the Board of Trustees upon recommendation of the faculty of the University on this the

eleventh day of May, 1991.

E. Pope Dayer
President

Ronald Eggers
Interim Dean

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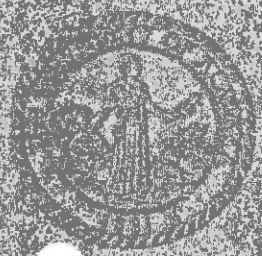

President

Interim Dean

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E. Roger Sayer
President

Lorrie Boger
Interim Dean

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E. Roger Sayre
President

Harold Logan
Interim Dean

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eleventh day of May, 1991.

E. Roger Sayers
President

Ronald Cogen
Interim Dean

# Louisiana State University
and
# Agricultural and Mechanical College

On the nomination of the Faculty of the
**Graduate School**
has conferred upon
## Sue Duvall Steib
the degree of
## Doctor of Philosophy
with all the Honors, Rights and Privileges to that degree appertaining.
In testimony Whereof, the seal of the University and the signatures as authorized by the Board of Supervisors are hereunto affixed. Given at Baton Rouge, Louisiana on the eighteenth day of May in the year two thousand and one.

Chairman of the Board of Supervisors

President

Chancellor

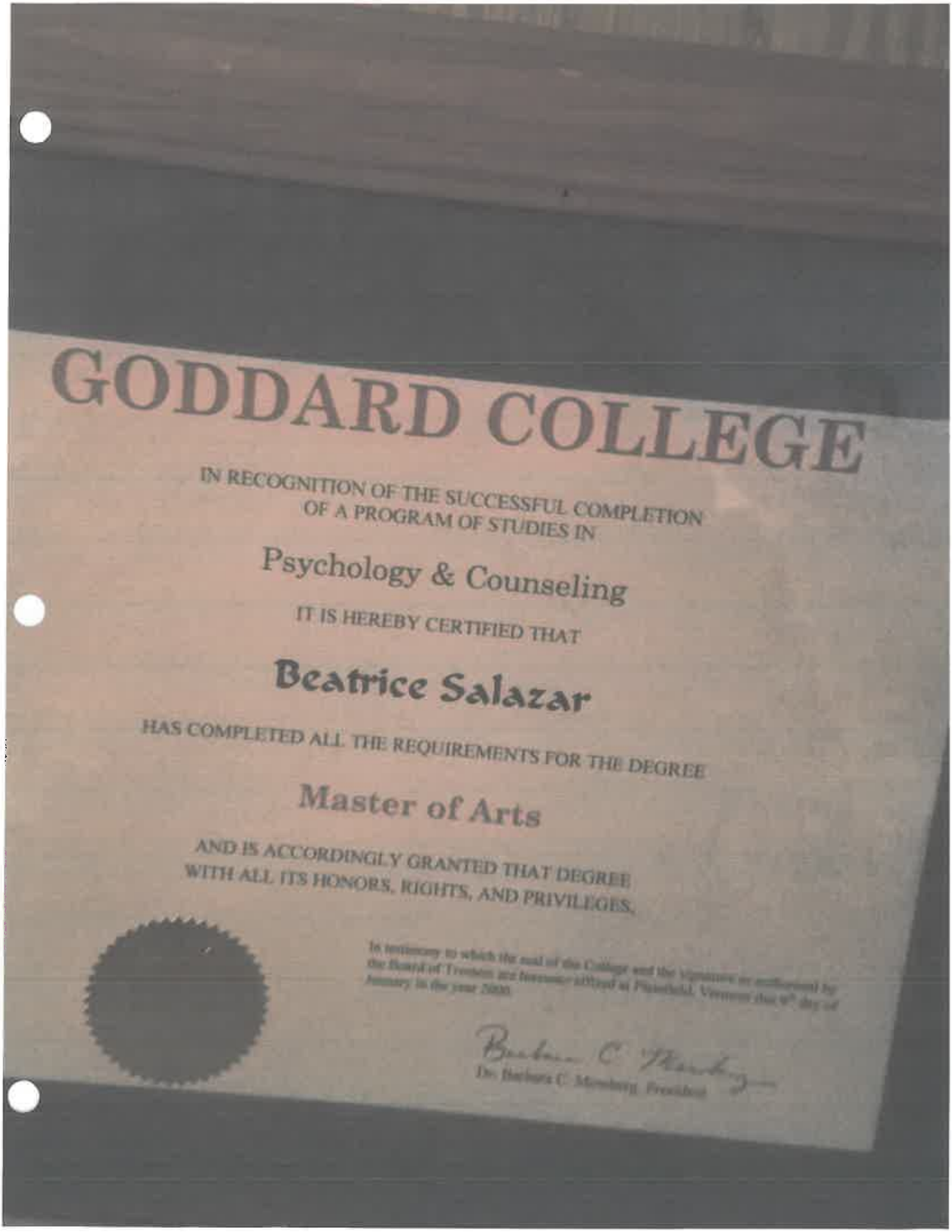
Dean

.ease find enclosed your renewal identification card for the current fiscal year. Licenses are renewed annually. Your renewal notice will be mailed to the address listed below in June of each year. Please keep this office informed of any name or address change. Changes can be made on our website www.labswe.org through the "Licensee Login" or contact the Board at 18550 Highland Road, Suite B, Baton Rouge, LA 70809.

**LOUISIANA STATE BOARD OF SOCIAL WORK EXAMINERS**
**PHONE: 225-756-3470**

**SUE D STEIB**
**Licensed Clinical Social Work**
[redacted] **Exp. 08/31/2020**
[redacted]

**CHAIRPERSON** **CARDHOLDER**



# GODDARD COLLEGE

IN RECOGNITION OF THE SUCCESSFUL COMPLETION
OF A PROGRAM OF STUDIES IN

## Psychology & Counseling

IT IS HEREBY CERTIFIED THAT

## Beatrice Salazar

HAS COMPLETED ALL THE REQUIREMENTS FOR THE DEGREE

## Master of Arts

AND IS ACCORDINGLY GRANTED THAT DEGREE
WITH ALL ITS HONORS, RIGHTS, AND PRIVILEGES.

In testimony to which the seal of the College and the signature as authorized by the Board of Trustees are hereunto affixed at Plainfield, Vermont this 8th day of January in the year 2000.

Barbara C. Mowbray

Dr. Barbara C. Mowbray, President

Memorandum

CRFP 0506 hhr2000000001

September 11, 2019

Re: Paul J. Vincent, MSW

Mr. Vincent requested/ordered a duplicate diploma (MSW) from the University of Alabama. Mr. Vincent has been notified by the registrar at the University of Alabama that a copy of his duplicate diploma cannot be available until September 19th. Mr. Vincent's credentials are impeccable, including the MSW, and we regret that the university was not able to submit a copy prior to submission.

Freida S. Baker, Executive Director
The Child Welfare Policy and Practice Group

9-11-2019
Date

**Curriculum Vitae**
**Freida S. Baker**
**September 2019**

**Address: 2512 College Street**
**Montgomery, Alabama 36106**
**Phone: Office: (334) 264-8300**
**Cell: (334) 451-0314**
**Current Position: Executive Director**
**The Child Welfare Policy and Practice Group**

## Education

MSW, The University of Alabama, 1991
BA, Sociology, Speech Communication, 1982

## Professional Experience

*Executive Director, The Child Welfare Policy and Practice Group (CWG)*
*April 2019 – Present*
*Acting Director, The Child Welfare Policy and Practice Group*
*January 2019 – April 2019*
Serve as director of private, non-profit child welfare organization. Responsible for ongoing demonstration of the mission of the organization. Conduct systems assessments, prepare reports and other writings, manage range of organizational projects, support independent consultants, oversee curriculum development and other writings, manage fiscal and budgetary operations, conduct and support outreach and marketing, led internal continuous quality improvement plans and implementation, and work with the CWG board. Engage colleges and universities in order to support MSW and BSW field placements, manage and supervise field placements, oversee website and social media, and promote national and local interest in practice, training, and policy.

*Program Coordinator, The Child Welfare Policy and Practice Group*
*March 2018 – January 2019*
Conducted Quality Service Reviews (QSR), developed CWG website and social media operations, supported curriculum development, conducted practice and marketing research, wrote reports and marketing materials. Supported curriculum development in family teaming, and designed the initial field placement model with The University of Alabama and Troy University.

*Independent Child Welfare Consultant*
*August 2017 – March 2018*
Conducted Quality Service Reviews for CWG, research, and marketing/outreach activities. Began initial work on new CWG website, worked with other independent consultants in order to learn more about CWG's training, coaching, and mentoring model.

*Alabama State Department of Human Resources (DHR)*
*July 2000 – August 2017*
*Deputy Director, Family Services*

Managed wide range of child welfare programs, including statewide implementation of R.C. consent decree, practice and training, foster care, adoptions, Interstate Compact on Placement of Children (ICPC), federal requirements and reporting, policy, child welfare consultation, and child protective services. Prepared federal, state, and internal reports and other writings, wrote successful proposals for funding and support for initiatives, for example, selection of Alabama into the Three Branch Institute, managed liaison and budget work with Casey Family Programs, Jim Casey and other financial supports. Conducted child welfare workshops in Colorado, Maine, North Carolina and in-state. Prepared reports for the State DHR board, wrote status reports to the court, developed child welfare policy and procedures, worked closely with director and other deputies in order to support a unified management model and other responsibilities. Alabama successfully exited the Consent Decree in 2007.

*Alabama State Department of Human Resources (DHR)*
*May 1995 – July 2000*
*Program Manager, Family Services*

Co-managed implementation of the wide-ranging R.C. settlement. Created statewide implementation strategies, conducted focus groups, developed policies, training initiatives and curriculum, wrote reports, and other responsibilities. Supervised the child welfare consultant program, which featured staff with significant practice expertise and who were in charge of onsite work in the counties as they achieved conversion and compliance with the principles of the decree. Worked in partnership with agency and plaintiff's attorneys toward implementation. Conducted child welfare and management trainings for DHR staff, law enforcement, the judiciary, and others.

*Alabama State Department of Human Resources*
*December 1991 – May 1995*
*Consultant, System of Care*

Worked in partnership with agency and external resources in order to develop plans and procedures for implementation of the R.C. settlement. This included individualized planning with 67 counties, outreach work with families, local resources, local and statewide leadership and others. Established standards for county "conversion" as the state experienced a paradigm shift in its practice model, resource development, funding, and quality assurance. Demonstrated and conducted onsite leadership through modeling and coaching the new individualized service planning process. Conducted child welfare and management trainings for DHR staff, law enforcement, the judiciary, and others.

*Washington County Department of Human Resources*
*March 1986 – December 1991*
*Supervisor, Child Welfare Program*

Provided supervision of all child welfare programs, including child protective services, foster care, and adoptions. Supervised administrative support unit. Worked closely with community partners, including initiatives and/or training with the local judiciary, education, mental health, and law enforcement. Prepared reports for the county director, ensured policy review and compliance, provided feedback for capacity-development of social work staff, conducted performance appraisals and served as liaison and/or committee member for various projects in the community. Provided oversight of recruitment of foster and adoptive resources.

*Washington County Department of Human Resources*
*July 1983 – March 1986*
*Social Worker, Child Welfare Program*
Served as caseworker in child welfare and adult services. Provided in-home services, conducted safety assessments, managed foster care and adoption cases, supported recruitment and retention activities, worked with local mental health and other partners and providers in planning and service delivery, ensured compliance with state and federal requirements regarding timely permanency.

**Sue Duvall Steib, PhD, LCSW**

**Qualifications**

- Over 45 years of child welfare experience including direct practice, management, administration, research, and consultation.
- In depth knowledge and understanding of
  - child welfare workforce planning and support
  - evidence-based and research-informed practice
  - program and systems evaluation
  - organizational leadership, culture, and climate
  - analysis of systems process and outcome data

**Education**

- Ph.D., Social Work: Social policy and research; Minor: Educational Research
  Louisiana State University, 2001

- MSW, Louisiana State University, 1983

**Licensure**

- Licensed Clinical Social Worker (LCSW), Louisiana license [redacted]

**Professional Affiliations, Appointments & Awards**

Catholic Community Services Adoption Advisory Board, Baton Rouge, Louisiana, 2001-2004
*Children's Voice Magazine*, editorial board, 2006-2008
Council on Accreditation, National Research Advisory Panel, 2004 to 2007
*Journal of Public Child Welfare*, editorial board, 2005 to present
*Journal of Public Child Welfare*, editor, *Practitioner's Corner*, 2005 to 2014
Louisiana Children's Cabinet, Comprehensive Planning Advisory Committee, 1999-2000
Louisiana Law Institute, Children's Code Advisory Committee, member 2000 to 2015
Louisiana State University School of Social Work, Distinguished Alumni Award, 2004

**Professional Experience**

*Principal, Sue D. Steib Consulting, LLC*
*Independent Child Welfare Consultant*
*May 2016 to present*
Serves as a policy and practice consultant to child welfare service providers individually and in partnership with other consulting organizations. Areas of specialty include the child welfare workforce, selection and application of evidence-based practice, systems evaluation, and leadership. Projects include child welfare systems reviews in Philadelphia, Iowa, and Indiana and a child welfare workforce assessment in S. Carolina. Smaller more focused work has been conducted under contract with Casey Family Programs in the child welfare systems in Oklahoma and Broward County, Florida.

*Casey Family Programs (CFP)*

*March 2008 to April 15, 2016*
*Senior Director, Strategic Consulting*

Served as a project director in CFP's work to engage public child welfare jurisdictions in safely reducing the need for out-of-home care for children, improving well-being of children and youth served by child welfare, expediting timely and stable permanency for those served in foster care, and reinvesting foster care expenditures in community-based services and supports that strengthen families. Managed CFP's efforts to engage and partner with child welfare system leaders and advocates in assigned jurisdictions to assess their organizational needs and to plan and implement strategies to achieve positive outcomes related to child safety, well-being, and permanency. Participated in planning and development activities within CFP's Systems Improvement section and across the organization.

*Child Welfare League of America (CWLA)*
*September 2001 to March 2008*
*Senior Consultant/Director, Research to Practice*

Served as project director/senior consultant in consultation contracts with public and private human services agencies and governmental boards and commissions. Directed systematic reviews and syntheses of the empirical literature across the broad spectrum of child welfare, juvenile justice, children's mental health and related fields. Oversaw CWLA's efforts to make research-based information more accessible to practice and policy professionals through: development and web-based publication of annotated bibliographies and research briefs; presentations at national and regional conferences; and provision of on-site consultation, training, and technical assistance to jurisdictions and organizations undertaking evidence-based practice change.

***Louisiana Department of Social Services (now Department of Children and Family Services), August 1970-September 2001***

*Child Welfare Program Director*
*November 1997 to September 2001*

Responsible for direction of planning, budgeting, resource and policy development for the statewide public child welfare programs in Louisiana. Served as primary legislative liaison for the agency in child welfare program issues. Supervised the administrators of the child protection, family services, foster care, and adoption programs who, along with 14 subordinate professional staff, provided functional supervision to approximately 1100 caseworkers, supervisors, and regional level staff throughout the state.

*Administrator, Foster Care and Adoption Programs*
*May 1991 to November 1997*

Responsible for statewide administration of the foster care and adoption programs.

*Administrator, Child Protection and Family Services*
*February 1987 to May 1991*

Responsible for the statewide administration of the child protection and in-home family services programs.

*Social Services Supervisor*
*May 1980 to February 1987*

*Caseworker*
*August 1970 to May 1980*

**Selected Publications**

Alwon, F., Steib, S., & Schmidt, B. (2010). *On the job in child welfare: recruiting, retaining, and supporting a competent child welfare workforce*. Washington, DC: Child Welfare League of America.

Blome, W.W. & Steib, S. (2004). Like musical chairs? Become a child welfare worker. *Child Welfare, 83*(4), 381-384.

Blome, W.W. & Steib, S. (2004). Whatever the problem, the answer is "evidence-based practice" – or is it? *Child Welfare, 83*(6), 611-615.

Blome, W.W. & Steib, S. (2006). Strategies for empowering the child welfare administrator facing class action litigation. *Journal of Public Child Welfare, 1*(2), 5-27.

Blome, W.W. & Steib, S. (2007). An examination of oversight and review in the child welfare system: The many watch the few serve the many. *Journal of Public Child Welfare, 1*(3), 3-26.

Blome, W.W. & Steib, S. (2014). The organizational structure of child welfare: Staff are working hard, but it is hardly working. *Children and Youth Services Review, 44*(2014), 181-188.

Ellett, A.S. & Steib, S. (2005). Child welfare and the courts: A statewide study with implications for professional education and practice. *Research in Social Work Practice, 15*(5), 339-352.

McVicker, C. & Steib, S. (2002). Covenant House: From the streets to success. *Children's Voice, 11*(6), 33-38.

Steib, S. (2003). Special parents for special children. *Children's Voice, 12*(4), 18-19.

Steib, S. (2004). *Parenting Wisely*: On-the-job-training for parents. *Children's Voice, 13*(3), 35-36.

Steib, S. (2006). Child welfare in the legal setting. Review of book. *Journal of Public Child Welfare, 1*(1), 139-141.

Steib, S. & Blome, W. W. (2009). Can Neglected Organizations Serve Neglected Children? *Protecting Children,* Englewood, CO: American Humane Association.

Steib, S. & Blome, W.W. (2008). Talking the talk is easy….walking the walk is much harder: Implementing evidence-based programs and practices. *Children's Voice.*

Steib, S., & Blome, W.W. (2006). Gaining ground—organizational approaches to three common problems. *Common Ground, 21*(2), 10.

Steib, S. & Blome, W.W. (2004). Fatal error: The missing ingredient in child welfare reform, part II. *Child Welfare, 83*(1), 747-750.

Steib, S. & Blome, W.W. (2003). Fatal error: The missing ingredient in child welfare reform, part I. *Child Welfare, 82*(6), 747-750.

**References**

- Eva Gladstein
  Deputy Managing Director for Health and Human Services
  1430 Municipal Services Building
  1401 J.F. Kennedy Blvd.
  Philadelphia, PA 19102
  eva.gladstein@phila.gov
  215 686 3696

- Terry J. Stigdon, MSN, RN
  Director, Indiana Department of Child Services
  302 W. Washington Street, Room E 306-MS47
  Indianapolis, IN 46204-2739
  Terry.Stigdon@dcs.IN.gov
  317-234-3323

- Page Walley, PhD
  President, Chief Public Policy Officer
  St. Francis Ministries
  Office: 785-914-5238; Cell 334-707-0890
  814 Shelby Ln., Bolivar, TN 38008
  Page.Walley@saintfrancisministries.org

Beatrice (Bea) Salazar
[redacted]

**Professional Summary:** **25+ years working within the realm of human services, population health, and behavioral/mental health. Have worked within the environments of nonprofits, state entities, and independent consulting/contracting. Extensive experience implementing, managing and overseeing numerous federally funded projects/programs. Have worked with diverse populations from a direct care front line provider level to director level positions in the areas of child protective services, juvenile justice, mental & behavioral health, HIV/AIDS, integrated community health development, policy and program development, development and implementation of practice fidelity tools, developing curricula and facilitating trainings. Possess effective communication skills that enhance ability to engage and meet individuals "where they are" in their journey to successful functional outcomes. Cultural competence/diversity & inclusion are critical components woven throughout my work.**

## Professional Strengths

Ability to work as a collaborative team member at various organizational and community levels
Demonstrated ability to provide leadership and team management
Ability to balance competing priorities and make independent judgments and decisions
Ability to work in a professional, confidential, and collaborative capacity
Possess excellent communication skills
Possess sound knowledge of basic operating systems: Microsoft Work, PowerPoint, Internet, etc.
Familiar with clinical and non-clinical support strategies
Ability to evaluate programs and analyze data
Manage budgets and carry out fiscal responsibilities for individual programs and greater departments
Possess comprehensive knowledge of the principles and practices of delivering services to diverse populations
within a holistic strength-based integrated health care approach
Understand and practice HIPPA and CLAS Standards rules and principles

## Professional Experience

2016-2018 **Native American Community Health Center (DBA as Native Health), Phoenix, AZ**
**Director of Integrated Community Health and Wellness Department**
**Responsibilities:**

- Native Health Senior Administrative Leadership Team member, working directly with the CEO and Native Health Board of Directors.
- Provided direction to the planning, program design, and operation of Native Health's Community Health and Wellness Department (CHWD) programs and strategies.
- Responsible for oversight and management for 10 programs funded by federal, state, tribal, and community grants to include all grand deliverables, fiscal management, reporting requirements, and renewals.
- Regularly monitored, analyzed, and reported on the status of CHWD.
- Led and managed 30-35 staff through a mentoring, coaching, and supervision model ensuring staff engagement and team alignment in order to meet organizational and departmental goals and objectives.
- Responsible for ensuring the integration of all CHWD programs with behavioral health, primary health clinic, and dental clinic.
- Provided education and training for CHWD and other Native Health departments.

- Provided analysis, and administrative information which informed Native Health policy development, decision making, and priority setting,
- Represented Native Health as a member of Native Health Integrated Health Care team throughout Maricopa County to include such entities as the Regional Behavioral Health Authority, Department of Child Services, The Coalition for Health Disparities, various school districts, etc.
- Participated as a member of several state and community sponsored committees/work groups.

2006 – 2015 **People of Color Health Care Network (PCN), Phoenix, AZ**
**Director of Children & Families' Integrated Health Care Services and Director of Diversity & Inclusion**

**Responsibilities:**

- PCN Senior Executive Team member involved in organizational strategic planning, direction and execution.
- Responsible for the overall coordination and management of Children and Families' integrated health care needs.
- Responsible for the performance and practice of 40+ direct care staff who provided High Needs Case Management Services to 425-450 children/youth with complex health care needs and their families.
- Responded to the tasks of organizing, planning, delivering, and evaluating services for Children and Families with complex intense needs to ensure fidelity to **Child and Family Team Practice Protocol, System of Care Principles of Practice,** best practices promoting **Family Driven Care, In-Home and Community Based Services, Cultural and Linguistic Responsiveness,** and **CLAS Standards.**
- Developed and implemented **Community Based** programs and trainings that responded to the unique needs of diverse community members.
- Promoted **culturally and linguistically** responsible and responsive care that supported measurable functional outcomes for **children/youth/families** to include **Native Americans, Latinos/Hispanics, African American, Asian/Pacific Islanders, Refugee populations, Whites, and LBGTQ/Two Spirited** populations.
- Organized and facilitated a **Community Diversity and Inclusion Network** to develop, implement and monitor a **Network Cultural Competence Plan.**
- Represented People of Color Network at the funder, the State, community, and stakeholder level.

**Four Direction Consulting, LLC, Owner Riverton, WY :**
2000 – 2006: **System of Care Consultant, Trainer and Coach:** Provided System of Care and Family-Centered Practice program development, training, coaching, and professional mentoring at a micro and macro organizational level. These services were provided to State child welfare and behavioral health agencies, private, and non-profit entities as well as Tribal communities to include the Northern Arapaho, Eastern Shoshone, Navajo, Lakota Sioux, and Pima Nations/Tribes.

Sub-contracted with **The Child Welfare Policy and Practice Group as a National System of Care Consultant** to provide culturally responsive training, coaching, professional mentoring, technical assistance, and consulting for the Maricopa County Regional Behavioral Health System through a System of Care Philosophy and model utilizing the Child and Family Team, Wraparound, and Family-Driven philosophy and practice modalities. Child welfare and behavioral health participants in this

system included a diverse population of children/youth ages birth through 17, transitioning aged young adults 18 through 24 and their families who were Medicaid eligible.

- Sub-contracted with the **Eastern Shoshone Tribe, Wyoming** to provide culturally responsive consulting services for program development, training, and coaching in Systems of Care and Wraparound practice for Tribal Social
  Services programs to include **child protective services.**
- Sub-contracted with the **Northern Arapaho Tribe and Wyoming Department of Family Services** to provide integrated in-home and community mentoring, coaching, and Child and Family Team facilitation training for federal and state funded programs.
- Contracted **with local attorneys** (Riverton, WY) to provide mediation services and home studies for divorced families and Wyoming Child Protection Services custody cases.
- Provided various trainings, development and implementation of to each of the entities listed above.

**Northern Arapaho Nation With Eagle's Wings Children and Families Services, Arapaho, WY**
1999 – 2001: **Project Manager for SAMHSA-funded Mental Health Project**

**Responsibilities:**

- Partner with Tribal Council and community members, SAMHSA program developers and project team to develop all aspects of the **System of Care Mental Health Project**
- Develop policy/procedures, practice protocols, job descriptions, recruitment, hiring, and retention processes.
- Supervise 15-20 employees
- Facilitate training, mentoring, coaching in System of Care and Wraparound process and protocol
- Work with Tribal community members to ensure cultural competence throughout the program
- Assess and facilitate the development of personnel improvement plans
- Facilitate internal and community trainings
- Provide one-on-one mentoring for staff skills development and counseling as appropriate
- Develop and maintain training measures and data to assess and track progress of staff and participants
- Share responsibility for implementing Continuous Quality Improvement (CQI) to include cultural competence
- Organize and present training workshops for staff, parent participants/advocates, children/youth, collaborative partners, cultural elders, and spiritual healers

**Educational Summary**

2000: **Master of Arts Degree in Counseling/Psychology**
Goddard College
Plainfield, VT

1993: **Bachelor of Social Work Degree**
University of Wyoming
Laramie, WY

1988: **Associates of Arts Degree**
Central Wyoming College
Riverton, WY 82501

Paul Vincent
Independent Child Welfare Consultant
[redacted]

**Education**

BA, Huntingdon College 1969
Major: Psychology, Sociology
MSW, University of Alabama 1972

**Employment History**

***Child Welfare Worker, Alabama Department of Human Resources, 1969-1970***

***Program Analyst, Special Programs, Alabama Department of Human Resources, 1972-1973***

Supervised a portion of the providers with purchase of service contracts for the delivery of services to children, families and vulnerable adults.

***Director of Special Programs, Alabama Department of Human Resources 1973-1975***

Directed the Department's social services purchase of services program, involving over sixty providers and supervised a staff of sixteen.

***Title XX Coordinator, Alabama Department of Human Resources 1975-1976***

Served in a temporary assignment to develop the Department's first Title XX Plan.

***Director of Special Programs, Alabama Department of Human Resources 1976-1979***

Returned to former position.

***Acting Director of Social Services, Alabama Department of Human Resources 1979-1981***

Served as the Department's first overall Social Services Director, overseeing child welfare, adult services and disaster services.

***Director of the Division of Child Support, Alabama Department of Human Resources 1981-1988***

Directed the Department's Child Support Enforcement program.

***Director of the Division of Family and Children's Services, Alabama Department of Human Resources 1989-1996***

Directed the state's child welfare program, including childcare and residential services licensure.

***Director, The Child Welfare Policy and Practice Group – 1996-2019***

Paul was the Director and founder 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 though strengthening front-line practice in child welfare and children's mental health systems. Current technical assistance work includes the child welfare systems in Florida, Illinois, Pennsylvania, Oklahoma, and Michigan. Work in these systems includes strategic planning, curriculum development, training, front-line practice coaching and system evaluation.

Mr. Vincent directed 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 led the organization's participation in the provision of technical assistance in systems involved in class action litigation, such as in Los Angeles County, where he serves as Chair of the Katie A. Advisory Panel, and In South Carolina, where he serves as co-monitor. He has also served in court monitoring roles in New York City and Utah in past years.

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. The settlement focused on a class of children in child welfare with mental health needs. 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. He was awarded NAPCWA's Annual Award for Excellence in Child Welfare Administration in 1994.

Mr. Vincent and staff, along with the federal court monitor, also developed the Qualitative Service Review (QSR) process during the same period. The QSR is an interview-based method of evaluating practice quality in child welfare, mental health, developmental disabilities and special education settings and has been used in more than 20 systems nationally.

**Child Welfare Group Technical Assistance Experience**

Relevant to mental health systems, Mr. Vincent led Alabama's R.C. settlement implementation, which required the development of a system of care for children with mental health needs served by child welfare. He currently serves as Chair of the Katie A. Advisory Panel, which is the court monitor in a settlement involving a class of children with mental health needs served by child welfare. A primary goal of the settlement was the creation of an array of intensive home and community based mental health services that meet the needs of children in their own homes and communities. Mr. Vincent has also been involved in providing mental health practitioner training and coaching for Foundations, a Washington DC based mental health provider serving children in the District's child welfare and children's mental health systems. The Child Welfare Group was involved in developing direct mental health supports and provision of training of managed behavioral health care staff (Value Options) in the child and family team process in Phoenix, AZ for three years, pursuant to the State's J.K. settlement. Other Child Welfare Group technical assistance has included:

- Evaluation assistance to the federal court monitor in the Oklahoma Terry D. case

- Curriculum design and training of the Oklahoma child welfare staff in engagement skills, strength-based assessment and case planning

- Performance review, with the American Humane Association and The National Child Welfare Resource Center for Organizational Improvement of the Department of Children and Family Services in Cuyahoga County (Cleveland), Ohio

- Review with the Center for the Study of Social Policy of the child protection assessment initiative in Iowa (variable response)

- Court monitor in the David C. child welfare settlement agreement between the National Center for Youth Law and the Utah Division of Child and Family Services

- Participation in a qualitative practice review of managed behavioral health care in Arizona

- Design of basic competency curriculum for Utah child welfare staff, training of trainers in its use (engagement skills, assessment skills, teaming, case planning and implementation) and consultation/coaching for trainers and system staff

- Membership, by Paul Vincent, on a five-person federal court panel, overseeing and advising New York City's implementation of a class action child welfare settlement agreement

- Evaluation of practice quality and law enforcement child protection role in Arkansas

- Evaluation of frontline child welfare practice in the eight Washington, DC Neighborhood Collaboratives

- Evaluation of child welfare practice, with The National Child Welfare Resource Center for Organizational Improvement, in Sonoma County, CA

- Evaluation of frontline child welfare practice and training of system staff in the qualitative practice assessment process, Iowa Department of Human Services

- Training and consultation for Alabama's child welfare system
- Training and coaching for Georgia's child welfare staff in ASFA implementation, assessment and qualitative practice evaluation
- Coordination of and provision of training for Georgia's annual foster parent institutes
- Case coaching and training for CPS staff in Fulton County (Atlanta) Georgia
- Training of trainers in Florida's child welfare Professional Development Centers related to Family Team Conferencing
- Completion of an evaluation of the Georgia Training Academy
- Completion of a qualitative practice review in Broward County Florida (District Ten)
- Review, with the American Humane Association, of CPS practice in Iowa
- Training of juvenile probation officers in Family Team Conferencing in St. Louis, MO
- Frontline practice training for FLOC, a Washington, DC neighborhood collaborative
- With the support of the Annie E. Casey Foundation, curriculum development assistance to the New York City Administration for Children's services
- Qualitative review of practice in seven of the districts of Florida's Department of Children and Families
- Training in Family Team Conferencing of child welfare trainers, supervisors and caseworkers in Maine
- Participation by Paul Vincent on a Tennessee court ordered technical assistance committee, pursuant to a class action child welfare settlement agreement
- Qualitative practice review in Dade County (Miami) Florida pursuant to the Rilya Wilson case
- Frontline practice training in Westchester County, NY
- Provision of Family team Conferencing training for District child welfare staff in Florida
- Independent, third –party evaluation of child welfare privatization in Broward County, FL

- Training and coaching in family engagement, family team conferencing, assessment, planning and strengthening case manager visiting practice for the New Jersey Child Welfare System
- Assistance to the New Jersey child welfare system in developing the QSR process
- Assistance to Indiana in developing and implementing the QSR process, developing and implementing new training curricula and training and coaching staff
- Assistance to Wisconsin in developing and implementing the QSR process, developing and implementing new training curricula and training and coaching staff
- Conducting a QSR for the Washington DC special education system
- Providing coaching to in-home and out-of-home supervisors for the Child and Family Services Agency in Washington DC
- Coaching Family Centered Practice in Florida
- Assisting the Pennsylvania child welfare system in implementing the QSR
- Supervisory coaching in New York State
- Training and coaching in Family Team Conferencing in Louisiana
- Evaluation of "Long Stayers" in Hamilton County, Ohio
- Evaluation of removal decision-making in Oklahoma and supervisory coaching
- Partner with North Highlands, a technical assistance organization, assisting Florida DCF with predictive analytics regarding child deaths
- Partner with North Highlands, a technical assistance organization, assisting Florida DCF in developing a Results Oriented Accountability Plan
- Conducting a review of the effectiveness and fidelity of the CFSA (Washington DC) CQI system
- Assisting Michigan in implementing the Qualitative Service Review
- Conducting an Assessment of the Strengths and Challenges in the Arkansas Child Welfare System
- Conducting an Assessment of the Strengths and Challenges in the Arkansas Child

Welfare System

- Providing Coaching to DCF Child Protective Investigators In Dade County (Miami) Florida
- Conducting a Qualitative Review of Front-End Decision-Making in Broward County Florida
- Training and Coaching in Illinois
- Quality Service Review implementation support in Michigan
- Evaluation of the Philadelphia child welfare system
- Evaluation of the Iowa child welfare system

Proposal of the Child Welfare Policy and Practice Group in Response to West Virginia Request for Proposal CRFP 0506 HHR2000000001

Child Welfare Policy and Practice Group
Large Project Management Information
September 11, 2019

Alabama – R.C. vs. Hornsby
Manager – Paul J. Vincent
428 East Jefferson Street
Montgomery, AL 36104

Illinois - Illinois vs. Smith
Manager – Paul Vincent/Cornelius Bird
428 East Jefferson Street
Montgomery, AL 36104

Los Angeles County – Katie A.
Manager – Paul Vincent
428 East Jefferson Street
Montgomery, AL 36104

New Jersey – Nadine H. Settlement Agreement
Manager – Cornelius Bird
428 East Jefferson Street
Montgomery, AL 36104

New York City – Marisol Monitoring Panel
Manager – Paul Vincent
428 East Jefferson Street
Montgomery, AL 36104

Oklahoma – DG vs. Yarbrough Settlement Agreement
Manager – Cornelius Bird
428 East Jefferson Street
Montgomery, AL 36104

Tennessee – Brian A. Settlement Agreement
Manager – Paul Vincent
428 East Jefferson Street
Montgomery, AL 36104

Utah – David C. Settlement
Manager – Linda Bayless, PhD. (Deceased)
Cornelius Bird
428 East Jefferson Street
Montgomery, AL 36104

Washington, D.C. – QSR
George Taylor
428 East Jefferson Street
Montgomery, AL 36104

South Carolina – Michelle H. Settlement Agreement
Paul Vincent
428 East Jefferson Street
Montgomery, AL 36104


# Iowa Department of Human Services
# Initial Targeted Child Welfare Review

**Conducted by:**

**The Child Welfare Policy and Practice Group**
**October 31, 2017**

# Reviewer Biographies

**Paul Vincent, MSW, LCSW**
**Director, Child Welfare Policy and Practice Group**
Paul Vincent is director of the Child Welfare Policy and Practice Group, a nonprofit technical assistance organization focused on front-line practice change. Vincent has directed the Child Welfare Group since its inception in 1996. In that role, he has led the organization's work in over twenty states, providing technical assistance in strategic system design, practice model development, curriculum development, training, practice coaching, and quality assurance. The Child Welfare Group has also been involved in several court monitoring roles. Vincent served as a member of the Marisol Advisory Panel in New York City, and is currently a member of the Tennessee Technical Assistance Committee related to the Brian A. settlement and chair of the Katie A. Advisory Panel in Los Angeles. The Child Welfare Group also served as the court monitor in Utah's David C. child welfare settlement.

Prior to the creation of the Child Welfare Group, Vincent worked for twenty-five years in the Alabama Department of Human Services, where, as child welfare director, he led the implementation of the RC class action child welfare settlement agreement during its first six years. The RC reforms had a transformational effect on child welfare practice and outcomes in Alabama. During that period, Vincent was awarded NAPCWA's Annual Award for Excellence in Child Welfare Administration.

**Sue D. Steib, PhD, LCSW**
**Independent Consultant**
Sue Steib has over forty-five years of child welfare experience including direct practice, agency administration, research, and consultation. Prior to becoming an independent consultant and joining the Child Welfare Policy and Practice Group in this initiative, she was senior 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 Louisiana and Oklahoma, joining with child welfare leaders there in their efforts to reduce the need for out-of-home care for children. Additionally, she served as part of a consulting team providing support to child welfare systems in fifteen states. From 2001 to 2008, 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 and make it accessible to agency leaders and direct practitioners through papers, workshops, and direct consultation. Steib came to CWLA after a thirty-one year career in Louisiana's child welfare system, where she served in positions ranging from caseworker and casework supervisor to administrator, leaving as the statewide child welfare program director.

## Table of Contents

# Iowa Department of Human Services
# Initial Targeted Child Welfare Review
# Conducted by:
# The Child Welfare Policy and Practice Group
# October 31, 2017

## I. Purpose and Focus of the Review

The Child Welfare Group was contacted by the Iowa Department of Human Services, Child Welfare Division following the deaths of two children who had been placed in adoption through the department. These youth, both girls in their teens, were in finalized, subsidized adoptive placements in separate homes. Both were home schooled; both died of starvation even while other children in the homes remained healthy. These two incidents, happening within a few months of each other, caused child welfare and state leaders to question what, if any, role policies and practices in the agency may have played.

Full scale reviews of child welfare systems can be very lengthy. Because the state is anxious for direction in preventing such tragedies in the future, the Child Welfare Group was asked to conduct a two-phase review, with the initial phase being designed to identify areas calling for immediate action as well as those which require further study. Thus the review and findings described in this report are limited in scope and, in many instances, raise additional questions.

Reviewers did not conduct an analysis of the two index cases that precipitated this work; that is being done by the Iowa Ombudsman. Rather, the focus of this review was on system concerns which these cases raised and primarily on those involving the child protection intake and assessment functions of the child welfare system. Obviously, given that both of these youngsters were in adoptive placements, their situations also suggest the need to examine placement decision making. However, the more immediate concerns related to the fact that both had, since their respective adoptions, been the subjects of reports child maltreatment reports that did not result in intervention to prevent their deaths.

## II. Methodology

### A. Data Collection and Analysis

Reviewers used a variety of data collection techniques including interviews of both individuals and groups; review and analysis of quantitative data, especially that related to the DHS workforce and workload and to intake and assessment activities; and documents including intake and assessment forms, practice guidance, training topics, and service contracts.

Interview participants included DHS administrators, managers, supervisors, and case managers; judges; attorneys representing the state, parents, and children; service providers; parents and grandparents; youth; foster and adoptive parents; law enforcement; medical professionals; representatives of the school system; and leaders of community prevention and service groups. One or both reviewers interviewed a total of 137 individuals in 39 sessions. Some participants were interviewed more than once to capture additional information.

All interviews followed a format of inquiring about agency and system strengths and needs. Where needs, in particular, were identified, interviewees were asked about underlying reasons, history, and barriers to improvement. Interviewers took detailed notes which were later transcribed.

Analysis of interviews to identify themes was accomplished by standard coding processes for qualitative data in which interview notes were coded according to a priori and emerging codes. A priori codes included expected categories such as workforce and workload, organizational structure, leadership, data and technology, administration and management, courts and legal system, placement resources, and service resources. Codes such as communication and resource family support emerged from the data.

Assessment of documents focused primarily on consistency with reviewers' understanding of current best practices in child welfare while review of quantitative data was directed to identifying work flow in the agency's intake and investigations functions and, where possible, comparison with national norms.

B. Limitations of the Review

Time and resources provided for this review limited its scope and depth in a number of ways. First, interviews were conducted primarily with state level DHS administrators, and with lower level staff, larger system stakeholders, service recipients, and others in the community only in the Des Moines and Cedar Rapids services areas. Additionally, reviewers did not read case records or observe the actual work of direct service personnel as might be done in a more in-depth assessment.

There was limited availability of what are generally viewed as key sources of information about practice and performance. While some quantitative data concerning intake and assessment were able to be obtained fairly quickly, this was not true of data reflecting the volume and outcomes in ongoing services due to the limitations DHS currently experiences in the facility of its data system and in the availability of personnel with the capacity to produce reports. Further, reviewers understood that agency policy was undergoing revision and thus relied upon practice guides to gain an understanding of policy related to intake and child abuse and family assessment processes. Finally, reviewers did not delve deeply into the department's human resources functions as they affect the child welfare workforce. Thus many questions remain concerning the hiring and selection process, length of time required to fill vacancies, the performance assessment and professional development processes, and the metrics applied in calculating caseload and workload.

## III. Agency Structure and Capacity

A. Structure

The Iowa Department of Human Services (DHS) is a large human services agency that has responsibility for the administration of multiple programs. In addition to being the state's legally mandated child protection and child welfare authority, it administers adult protective services, placement and supervision of the juvenile justice population, child support enforcement activities, public assistance, and medical services.

Activities of DHS personnel in five service area offices across Iowa are managed by the DHS operations division. Staff who fulfill functions related to child protection investigations and the provision of ongoing services to children and families who are the subjects of child maltreatment reports are located in county offices which also house personnel who fulfill the other functions of DHS. Direct services staff are

specialized in that they provide only child welfare and adult protection functions and are supervised by personnel who work only in these areas. Above the level of the direct services supervisor, managers also have responsibility for the other functions of the department.

Child welfare policy and practice guidelines are developed by the Child Welfare Policy Division at the state level. These staff do not have direct oversight of the frontline workforce that actually executes the child protection and ongoing child welfare functions in the county offices but rather work in tandem with the operations division which actually exercises authority over the activities of the county offices. The human resources, quality assurance, and data functions are also within the operations division.

DHS has full-time offices in 42 of the state's 99 counties. The other 57 counties have office space, but it is not staffed on a full-time basis. This means that personnel from the nearest fully staffed offices travel to work in those counties.

DHS uses a model of child welfare service delivery in which its front-line staff serve as "case managers," meaning that they coordinate casework activities, many of which are actually performed by individuals who are employed in organizations under contract with DHS or in other agencies. The majority of direct services to families are provided by Family Safety, Risk, and Permanency (FSRP) staff who work for contracted agencies. Contracted personnel also have primary responsibility for direct services in family reunification, monitoring of in-home safety plans, and in recruiting, assessing, and training resource families who provide care for children in protective custody.

B. The Child Welfare Workforce and Workload

*Staffing and Qualifications*

Service delivery staff in child welfare are of two primary classifications: Social Worker II and Social Worker III. The Social Worker II position is responsible for ongoing services while the III performs the child abuse or family assessments that are done following a report of suspected abuse or neglect being accepted at intake. Their activities are over seen by Social Work Supervisors, most of whom have risen from positions as social workers in direct services.

Social worker is not a legally protected title in Iowa and thus there are no educational or licensure requirements for staff beyond possession of a general baccalaureate degree. Those without social work degrees are required to have at least three years of experience in some aspect of social services although it was not clear to the reviewers just what kinds of work fulfills that requirement. Persons having a baccalaureate degree in social work must have two years of experience and those with a master's degree in social work may hired without experience.

Some of those interviewed expressed concern that many of the personnel responsible for service delivery lacked the level of expertise required, commenting that educational requirements are not has high as they should be or that there should be a greater commitment to professional social work practice in the rank and file of the agency.

*Staff Stability*

Rates of turnover among DHS child welfare staff are relatively low compared with those in many other states. It was reported that turnover among both Social Worker II and III positions over the last five years has ranged from 3.4 percent to 8 percent. Last year it stood at less than 2 percent, lower than the

8% for state employees overall. The average tenure among Social Worker IIIs performing child abuse and family assessments is 14 years and among Social Worker IIs, 11 years. These figures depict a much more stable workforce than is typically seen in child welfare agencies in the United States where turnover rates average about 20 percent and are often much higher.

Workforce stability is attributed largely to the fact that salaries are relatively good. Additionally, Social Worker IIIs performing child protection assessments are able to draw overtime. Reviewers were told by a number of these staff that they would never consider moving to supervision as the loss of overtime would mean a reduction in pay even with a promotion since supervisors are not eligible for over time compensation.

While statewide figures depict an exceptionally stable workforce, information obtained in interviews indicated that there are exceptions in some counties. Polk County was consistently described as being a county with very high turnover and high turnover was cited in Linn County as well.

*Workload*

Workload in child welfare is an issue of concern at the current time. Reviewers were unable to determine the exact status of current caseloads. Figures were provided for average caseloads based on the number of positions provided. Reviewers were told that case managers generally carry about 15 families or about 30 children in a combination of out of home care and in-home services cases. Assessment staff receive an average of 11.5 new cases per month, down from 13.9 in 2012. This figure was reported to have been stable for the past few years.

Actual caseloads in some counties were reported to be much higher than the statewide average. Reviewers were told this was true in both Polk and Linn counties. Some counties were reported to have ongoing caseloads as high as 40 families with child protection averaging over 20 cases per month. In the two service areas in which interviews were conducted, system partners in the courts, other public agencies, and providers consistently expressed concern about workloads in DHS, with some using the terms "brutal" or "overwhelming".

A report of cases per worker as of April of 2017, showed 119 of 1995 Social Worker IIIs receiving an average of between ten and fourteen cases per month with 61 having receiving between fifteen and nineteen. Two had greater than twenty and only thirteen received nine or less. Among 312 Social Worker IIs, 275 were reported to have caseloads of fifteen cases or greater with 144 of those at thirty or greater and over forty exceeding forty. In the case of Social Worker IIs, it is not clear whether cases are considered individual children or families. However, even if these are weighted more heavily as children, these caseloads far exceed those prescribed by Child Welfare League of America Standards.

The ratio of supervisors to case managers is one to seven which exceeds the one to five ratio recommended by the Child Welfare League of America. Workloads of some supervisors are also affected by the fact that they must travel to multiple counties. In addition to case consultation, supervisors have responsibility for overseeing and documenting the transfer of learning of new staff who are undergoing training during their first year of work. Although this is a duty that is certainly appropriate for supervisors, it does increase workload, particularly in those counties with higher turnover in which supervisors are thus being assigned new trainees more frequently than in those counties where the workforce is relatively stable.

*Training and Professional Development*

New staff receive four weeks of training consisting of about 160 hours over the course of their first year of work with on-line and classroom training being interspersed with field experience. All child welfare personnel are required to have 24 hours of ongoing training per year. DHS has a relationship with Iowa State University to provide some training using either its own faculty or subcontracting with other professionals who have received positive staff evaluations based on delivery of prior training. In addition, some DHS staff also serve as trainers.

DHS conducts annual training needs surveys and undertakes to develop new course offerings based on those results. Individual needs for ongoing learning are intended to be identified as part of the annual performance assessment process. It was not clear to reviewers, however, to what extent that is actually being done.

A number of those interviewed, including some DHS staff, indicated that training is insufficient. Areas in which some external professionals indicated having observed deficiencies are in interviewing skills, particularly in interviewing children, skills in engaging parents and other subjects of reports, assessing the vulnerability of children, and familiarity with indicators of maltreatment.

DHS has a contractual relationship with Iowa State University using federal Title IV-E funding that provides subsidies for the professional development of child welfare staff. In many states, such university-agency partnerships also support stipend and internship programs designed to recruit BSW students into child welfare practice and to provide opportunities for those already employed, especially supervisors, to pursue masters in social work. Iowa DHS does not currently use its IV-E funding capacity in this way.

*Staff Morale*

Staff morale in the service areas reviewers visited was described by many of those both within and outside of DHS as poor. Recent legislative changes in collective bargaining, budget cuts, workload, and a culture that seems heavily compliance focused were all cited as reasons for this. One advocate observer commented that, "There has for a while now been the expectation of doing more with less. After a point, it becomes impossible."

Some also referenced lack of support within offices with external system partners in particular observing that front line staff seem to feel that "no one has their backs", and that case managers or supervisors risk becoming scapegoats in case crises regardless of their level of skill or other work record.

C. Administrative Systems

*Child Welfare Policy Division*

Reviewers had multiple interviews with both the Child Welfare Policy Director and the Child Welfare Bureau Chief as well as with lead administrators in key program areas such as child protection, foster care, adoptions, and those overseeing contracts with service providers. In general, these individuals have impressive credentials. Most are degreed social workers with several, including the policy director and bureau chief, having Masters in Social Work, and they have lengthy child welfare experience. Most demonstrated knowledge of current best practices including a number of evidence-based models and were able to identify challenges as well as strengths in their areas of responsibility.

Leaders of provider agencies and other system stakeholders tended to express confidence in these administrators, indicating that they were able to communicate well with them and that they found them to be collaborative and supportive of public-private partnership efforts to improve services to children and families. They were also described by several informants outside of DHS as being forward thinking and as doing the best that can be done with resources that, in some respects, are very limited.

*Data Capacity*

DHS uses the web-based Results Oriented Management (ROM) system for its intake and assessment functions. This system is updated daily and is reported to provide easily retrievable data tracking intake of reports and their disposition. Unfortunately, the department's capacity to track and easily access and analyze data for ongoing services and children and families involved in out of home care is far less robust. Administrators report that it is badly outdated and that the length of time required to provide data requested by reviewers in the form in which it was ultimately suggest a system that is incapable of providing the kind of readily accessible and detailed reports that twenty-first century child welfare systems require to manage effectively and to actively use data to drive continuous practice assessment and improvement.

Reviewers were told that DHS has outlined a plan for revision of the current child welfare system, but has no timeline for when resources many become available to build it. Currently, the majority of funds available for information technology are being devoted to the system that supports medical assistance.

B. The Continuum of Child Welfare Services

*Intake*

Conditions under which reports of maltreatment are accepted and assessed by DHS are prescribed by state law and DHS policy. As in other states, Iowa's law and policy provide that the mandated child welfare agency is responsible for investigating reports alleging that a child is being abused or neglected by a person responsible for his or her care. Reports of maltreatment that do not involve a caregiver as an alleged perpetrator are the sole responsibility of law enforcement. The legal definition of a person responsible for a child's care in Iowa is, however, broader than that of many states and substantially broader than some. Although Iowa does not stand alone in its liberal definition, it is definitely, in the opinion of reviewers, as broad as any and broader than most. A number of states confine the person responsible for a child's care to parents and legal guardians or custodians. Others also include other adults in the child's household, or employees of institutions that have a legal responsibility for the care of the child. The Iowa definition has no limits based on age of the caregiver, legal status, or duration of the caregiving responsibility. This means that DHS can also be required to investigate reports of abuse involving only other children as alleged perpetrators in a household or care setting and that it could be required to investigate reports involving a child in almost any setting.

During regular business hours, reports alleging abuse or neglect are received by a central unit or "hotline" which is staffed by 25 Social Worker III level staff. These personnel assess whether incoming calls meet the legal requirements of reports and are charged with getting as much information as possible on which to base decisions about the level of priority that will be assigned to a report and to facilitate the initiation of the assessment by designated staff. All calls that are initially rejected by intake staff are subjected to a supervisory review to confirm that the report should have been screened out.

The intake unit also uses two senior level caseworkers to review reports to identify needs of individual staff for further training and coaching.

The central intake unit currently receives an average of 250 calls per day and reports that call volume has increased this year. Since the two child deaths which precipitated this review, intake staff have been instructed to accept reports that otherwise meet the legal prerequisites whether or not the reporter is able to offer any information to indicate that the child has sustained harm or is actually threatened with harm as a result of the alleged maltreatment. The number of screened out intakes in Iowa has declined from about 50 percent to about 35 percent of all calls. This places Iowa above the national average of 41.1 percent in the proportion of reports that are screened in.

After hours child protection intake is handled by operators at the Iowa State Training School for boys. Calls are then referred to designated Social Work Supervisors. Several of those interviewed within DHS voiced concern about lack of consistency in the after-hours intake process and expressed the view that the central intake unit should be expanded to receive calls around the clock.

Intake designates an assessment track and a response time for each accepted report based on the type of abuse or neglect alleged. Iowa, like many other states, uses a differential response (also called alternative response in some states) system that directs reports deemed to constitute lower risk to a less rigorous family assessment process. These reports allege denial of critical care, but without any information to suggest imminent danger or injury. The response time for family assessments is 72 hours. As of January 2017, any report that alleges parents are using drugs other than marijuana cannot be referred to this track.

All reports that include allegations of immediate danger or harm are referred for child abuse assessments which have more detailed and rigorous investigation requirements. A response priority of one hour, 24 hours, or 96 hours is assigned depending upon the nature of the allegations and the circumstances described by the reporter.

*Child Protective Services*

Social Worker IIIs, who are based in county offices, conduct both family and child abuse assessments. Iowa, like other states, uses safety and risk assessment tools and all reports, regardless of the track designated, receive a safety and risk assessment. Assigned caseworkers have ten days to complete a family assessment and twenty days to complete a child abuse assessment.

DHS uses a safety assessment instrument that closely tracks those in use in other systems. It includes items intended to assess present or impending danger, caretaker capacities, current conditions within the family, child-caregiver interactions, and the home environment. Caseworkers are also required to describe current safety threats and to identify protective factors and the extent to which they might mitigate safety threats. Each child who is the subject of an assessment must be found to be either safe, unsafe, or conditionally safe based on protections that can be put in place to address specific dangers.

Both family and child abuse assessments also use a risk assessment tool to assess the degree of risk of significant harm in the longer term. Iowa uses a risk assessment tool developed and tested in Colorado. Reports of reliability and validity testing conducted by Colorado State University indicate that its items have at least moderate reliability and that they acceptably discriminate between those with greater and lesser likelihood of future referrals of maltreatment.

Child abuse assessments result in a finding of either "not confirmed", "confirmed", or "founded". A designation of confirmed indicates that, while a finding of maltreatment was made, it was determined to be "isolated, minor, and unlikely to happen again". Confirmed findings are not placed on the central child abuse registry. Founded cases are those deemed to involve greater degrees of harm and/or additional risk and are placed on the child abuse registry.

Practice guidances for child abuse assessments reviewed raised some questions for reviewers. First, caseworkers are required to obtain parental consent of court order to meet with and interview child victims. It is unclear how this might work when combined with short response times, especially those requiring that a child's safety be assured within one hour. Likewise, the assessments time frames of twenty days for suspected child abuse and ten days for family assessment are shorter than those in many jurisdictions which often provide for between thirty and sixty days.

Iowa DHS implemented it differential response system in January of 2014. A 2016 report issued at the end of calendar year 2016 found that they system was working as intended and that outcomes overall were positive. Specifically, it noted:

- 95% of children who received a family assessment did not have a substantiated abuse report within six months.
- 98.09% of families referred to Community Care services do not experience a Child in Need of Assistance (CINA) adjudication within six months of service.
- 92.92% of families referred to Community Care services do not experience a substantiated abuse report within six months of service.
- 3,815 families were referred to Community Care.
- 1,350 of 8,857 families originally assigned to the family assessment path were re-assigned to the child abuse assessment pathway.
- Reassigned families constitute 5% of all accepted intakes for CY16. Of the families reassigned, 50.5% resulted in a confirmed or founded outcome, which indicates pathway reassignment is being utilized as designed

As of January 2017, a change in intakes eligible for designation as family assessment rather than child abuse assessment was made that excludes any involving allegations that a child's caregiver is using dangerous drugs. All such reports must now be referred for child abuse assessments.

Despite the outcomes stated above, however, several of those interviewed expressed concern that differential response as it currently exists, is not sufficiently accountable. A chief complaint was that families may be referred for Community Care whether or not they have committed to be voluntary involved in a plan of services. Reportedly, Community Care providers are paid a few of $500 per family whether or not a family actually engages in services.

*Ongoing Services*

When children are placed in the protective custody of DHS or families referred for ongoing services following a child abuse assessment, they are referred to units staffed by Social Worker IIs who serve as case managers. These staff coordinate case activities and carry responsibility for ensuring the development of case plans, provision of services and working with the courts toward final disposition. They are required to have regular in-person contact with parents and children and visits with children must occur at least monthly in the homes where they are placed. Most direct services, however, are provided by contracted staff.

C. Key Issues in Policy and Practice

*Family Engagement*

Although case managers are required to have monthly contacts with parents, these do not have to occur in parents' homes. Thus, they often take place incidentally in association with parent-child visits, court hearings, or other case activities.

Interviews with youth, parents and grandparents, foster parents, and DHS case managers indicate that many believe there is insufficient focus on engaging children's parents in assessing needs related to child safety, planning interventions to address them, and evaluating progress. One long-time external partner observed that the emphasis on working with families and on reunification seemed to have been lost.

Some of those interviewed expressed concern about the number of people, including contracted providers and case managers that are involved with families. They wondered whether, with multiple service providers, particularly when many of them have overwhelming workloads, families really have an opportunity to form a working alliance with anyone.

*Family Teaming and Case Planning*

DHS policy does call for family team meetings which are to be held quarterly. However, they are reportedly not held consistently. Interviewees indicated that case plans may be crafted outside of team meetings, either by case managers themselves, by the court, or by both without input from the family. Some expressed concern that, even when team meetings occur, parents may not be adequately prepared for them and may not understand that they can invite extended family, friends, or other significant persons to be present. Team meetings were described in some locations as often being "too attorney driven" and without strong and expert facilitation. Reviewers were also told that, too often, case plans are "cookie cutter" meaning that they do not appear individualized to meet family needs.

Despite reported concerns related to the quality and consistency of teaming, reviewers were told that requirements related to facilitation training and the format and timing of team meetings in FSRP contracts are quite detailed and rigorous. All facilitators must undergo a 3 day training followed by a six month period in which they work with a coach who is already an approved facilitator. The trainee must then co-facilitate with the coach, who evaluates his or her performance and makes a recommendation for approval. There is a separate 1 day training and an additional coaching process for Youth Team Decision Making facilitators. All facilitators must be re-authorized every 2 years and complete 6 hours of training quarterly. Unless there is turnover in facilitators, families are to have the same one at all team meetings.

*Communication and Confidentiality*

External professionals involved in making referrals to or in serving the child welfare population frequently cited problems related to their inability to communicate with DHS beyond making a report to the central intake section. Physicians, educators, and providers of community-based prevention services, all of whom are mandated reporters of suspected maltreatment, expressed frustration with their inability to communicate with DHS, particularly following their having made a report. Most indicated that they are unable to learn to whom a report has been assigned so that they can communicate additional information.

Educators and community-based prevention providers, in particular, also expressed concern about the way assessments are handled stating that they often result in parents being provided with information that allows them to conclude who made a report or who was contacted as collaterals, causing them to disengage in contacts with the school or with community services even when no intervention occurs to otherwise ensure the safety of the child who was a subject of the report. Several also cited situations in which this has resulted in parents' retaliation against children as information made available to the parents made it clear that children had made disclosures alleging maltreatment. In these cases, children may cut off communication with teachers, counselors, or mentors whom they had previously trusted.

Youth interviewed also expressed concern about communication. Most said that they had had difficulty reaching their caseworkers and several recalled instances in which they had been unable to participate in school or extra-curricular activities because their parent's or caseworker's permission was required and they had been unable to secure it in time for the event. Both youth and resource parents also expressed frustration with being unable to get copies of needed documents, especially children's birth certificates, which are often needed, particularly by youth as they reach age 18. Apparently birth certificates that DHS obtains are stamped "for DHS use only" and cannot be used for any other purpose such as for a youth to obtain a driver's license.

*Concurrent Planning*

DHS practice guidance endorses concurrent planning, the practice of identifying an alternative permanent plan for a child in out of home care, even while still working diligently with his or her family of origin to achieve reunification. Concurrent planning is an accepted practice in child welfare that is designed to ensure that children achieve permanent placement outside of foster care at quickly as possible. It is preferred to a sequential planning approach in which an alternative permanency resource is sought only after reunification has been ruled out. Despite the advocacy of concurrent planning, however, several of those interviewed indicated that they had not observed it to be practiced effectively in many instances. Some informants mentioned that, in their experience, efforts to locate family and consider them as alternative permanency resources, particularly those in a child's paternal family or who live some distance away, are inconsistent.

C. Review of Quantitative and Qualitative Data

*Quantitative Data*

During calendar year 2015, Iowa DHS received 46994 reports of alleged child maltreatment of which 24562 (48%) were accepted for assessment. In 2016, that number rose to 50091 reports with 25950 (49%) accepted, an increase in assessments of about 6%. During the first half of 2017, 27463 reports were received and 16925 (62%) accepted. If reporting and screening continues at these rates through the remainder of the year, the agency will receive 10 per cent more reports than last year and will conduct 31 per cent more assessments. This likely presents a challenge given that the number of Social Work III positions has not increased.

In 2016, of 18,481 child abuse assessments, 6575, or almost 36 per cent, were either confirmed or founded. Of those, 4,385, we referred for formal ongoing services within DHS while, 1806 were referred for Community Care and another 1, 268 received information and referral services to connect them with additional resources. As of the first five months of 2017, child abuse assessments have increased

substantially, by 43% over last year, likely reflecting lower screen-out rates and the fact that a greater proportion of accepted reports are being referred to the child abuse assessment track than prior to policy changes made this year. The portion of those assessments that are either confirmed or founded has dropped to just over 32 per cent.

Children enter and remain in out of home care in Iowa at a rate higher than the national average. At the end of 2016, Iowa had just under 6000 children in care, a rate of about 8.2 per 1000 children in the population compared with a national rate of about 5.5. Entries into care each year occur at a rate of about 6 per 1000 children in the population compared with a national rate of about 3.3. This number is somewhat difficult to interpret, however, given that children entering through the juvenile justice system are also included in the population. This is not true of foster care counts in many states.

A total count of calendar year 2016 showed that 10,200 children were in out of home care for some portion of the year. Of those, 1530 were placed through juvenile services, and 8670 entered through child welfare services. If these figures hold true currently, they suggest that, at any one time, about 18 per cent of children in care are placed through juvenile justice.

*Qualitative Data*

Evaluators reviewed the statewide CFSR case review data for FY 17. For the 65 cases reviewed, in the 18 items assessed, DHS performed well in areas such as Timeliness of Investigation Initiation (85.9%) and Services to Protect Children in the home and Prevent Removal/Re-entry (91.3%). The Department was challenged in the areas of Child and Family Involvement in Case Planning (53.5%), Needs and Services of Child, Parents and Foster Parents (50.7%) and Caseworker Visits with Parents (20.6%).

D. Contracted Services

Iowa DHS has begun to use performance-based contracting in the following areas:

- Child welfare emergency services
- Foster care group care services
- Supervised apartment living
- Recruitment & retention of resource families
- Training and support of foster parents

Both DHS administrators and providers were generally positive about this new contracting approach although some providers expressed concern with its "no reject, no eject" requirement with regard to accepting and maintaining youth in placement even when they believe their program is unable to provide the needed level of care.

The most widely used contracted service for families involved in child welfare appears to be Family Safety, Risk, and Permanency (FSRP), which serves needs related to family preservation and reunification. This includes service planning with families and carries a requirement that service plans be created within the first thirty days after referral, that they be based on the family's safety assessment, and that they align with the DHS case plan which must be created within sixty days. FSRP also arranges and provides supervision for parent-child visits when children are in out of home care, and provides facilitation for family team meetings.

The contract between DHS and providers of FSRP lists extensive functions that the "Care Coordinators" employed by FSRP agencies are to provide. These include help in improving family communication and

relationships including parent-child interaction, services to promote family reunification, parent education, parent coaching and mentoring, assessment of parent-child interactions in visits, support and supervision to maintain child safety when children have been reunited with the families, and many more.

Contracts with providers of FSRP specify staff qualifications of a baccalaureate or master's degree in "human services or a related field" and one year of child welfare experience or an associate's degree in human services and four years of child welfare experience. It was learned that requirements for these staff had been lowered recently based on contractor feedback. No training requirements are stated. However, providers are required to be accredited by an appropriate national accrediting body which has its own requirements for training. Accrediting bodes also specify requirements for supervisors. Contracted providers are allowed to have their staff attend the training that is provided for DHS staff through the Iowa State University Child Welfare Training Academy if space is available.

A consistent theme in interviews conducted during this review was that FSRP staff were not well-qualified for the level of the work they were expected to do and that turnover among the Care Coordinators is high. Some voiced the opinion that the functions they performed amounted to really just monitoring and transportation, not substantive service delivery. Administrators of FSRP provider agencies, on the other hand, spoke of onerous requirements for provision of transportation that consume large amounts of time. They also indicated that staff turnover "ebbs and flows" in relationship to DHS hiring as many personnel leave positions in contracted agencies for better pay and benefits at DHS. Indeed, reviewers noted that a number of case managers included in interview groups referenced earlier experience as Care Coordinators in FSRP. Reviewers were informed that FSRP contracts in the Cedar Rapids and Des Moines service areas experience the highest staff turnover.

FSRP providers elsewhere in the state are reportedly offering some evidence-based intervention models including SafeCare, which is being offered by five of the eight FSRP providers. Some are also offering The Incredible Years and the Boys Town parenting models.

In addition to FSRP, DHS also contracts with these providers for Safety Plan Services. This service is intended to provide short-term support in-home safety plans for children identified in a child abuse assessment as in danger. Staff are engaged for up to two 15 day periods, must meet with families within 24 hours of the initial, and be available to the family 24 hours a day every day to respond to any crisis. Some DHS personnel interviewed indicated that they lacked confidence that Safety Plan Services had the capacity to adequately monitor the safety of children in their own homes.

SPS (safety) services are a daily service; these provider safety plan monitoring. The service period is for 15 days, but it can be renewed. These contracts are not used consistently across the state.

E. Service and Placement Resources

*Service Array*

Information about the array of resources available to serve children and families involved with DHS is limited as this review is confined to the Des Moines and Cedar Rapids service areas. Those interviewed noted that they enjoyed a wealth of resources in many areas. The most consistently cited area of need was in mental health treatment, especially insofar as in-patient services are concerned.

Those interviewed in the Des Moines area in particular pointed to a wealth of resources as a substantial strength. However, it is now known to what extent that is true in other areas of the state.

The *Parent Partners* program which provides trained and supervised parents who have already successfully experienced child welfare services, operates in all counties in Iowa. It currently employs 150 "partners" under the supervision of 18 coordinators. Although most agreed that it needed greater capacity. This model was mentioned by DHS and contracted services staff, court personnel, and parents themselves as being one of the most favorable aspects of the service array.

Staff in Linn and Polk counties enjoy the support of other disciplines, including medical and law enforcement professionals, in making decisions in especially complex cases. In Polk County in particular the interdisciplinary team which DHS supports and coordinates, was cited as very beneficial. When, earlier this year, it went for several months without meeting after the loss of the supervisor that chaired it, it was much missed by both caseworkers and external professionals.

*Placement Resources*

Given the number of children in out of home care in Iowa, the demands upon DHS for the provision of suitable placements is significant. Currently, DHS is making efforts to place children as close as possible to their families of origin, an effort which reviewers strongly support since keeping children in close proximity to their families greatly contributes to maintaining family connections and increases the chances of reunification.

With few exceptions, resource parents interviewed in this review stated that many needed supports were lacking, that they had great difficulty communicating with case managers, and that they did not know to whom to turn within DHS when case managers could not be reached or were not responsive to requests. Specific concerns included inability to get critical information about children being placed in their care, denials or delays of permission for children to participate in activities, to get haircuts, or routine medical care because parents must give permission, a rate of payment that makes acceptable child care practically unavailable, long delays in receiving reimbursements, and disrespectful treatment when, as often happens, they are subjects of unwarranted maltreatment reports.

DHS staff encounter difficulty finding suitable placements from among the available families and some of those interviewed expressed the belief that there are many families who are unable or unwilling to provide the quality of care that children require. Apparently, in Iowa, there is a right to be a foster parent as some who homes are closed file appeals that are upheld by state hearing officers. It was also reported to be common to allow variances beyond licensed capacity in resource family homes due to the shortage of placements.

DHS also uses shelter care placements across the state. Most of these are licenses for older youth, but some also care for infants and young children. Shelter placement for any age child is intended to be only for very short periods of time. However, several of the youth interviewed indicated that they had been in such placements for several weeks and one for almost a year. These youngsters recalled that shelter placement is inherently anxiety producing as their own futures remain uncertain and they watch other children come and go on almost a daily basis. Because it is designed to be very short term, shelter programming is not designed to provide intervention tailored to children's individual needs. One youth stated, "No healing takes place in shelter care."

G. Courts and Legal System

Dependency courts throughout Iowa use a one family-one just model which is considered to be good practice in that it provides continuity in oversight of a family's progress in making the changes necessary to make children safe and in moving children to stable permanent family placements outside of foster care. Reviewers were also impressed with the reported level of activity by Iowa's Children's Justice Initiative (CJ), the state's Court Improvement Program which operates under the auspices of the state Supreme Court. CJI has 5 full-time staff (4 program and 1 financial manager). It conducts assessments of the court process and court orders in dependency and provides consultation for courts on best practices in dependency. It also manages the grants for the family treatment courts in the state, convenes the various committees and advisory councils involved in the state's child welfare system, and provides some cross training for CW and legal professionals involved in dependency cases.

Iowa has a number of specialized courts for families involved in child dependency matters. The state, through CJI, received a Community-Based Regional Partnership Grant in 2007 and initially set up 6 family treatment courts. The number has now increased to 12. The treatment court program uses the Strengthening Families model which provides families of children 3-5 years old and 6-11 years old with 14 weeks of treatment. A pilot site has been established for parents with children 0-3. Treatment also includes Recovery Support which invoives both professional and peer support. Treatment Courts use the UNCOPE substance abuse assessment.

County attorneys present dependency cases on behalf of the state in Iowa and serve to unofficially represent DHS. In particularly complex cases and in all terminations of parental rights, DHS is represented by attorneys from the state Attorney General's office. Both children and parents are represented by legal counsel. Parents, if indigent, are represented either by the public defender or by private appointed counsel.

Reviewers were able to talk with court personnel in both Polk and Linn counties. In Linn, parents who are indigent are usually represented by attorneys with public defender's office. Attorneys who represent children are contracted. In Polk County, the court appoints private counsel for parents from a list of attorneys who have registered with the court. Judges are required to select attorneys at random. Attorneys are required to have three hours of specialized training per year to retain their eligibility to represent parents. Children's attorneys are provided by either the Juvenile Public Defender, Youth Law Center, or the Drake University Children's Law Clinic.

In Polk County the juvenile bureau within the Office of the County Attorney is reported to be staffed with seasoned attorneys with a commitment to juvenile law. This is also true of the bench, which has dedicated juvenile judges with several of the current six having substantial experience in juvenile law.

Agency-court relationships in both Linn and Polk counties appeared to be reasonably positive. Differences across sections of court sometimes challenge DHS, contracted providers, and resource parents, and workloads are viewed as a factor that sometimes keeps DHS from producing needed documentation such as reports or social summaries on time. However, the relationship with the County Attorney's office helps ensure that interactions with the court run smoothly for the most part.

Some parents, youth, and resource families who were interviewed indicated that they had been visited by their attorneys or had had interactions with them outside of court. This was not, however, the norm.

Two foster mothers, each with greater than 25 years' experience and having cared for dozens of children, indicated that they had, respectively, experienced two visits and one visit by attorneys with children placed in their homes.

H. Client Advocates and Service Recipients

*Parents and Grandparents*

Parents, grandparents, and client advocate groups interviewed appreciated the use of Parent Partners. They also acknowledged that some services to which they were referred by DHS addressed needs in their families. However, they consistently voiced mistrust in DHS and in the courts.

Specific issues raised had to do with the belief that actions to remove children from families were monetarily driven based on federal funding streams which provide monies for out of home care rather than support of in-home services to families; that reasonable efforts to prevent removals are not consistently required; and that relatives are not properly evaluated as placement resources.

Families also expressed concern that service providers were not sufficiently qualified based on education and licensure to offer services to address identified needs. They feel that there is insufficient accountability and that there are no mechanisms in place to ensure that the services they receive, ostensibly to help them address deficiencies identified by DHS and the courts, are effective and in sufficient supply.

*Youth and Youth Advocates*

Iowa has an active and well-supported organizational structure for its older youth and recent alumni of foster care. There are 15 youth councils statewide; councils provide input into agency policy and legislation. About 45 youngsters each year are able to attend a one week summer camp that teaches leadership skills.

Although Iowa does not allow youth, with the exception of those having significant development needs, to remain in foster care status until age 21, DHS does support an aftercare program which provides some case management, educational supports, and a stipend of up to $600 per month which may be adjusted downward if other resources are available to the youth. Youth must enter the aftercare program voluntarily when they become 18 years of age. Eligibility ends at age 21 but a youth may retain eligibility for scholarships and medical assistance.

Youth who were interviewed in this review were appreciative of the aftercare supports offered. Many also felt, however, that they could benefit from more mentoring and from the opportunity to receive aftercare case management until age 24. They pointed out that, given the chaotic backgrounds and educational delays that are characteristics of youth who have experienced foster care, many are not really ready to function independently even at age 21.

**IV. Discussion**

This section of the report examines the findings detailed in section III above in light of critical aspects of child welfare system organization, administration, and functioning.

A. Organizational Structure and Capacity
*Structure*

Reviewers have some concern about the placement of child welfare within the array of responsibilities assigned to DHS. As previously stated, DHS has a wide range of responsibilities. These are all critically important public services and deserving of conscientious and efficient administration. However, child welfare differs greatly from the more regulatory functions associated with public assistance, child support enforcement, and medical assistance. Even adult protective services, which may be most akin to child welfare in that it involves assessing the care and treatment of vulnerable individuals, differs significantly in terms of the clinical knowledge and skill needed for competent assessment, the need for long range planning, and the legal and practice pathways of disposition and resolution that are available.

As stated above, reviewers' impressions of the knowledge and performance of staff in the DHS child welfare policy section is generally positive. However, the degree to which the policies and initiatives they design are actually implemented in a system in which administration and management is layered with responsibilities for multiple programs and in which mid-level managers may or may not have child welfare experience or formal social work training is questionable. Such a structure seems to invite the adoption of practices based more on system efficiencies than on the values and knowledge base of professional social work and what is known about the underlying causes and effective treatment of child maltreatment.

Assessing the often multiple and complex needs of families and children who present to child welfare systems requires substantial clinical knowledge and skill in gathering and interpreting information, applying intervention, and determining the sufficiency of change related to child safety. This is often a challenge for front-line caseworkers in today's child welfare agencies and calls for them to have substantial expert support in the ranks of supervision and management. If that is absent, even long experience may serve only to ingrain practices that do not lead to accurate and complete assessment as a basis for sound decision making about the safety needs of children.

*Data*

The data system currently in use for intake and child protection functions of DHS appears to be working well. It is reportedly both current and accessible for administrators and managers. The older system on which DHS must rely for ongoing services, including those pertaining to children in out of home care, is out of date and so difficult to use as to be considered all but unavailable to staff. Indeed, the information that reviewers received from that system was in a format that would make it daunting for analysis and interpretation.

Forward-thinking child welfare professionals of today are teaching staff to use data to assess their performance, identify areas of practice needing attention, and actively monitor key metrics as they adjust efforts toward improving outcomes. This cannot be accomplished with the kind of data base now in use for ongoing services in Iowa DHS.

B. Policy

This preliminary review did not involve a complete analysis of current policy in DHS, but rather of intake policies and practice guidances to be applied in child abuse and family assessments. In terms of intake, it appears that state law and its interpretation, particularly as it pertains to the definition of a person responsible for the care of a child, the variable which most distinguishes maltreatment concerns that are

directed to the child protection agency rather than to law enforcement alone, is exceptionally broad. (For purposes of comparison, details of state child abuse reporting laws current as of 2016, may be accessed at https://www.childwelfare.gov/pubPDFs/define.pdf.) Additionally, since the two index cases which precipitated this review, DHS has changed its intake screening procedures with the result that the percentage of reports accepted has risen from about 50 percent to about 65 per cent. This has occurred during a period of increased reporting as a well as a shift in policy which assigns more investigations to the child abuse assessment track rather than to the less rigorous family assessment track. Child abuse assessments carry demands for response times that may be as little as one hour and are in most cases within 24 hours.

These policy measures, the broadening of intake and the lowering of screen-out rates, are familiar; they follow a pattern often followed by states in the wake of child fatalities or other high profile cases in well intentioned attempts to ensure children's safety. They have, however, in the reviewers' experience, seldom if ever had the intended effect. Such actions can, in fact, serve to place more children at risk by adding to workload requirements that are frequently already overwhelming and broadening the scope of intervention far beyond the expertise or experience of child welfare personnel.

One fact that is frequently lost in child welfare reform efforts is that child protection intervention can, if too broadly targeted or poorly executed, cause great harm, inflicting trauma on children and families that has far worse effects than the maltreatment it is intended to prevent in all except the minority of particularly egregious incidents. Indeed, a number of mandated reporters interviewed during the course of this review, expressed just that fear, citing instances in which they believed their reports or those of their colleagues, given the way that they were acted upon, may have caused parents to retaliate against children and other family members or to disengage from association with individuals or organizations that had provided a safety net for the children in question. If such harm is to be avoided, the demands placed upon child welfare systems must be reasonably aligned with their resources in terms of workload, the knowledge, skill, and oversight of personnel, and the interdisciplinary resources at their disposal in making critical decisions.

C. The Child Welfare Workforce and Workload

This review raised several questions about the capacity of the child welfare workforce and its workload. Given that personnel are not required to have any formal social work education upon entry, a lot is expected of both trainers and supervisors within DHS if they are to produce competent practitioners. Reviewers did have an opportunity to review the list of training topics provided to new staff but have no knowledge at this point of the content associated with them. At this point the following questions remain concerning training:

- To what extent does training in identifying child maltreatment include typologies of abuse and neglect and detailed information in assessing child vulnerability based on factors other than age? For example, do all staff understand that a child's status as an adoptee, especially if adopted from the child welfare system, constitutes an indicator of special vulnerability? Can personnel accurately distinguish between various types of neglect and caregiver behaviors that constitute neglect as opposed to the intentional maltreatment associated with more egregious forms of abuse? Are any demonstrated subject content experts, as identified by the university or

by national child welfare organizations, involved in reviewing curricula and mandated course offerings?

- How skilled and knowledgeable are trainers? What clinical knowledge do they have? Is suitability as a trainer based on experience alone or are their other factors?
- Reviewers were pleased to note that training includes six hours in motivational interviewing. While this is insufficient to gain proficiency, it can certainly provide staff with an understanding of the techniques, principles, and the value of the approach in overcoming resistance and building a positive working relationship. It is not known, however, to what extent contracted personnel, who have the most intense contact with families, are provided with such training.

Reviewers noted that training for new case managers contains a course on social work ethics. However, the fact that there is no requirement for formal social work education, no incentive for recruiting from baccalaureate social work programs, and no continuing social work education support for existing staff coupled with the fact that mid-level managers may be those with experience in other fields, raises concerns on the part of reviewers about the extent to which these principles are really incorporated and applied in work with children and families. Iowa is certainly not alone in its lack of commitment to hiring front-line staff with social work education. This trend dates back to the "de-professionalization" of child welfare that began following the passage of the Child Abuse Prevention and Treatment Act in 1974 and the ensuing avalanche of child maltreatment reports that caused states to lessen their qualifications for child welfare staff in order to hire them in sufficient numbers. Many states do, however, maintain at least a strong preference for professional education, insist on it for staff in certain key positions, and use the federal funding available through Title IV-E to create opportunities to add to the number of staff with social work degrees.

It appears that, at least in the two major urban areas in which this review was focused and very likely in other parts of the state as well, workload is an area of immediate and rather critical concern. Caseloads appear to already be very high in the midst of a trend of increased reporting and less stringent screening that could cause them to go even higher.

D. Practice

*Family Engagement*

This review revealed concerns about the extent to which practice is focused on the engagement of children's parents and other caregivers. It is not unusual to identify this as a need in the functioning of child welfare systems in the current time. Federal requirements for tracking contacts with children, the level of skill needed to engage adults who are involuntarily involved in services, and the time it requires of caseworkers who are frequently overwhelmed with documentation and compliance requirements, make the difficult task of forming a true working alliance with parents beyond the capacity of the frontline workforce in many instances. It is, however, a fundamental truth in child welfare that, while agencies do have a responsibility to monitor the safety and well-being of children in their care, the real work of achieving safety and permanency for children is in helping their parents or other potential permanent caregivers to make the changes necessary to enable them to nurture their children and keep them safe. With few exceptions, children do not enter out of home care, or come to the attention of child welfare at all, based on their own behavior but on that of their parents and it is their parents who must be the subject of efforts of support and treatment.

Many, if not most, parents who become the subject of child welfare intervention are themselves the victims of trauma with troubled histories that include prior negative encounters with service agencies that leave them fearful and mistrustful. It can indeed be a challenge to engage such parents. There is, however, a substantial body of research that shows that such engagement can be achieved and that many parents can be helped to make the changes necessary to enable them to remain with or be reunited with their children. Iowa's own development of the *Parent Partner* model is evidence that this can occur and that child welfare staff in Iowa have helped make it happen.

*Family Teaming and Case Planning*

It is encouraging that Iowa has invested substantially in a process to develop skilled facilitators and that policy calls for family team meetings to be held at least once each quarter. Team meetings, when families are properly prepared and meetings are well planned and facilitated, have been demonstrated to provide a foundation for the kind of strong assessment and planning that leads to good outcomes. It appears, however, that despite the efforts of child welfare policy staff to develop contracts that ensure good teaming practice, this may not be occurring in all instances.

*Communication and Confidentiality*

A number of those interviewed in the course of this review cited instances in which lack of complete or timely communication, including access to case managers, or interpretation of confidentiality had resulted in individuals lacking critically needed information or in their receiving authorizations for needed services or activities in a timely way. Such problems are not uncommon in large child welfare agencies as they seek to avoid risk and protect information. However, when staff are not sufficiently well versed in the intent of such policies or do not understand how to secure reasonable waivers, they can result in denial of needed services and also have the effect of frustrating and angering service recipients and agency partners. Further, reviewers suspect that in many of the cases cited, case manager workload, was a factor preventing timely access and response to information and policy clearances.

E. Contracted Services

Iowa DHS appears to have gone to great effort to create adequate casework supports through the use of contracted providers. This is a practice common in child welfare systems across the United States as state and county governments seek to limit the numbers of public employees without compromising needed public services. Further, private organizations can, in some instances achieve a degree of flexibility and tailoring of performance to meet local needs that can be difficult to achieve in public systems. In the two service areas in which this preliminary review concentrated, however, it appears that the quality and consistency of services, especially those offered through FSRP, is questionable.

The qualifications of staff, in accordance with the contracts reviewed, do not seem commensurate with the expectations outlined, particularly if they are not provided with very intense and expert supervision. They may be, but that was not clear from the information made available to reviewers and did not seem to be the case based on concerns almost uniformly expressed by those interviewed both within and outside of DHS and other formal system partners such as the legal system.

## V. Recommendations

Recommendations are divided into two sections, those based on the information gathered in the limited, targeted review just concluded and recommendations for follow up in a potential second phase of the review.

These recommendation are derived from the findings outlined in section III of this report and the discussion in section IV. They are separated into two tiers, those that can be undertaken immediately and those that call for further inquiry.

*Phase One Recommendations*

Tier I:

Recommendation #1: Exclude non-case carrying staff from calculations of caseloads in reports that are provided to the legislature and publicly. Provide ranges of caseloads across counties.

Recommendation #2: Review requirements for having face-to-face contacts with parents and other caregivers and for coordination between case managers and FSRP personnel to ensure that there is appropriate emphasis on having immediate, frequent, and purposeful contacts with parents, particularly parents of children in out of home care, to develop and implement a plan to achieve reunification or other timely permanency outside of foster care. Ensure that case managers and FSRP staff coordinate their efforts and those of support personnel in a way that is directed to provide a primary point of engagement for parents. In association with that effort, review training content to examine the degree to which case managers and FRSP staff receive training in appropriate skills such as solution focused approaches and motivational interviewing.

Recommendation #3: Examine legal and policy requirements related to communication and confidentiality and explore how well understood these are by frontline staff. Identify what processes are in place for service recipients, resource parents, and mandated reporters to make inquiries about decisions or case actions and ensure that they are frequently communicated. Ensure that all information that resource parents legitimately need to provide both physical and emotional care for children placed with them is communicated to resource families at placement or as quickly thereafter as it is obtained.

Recommendation #4: Develop a means of securing and providing important case and legal documents to youth when they exit formal foster care if not before.

Tier 2:

Recommendation #1: Work with DHS human resources to consider whether the current pay structure for front line staff is optimal in terms of promoting work-life balance, rewarding personnel who remain in direct service positions even as they develop greater expertise, and provide for incentives for those who are well-suited for supervision to move into that role.

Recommendation #2: Work with human resources, state universities, and federal regional ACYF representatives to explore development of resources to provide context experts to review training curricula and modules and to consider development of a program to recruit BSW students and provide continuing MSW education for existing employees with appropriate incentives, especially for those at

the supervisory or management levels. Review and development of training should consider especially the following:

- Content related to typologies of child neglect and abuse;
- Factors related to child vulnerability beyond age or diagnosed developmental disability;
- Caseworker behaviors associated with engagement of parents and caregivers;
- Behaviorally based case planning; and
- Matching of services to needs.

Recommendation #3: Examine workload and advocate for staff allocations and/or limitations on scope of responsibility that allow for comportment of staffing with extant workload studies of similar positions and Child Welfare League of America standards. This should include an effort to examine current state reporting laws against those of other states and the level of resources that they require. Develop a means of monitoring deviations from expected workloads in local offices and providing support in the timely filling of vacancies.

Recommendation #4: Work with the Children's Justice Initiative and other legal partners to develop a structure of accountability for attorneys representing children and parents in dependency proceedings, especially those of the private bar, to provide them with both the level of support and of oversight needed to ensure legal representation for children and parents that comports as closely as possible with the standards of the American Bar Association.

Based on interviews and recent CFSR case review findings, several areas stand out as needing improvement. These include:

- Child and Family Involvement in Case Planning
- Needs Assessment and Services to Parents

Improving performance in these two areas would significantly strengthen not only practice, but outcomes as well. Evaluators believe that improving the fidelity of the family team conferencing process and strengthening the quality and effectiveness of FSRP services could positively and materially improve family engagement and the effectiveness of service to parents and children. The following recommendations are made for a potential Phase Two of the evaluation.

Recommendation #5: Child Welfare Group would observe a sample of family team meetings to identify opportunities for improvement.

Recommendation #6: Child Welfare Group staff would conduct a small quality review of FSRP cases to assess quality and effectiveness.

Recommendation #7: Child Welfare Group staff would review and observe training modules in family interaction, confidentiality, assessment, and the basic training for both intake and child protection staff.

VI. Concluding Remarks

The Department of Human Services is to be commended for inviting an external review of system functioning. State and local DHS staff have been forthcoming about the challenges they face and persistent in their efforts to address barriers to positive outcomes for children and their families.

There seems to be little question that having to doing more with less where mandates and resources are concerned is having a negative impact on staff morale and, in the opinion of evaluators, on system performance as well. Within that constraint, evaluators believe that the Department has a foundation of assets on which to build that can help sustain it while it looks toward the additional resources that it needs. These assets include a spirit of hopefulness about the new agency leadership, a seasoned and dedicated work force, committed community partners and families that will respond to genuine partnerships with the Department. We hope that this initial appraisal contributes to promising improvements in the Department's operations and new opportunities to address challenges that impede positive outcomes.

# APPENDIX


# CWLA Progress Update to Governor Patrick and Secretary Polanowicz

## March 13, 2014

At the request of Governor Patrick and Secretary Polanowicz, CWLA is submitting a Progress Update, which includes a summary of activities competed to date by the CWLA Team, and preliminary guidance that has been provided to both the Governor's staff and EOHHS staff. This update does not provide findings or recommendations relative to Jeremiah Oliver, as the CWLA Team has not yet completed its comprehensive review of the case. The final CWLA report will contain an account of the case, and thorough findings and recommendations pertaining to DCF case practice, relevant policy, and systemic issues. It is anticipated that a final report will be submitted to EOHHS by mid-May.

The initial phases of this review have included fact-finding to identify concerns, as expressed by leaders within DCF, the executive branch, and the legislature. As a result of this process, EOHHS has asked CWLA to broaden the scope of its review.

## Initial Scope of Work

In January of 2014, the Massachusetts Executive Office of Health and Human Services (EOHHS) sought the assistance of the Child Welfare League of America (CWLA) in response to concerns regarding the safety of children served by the Department of Children and Families (DCF). EOHHS requested an objective third-party quality improvement review to examine the appropriateness, comprehensiveness, and consistency of certain agency policies and practices with nationally recognized best practices. Areas to be addressed included a review and analysis of:

- Relevant reports and related recommendations regarding Jeremiah Oliver, reported missing in December 2013;
  - DCF's Critical Incident Unit (CIU) investigation regarding Jeremiah Oliver and his family;
  - DCF's home visitation policies and practices;
  - The assessment methodology used to conduct the Tier Review Process including a review of practices related to young parents; children of parents with a history of substance abuse, domestic

violence, mental health or unresolved trauma; and, substance exposed newborns;
- DCF practices related to 51A reports including staff training and screening criteria;
- DCF intake and case assignment practices.

## Additions to Scope of Work

- Technology
- Staffing in North Central
- Medical screens
- Criminal Offender Record Information (CORI); Background checks
- Quality Improvement/case review process
- Caseload and Workload
- Case Practice and Policy/ Case Practice Model (ICPM)
- Staff Qualifications, Training and Supervision

## CWLA Team's Activities to Date

The CWLA Team has initiated or completed the following activities between January 15 and March 3, 2014:

- Met with the Secretary of EOHHS and appropriate staff
- Met with DCF Commissioner and senior DCF leadership
- Met with Governor Patrick and senior staff
- Conducted individual interviews with DCF senior leadership and other designated staff
- Received orientation to current FamilyNet and iFamilyNet data system
- Completed face-to-face interviews with all current DCF personnel who had direct involvement in the Oliver case. (Interviews were not conducted with those staff whose employment with DCF had been terminated.)
- Reviewed records relevant to the Oliver family
- Attended Public Hearing conducted by the House Post Audit and Oversight Committee and Committee on Children, Families and Persons with Disabilities on January 23, 2014
- Attended Governor's Press Conference on January 27, 2014

- Facilitated a focus group with representatives of the following state agencies, programs, and initiatives:
    - Children's Behavioral Health Initiative
    - Department of Early Education and Care
    - Department of Mental Health
    - Department of Public Health
    - DPH - Family Health and Nutrition
    - DPH - Substance Abuse Services
    - DPH - Community Health and Prevention
    - Department of Transitional Assistance
    - Department of Veterans' Services
    - Department of Youth Services
    - Executive Office of Education
    - Interagency Council on Housing and Homelessness
    - Mass Health
- Began interviews with external stakeholders
- Met with the Office of the Child Advocate staff
- Reviewed the March 28, 2007, Massachusetts Legislative Report issued by the House Committee on Child Abuse and Neglect
- Had five meetings with Senators, Representatives, and legislative staff members
- Reviewed examples of monthly reports issued by DCF, including:
    - Caseloads (investigations/assessments, and home visit reports specific to the North Central Office)
    - Statewide home visits reports
    - Statewide twelve month weighted caseload summaries
    - Statewide monthly caseload/weighted summaries
    - Statewide monthly supervisor monitoring report
    - Statewide screening, supported and closing rates report
    - Statewide twelve month summary of completed investigations
    - Statewide social worker workload report and number of social workers with more that 22 cases for one reporting month
    - Statewide reports of child abuse and neglect-twelve month summary
    - Statewide initial assessments-twelve month summary
    - Statewide case management cases-twelve month summary
    - Statewide twelve month weighted caseload summary
    - Statewide adoption report-twelve month summary
    - Statewide family resource FTE needed
    - Statewide family resource total number of licensed homes summary
    - Statewide summary of total number of active, licensed family resource homes
    - Statewide summary of total number of ICPC homes

- Reviewed the Memorandum of Understanding (MOU) between Service Employees International Union (SEIU) and DCF regarding caseloads and caseload weighting
- Reviewed job descriptions, including educational and experience requirements, for the following DCF positions:
    - Director of Areas
    - Area Clinical Manager
    - Area Program Manager
    - Social Worker C, D, and E
    - Social Worker A & B
- CWLA staff have initiated research/data collection concerning:
    - Technology
    - Medical services for children entering care
    - Background checks conducted in other states on foster parents/kinship applicants and caregivers
    - Social work and other licensing requirements for child welfare staff in other states
- Began review of DCF policies and procedures
- Reviewed DCF draft bills from Senate and House concerning background checks and made suggestions for scope and content.

## Observations/Preliminary Guidance and Recommendations

The CWLA Team has interim guidance and recommendations regarding the following issues and concerns:

### STAFFING IN THE DCF NORTH CENTRAL AREA OFFICE

Following a review of the workloads/caseloads in the North Central Office, as well as a review of the "North Central Office Relief Plan," the CWLA team facilitated a conference call with the DCF Commissioner and members of her staff, and representatives from EOHHS. The CWLA Team shared its belief that while the presence of two investigators who volunteered to assist the North Central Area Office was extremely helpful, additional personnel were needed in a more expedited fashion than was presented in the Relief Plan. The caseload numbers, and therefore the workload, was growing daily, making it extremely difficult for staff to complete their required tasks.

The CWLA Team recommended an immediate infusion of support for the North Central Area Office. The Commissioner and her staff took immediate action on the recommendations.

## WORKFORCE/CASELOAD/WORKLOAD

While nation-leading policies are essential to meeting the safety and service needs of children served by DCF, the workforce is the primary means through which DCF discharges its mandate for the protection of children. It is, therefore, critical that the child welfare workforce be comprised of sufficient, diverse, well-trained, and highly competent individuals who are committed to high quality service, and have the tools, resources and supports they need to perform their roles effectively (CWLA, 2013).

Over the last 30 years, the literature has repeatedly documented the challenges that agencies face in establishing and maintaining a stable, skilled, and well-supported workforce. National estimates have found that average tenure for child welfare workers is less than two years, and turnover rates for child welfare organizations average between 20 and 40% (USGAO, 2003). According to a 2003 U.S. General Accounting Office report, the primary reasons that workers left child welfare included low salaries, worker safety, staff shortages, high caseloads, administrative burden, inadequate training, and poor supervision.

Further, research indicates that there is a critical relationship between workforce stability and the overall functioning of the agency (NCCD, 2006). In fact, the US Children's Bureau found that agencies with turnover rates above 15% also had rates of child re-abuse that were 125% higher than states with lower turnovers rates. Lower turnover was associated with lower rates of re-abuse and less disruption in case management activities including completion of case plans, timely completion of required duties, and regular contact with children and families. In one study of 19 public child welfare agencies, those considered high performing based on these and related measures tended to have the lowest turnover rates. They also provided significantly more training for new caseworkers, required less on call time or overtime, and paid higher salaries than their lower functioning counterparts.

### Caseload/Workload Guidance

The **recommended caseload standards for child protective services** (CWLA, 2003) are as follows:

| Service/ Caseload Type | CWLA Recommended Caseload/ Workload |
|---|---|
| Initial Assessment/ Investigation | 12 active cases per month, per 1 social worker |
| Ongoing Cases | 17 active families per 1 social worker and no more than1 new case assigned for every six open cases |

| | |
|---|---|
| Combined Assessment/ Investigation and Ongoing Cases | 10 active on-going cases and 4 active investigations per 1 social worker |
| Supervision | 1 supervisor per 5 social workers |

It should be noted that the caseload is based on new and active cases per month. In other words, new cases should not be added in a new month unless a comparable number of cases have been closed, assuming that the worker has a full caseload.

The **recommended caseload standards for family foster care services** are as follows:

| Service/ Caseload Type | CWLA Recommended Caseload/ Workload |
|---|---|
| Foster Family Care | 12-15 children per 1 social worker |
| Supervision | 1 supervision per 5 social workers |

**Calculating Workloads**

Although CWLA recommends caseload ratios for each area of child welfare practice, workloads are best determined through an analysis of the agency's policy mandates and careful time studies based on activities required to complete a specific set of tasks or units of work. For those agencies interested in developing their own specific workload figures, time required to conduct the following tasks should be calculated:

- direct case work contact with children and families;
- collateral visits, service referral and outreach activities;
- legal consultation, report preparation, and court hearings;
- emergencies that interrupt regular work schedules;
- supervision, case planning and review, case consultation, and collaboration;
- work with community groups;
- attendance at staff meetings;
- staff development, and professional conferences;
- administrative functions;
- travel;
- telephone contacts, e-mail communications, reading of records, case recording or computer entry, and reports of conferences and consultations; and
- annual leave including vacation, sick time, and personal leave.

**Caseloads should be computed separately for each worker category**

When computing any category of workers, staff that may play a role in service delivery but are not performing the specific functions of this category, should not

be included in the worker count. Though helpful, case aides, supervisors, and others who may assist with cases, do not perform the same functions, and including them provides a misleading caseload count.

**Caseload Management**

Referral trends and caseload demands may vary from area office to area office and from time to time. As such, the agency should have sufficient capacity to respond to changing caseload demands. The process of ensuring that caseloads remain manageable across area offices requires proactive strategies to fill positions and minimize the number of case worker and supervisory vacancies. It is also critical that the department closely manage the assignment of those positions across local offices.

DCF should ensure that its process for reviewing caseload trends, filling vacancies, and adjusting office specific staff allocations is based on up-to-date information regarding caseload size, and trends in intake and case closure. The agency should also ensure that procedures for adjusting the allocation of staff to area offices are responsive to both short and long-term shifts in staffing needs.

Case transfers and changes in case status should receive careful consideration. Caseload counts should accrue to the worker, not to the case. Multiple workers may address the practice needs of a family and its children in a given period. Whenever cases transfer from one worker to another within a specified period, they should be counted on each worker's caseload. The fact that this is a *single* case does not negate the need to count it as part of *each* worker's caseload. The same principle applies to changes in case status.

**Leadership**

Achieving the mandate of the public child welfare organization requires highly skilled, consistent, and committed leadership who are equipped to direct the agency, and engage partners and communities who can together work to assure the safety and well-being of children. Yet, it has been estimated that half the nation's public child welfare leaders will turnover in two to 2 ½ years. Experience has shown, that in many instances the lack of consistent leadership, and the challenges of leadership transition may further compromise the challenges facing the agency.

According to the National Conference of State Legislatures, it is important to ensure that the internal and external leaders maintain a focus on achieving substantive reforms over the long-term, and on bringing increased stability to leadership and improved outcomes for children and families (NCSL, 2008).

CWLA recommends that it should be EOHHS's priority to complete the current assessment of DCF, and to plan for implementation of recommendations that are specifically responsive to needed improvements in agency practice, policy, and overall operations. While this study is pending, stability is wise.

## TECHNOLOGY

In response to Governor Patrick's priority of developing capacity for access to real-time data, and EOHHS's request for information about successful data programs and tools, the CWLA Team has begun to research the handheld devices used by other jurisdictions and their respective capacity to enter and receive real-time data. The CWLA Team continues to gather information from states and counties across the country concerning the devices being used (smart phones, tablets, and laptop computers), the challenges involved, the devices and platforms that bring the most satisfactory results, and staff's ability to enter and access real-time data for such tasks as home visitation, collateral contacts visits/communication, identification of children, etc.

DCF staff currently use personal cell phones to communicate from the field and to respond to overnight and weekend emergencies while on-call. There are some laptops available for use from the field. Many workers use their home computers to complete work and reports. At present, the Massachusetts Statewide Automated Child Welfare Information System (SACWIS) does not accommodate real-time access from handheld devices.

The CWLA Team confirmed that representatives from EOHHS and DCF participate in the National Center on Child Welfare, Data and Technology, and recommends that Massachusetts take full advantage of the expert information available through this resource.

The CWLA Team recommends that, at minimum, any technological solutions include capacity to:

- Give workers immediate contact with supervisors and/or emergency personnel:
- Document visits in real-time;
- Upload photos of children to the Massachusetts SACWIS system (iFamilyNet);

The CWLA Team recommends that EOHHS consider the following additional technological functions:

- Ability for workers to access SACWIS (iFamilyNet) data from the field on handheld devices that provide data security;
- Ability to complete forms and obtain parent/guardian signatures in the field;
- Ability to access teleconference/web-based conferencing from the field.

## MEDICAL SCREENS FOR CHILDREN ENTERING CARE

The CWLA Team has provided EOHHS with current guidance for providing initial medical screenings and comprehensive evaluations from both the American Academy of Pediatrics (AAP), and the CWLA *Standards for Health Care Services for Children in Out of Home Care.*

The CWLA Team is examining recommendations that initial screening should be provided within 72 hours after a child enters care, and that if the initial screening is abbreviated, a more comprehensive examination should be provided within the first 30 days of care. CWLA is considering recommendations that will responsive to the concerns of children during the investigations process, young children who may not be able verbalize symptoms requiring medical attention, and others who may have special health care needs.

CWLA is gathering information from other states/jurisdictions that will help to inform its final recommendations on this issue. This will include technology supports and protocols that maximize real-time case level data sharing between DCF and MassHealth, so that case workers and caregivers have access to the most recent health information on the children they serve.

The CWLA Team recommends that whenever possible children in care continue to be served by their own pediatricians, in their medical homes (AAP, 2005).

## BACKGROUND CHECKS

The CWLA Team has made the following recommendations in response to questions raised by the Governor's Office, EOHHS, and DCF concerning background checks and approval of foster parents and kinship resources:

- DCF should implement heightened case monitoring, home visitation, supervision, or case oversight for placements that have been approved through the waiver process. Heightened monitoring should include documentation of key factors/indicators related to the safety and well-being of each child placed in these homes. Increased monitoring is of particular concern given the number of young children placed in homes with approved waivers. While some of these safety and well-being factors/indicators may be addressed in home visitation policies and in

quality case practice, greater clarity may help to ensure that agency expectations are understood by caregivers and have been implemented.

- The Team recommends that legal counsel review case law decision to determine whether statutory or regulatory action is needed.



- DCF and EOHHS should refrain from issuing any new exclusionary lists or revising exclusionary lists at this time.

- DCF and EOHHS should study current trends toward uniform approval processes for kinship and foster caregivers, including understanding the role of disproportionality in criminal prosecution and conviction, and the importance of placing children with relatives whenever possible.

- Draft standards in development by American Bar Association (ABA), National Association for Regulatory Administration (NARA), Generations United (GU), and Annie E. Casey Foundation (AECF) should serve as the foundation for background check standards in Massachusetts. These four organizations have been working for several years to establish standards that at once protect children and ensure that foster care/kinship applicants are assessed fairly. The draft includes mandatory, permanent exclusion for certain felony convictions, and exclusion for certain other convictions that have occurred within recent years.

  The draft includes factors that should be considered in reviewing foster care/kinship applications and renewals (Generations United, 2014).

  A. If a record check reveals a felony conviction for child abuse or neglect, for spousal abuse, for a crime against children (including child pornography), or for a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery, and a State finds that a court of competent jurisdiction has determined that the felony was committed at any time, such approval must not be granted.

  B. If a record check reveals a felony conviction for physical assault, battery, or a drug-related offense, and a State finds that a court of competent jurisdiction has determined that the felony was committed within the past 5 years, such approval must not be granted.

  C. If an applicant was convicted for a crime other than those included in A. and B., the applicant will **not** be automatically rejected as a foster parent. The agency must consider the following:
     1. the type of crime;
     2. the number of crimes;

3. the nature of the offenses;
4. the age of the individual at the time of conviction;
5. the length of time that has elapsed since the last conviction;
6. the relationship of the crime and the capacity to care for children;
7. evidence of rehabilitation; and
8. opinions of community members concerning the individual in question.

- The CWLA Team recommends that DCF's future process for completing and reviewing background checks should be an approval process rather than a waiver process. There should be clear criteria for positive



decisions to approve a foster/kinship applicant, rather than a waiver process that requires exception. The CWLA team is available to work with EOHHS and DCF to develop such a positive process.

- The CWLA Team recommends that the executive branch and the legislature should consider carefully potential ramifications that any changes to background checks for foster and kinship resources might have on background check completion for other child caring situations, including but not limited to licensed child care centers, family child care, residential providers, and adoptive parent applicants through DCF and licensed adoption agencies.

## YOUTH WHO HAVE RUNAWAY FROM PLACEMENT

A review of the DCF policies regarding the handling of cases involving youth who have runaway from placement indicates that the policy adequately provides for basic follow-up and notification of law enforcement and agency personnel.

In light of increased understanding regarding the reasons young people run away and the risks they face while on runaway status, the CWLA Team recommends that DCF consider protocols and related training to equip workers with knowledge needed to effectively reduce the incidence of runaway behavior.

There is growing awareness that youth on the run and those in care may be more likely targets of pimps and traffickers. The CWLA Team therefore recommends that DCF develop a protocol for addressing and reducing the potential for trafficking of children in out-of-home care or on runaway status.

The Team recommends that polices and procedures require a brief assessment for vulnerabilities that may place each child at heightened risk in the community in case of running away. Factors related to vulnerability to physical violence, sex trafficking, and exploitation are particularly important.

The CWLA Team recommends that DCF expand its polices and procedure to require that official electronic files contain a photo of each child who enters the care and custody of the agency. A review of intake policies is also warranted to ensure that photos of children in substantiated and open cases are also maintained.

## On-Going Tasks of CWLA Team

The CWLA Team continues its review of the Oliver case, and the issues and concerns that have been identified by the legislature, the executive branch, DCF, the Office of the Child Advocate, and the media.



Priority on-going tasks of the CWLA Team are:

- Continuing review of DCF policy being developed and/or revised. This review includes, at a minimum, the following policies:
  - Education Policy
  - Children Missing from DCF Care or Custody
  - Case Transfer
  - Ongoing Casework Policy, Procedures, & Documentation
  - Case Closing Policy
  - Policy for Review of Open Cases-Children Living at Home
  - Health Care-Policy for Children in DCF Care or Custody
  - Intake Policies (Protective, including Hotline) (Voluntary, Child Requiring Assistance, 51As in Certain Institutional Settings)
  - Foster Care Review

- Reviewing the DCF ICPM as well as models from other states that embrace family engagement, and can link improved outcomes for children and families to the use of their model.

- Researching the following issues:
  - Home visitation policies of other states/jurisdictions
  - Polices regarding boyfriends/non-relative household members
  - National trends relative to critical incident reports/child fatalities
  - Medical screening policies from other states/jurisdictions

- Conducting focus groups with representatives of various stakeholder constituencies, including:
  - Service providers
  - Service recipient families and youth
  - Foster parents
  - Adoptive parents

- Advocacy groups

The safety and security of children - especially those entrusted to the supervision or care of the state child welfare agency - are of vital concern to the citizens of the Commonwealth. Child welfare systems across the country are experiencing challenges similar to those of the Commonwealth. While far too many jurisdictions are facing failures in their ability to keep a child safe, these failures cannot become acceptable. It is the responsibility of all concerned to act with thoughtfulness, diligence, and a sense of urgency to determine how DCF and the Commonwealth can best work to keep children safe, and to address the complex concerns that bring children and families to the attention of the agency.

CWLA has worked extensively to conduct to program improvement reviews and to develop recommendations and action plans that develop more effective



approaches to child safety concerns. This update provides our initial observations, and preliminary guidance toward these ends. A full report of our analysis and our full recommendations will be provided in our final report.

## About CWLA

Since 1920, the Child Welfare League of America (CWLA) has been recognized as a consistent, strong, and non-partisan voice for children and families in the United States. CWLA is devoted to engaging all individuals, organizations, and systems in promoting the safety, permanence, and well being of children, youth, and their families. To further the mission of preserving, protecting, and promoting the well being of children, youth, and their families, CWLA develops standards of best practice to improve safety, permanence and well being for children served in child welfare systems. CWLA also provides technical assistance, training and consultation services to assist public and private child welfare agencies and to community organizations in reviewing programs and improving practice for the children and families that they serve.

CWLA uses its national recognized Standards for Excellence in Child Welfare as context for this work. CWLA's most recent set of standards, the CWLA National Blueprint for Excellence in Child Welfare, serves as a basis for its program specific policies and for the development of recommendations for quality improvement in service delivery. The National Blueprint for Excellence is intended to be a catalyst for change and to promote policies and practices that help organizations and communities more effectively ensure the safety and wellbeing of all children.

The following principles drawn from the CWLA National Blueprint serve as a guide in this quality improvement review, and for the initial guidance provided in this progress update.

1. **RIGHTS OF CHILDREN:** It is the responsibility of all members of society to work towards the shared goal of advancing the fundamental rights and needs of children.
2. **SHARED LEADERSHIP AND RESPONSIBILITY:** Families, individuals, organizations, and communities share responsibility for assuring the safety and well-being of children and youth. To help children and youth flourish, leaders at every level and in all realms ensure that individuals, families, organizations, and systems collaborate, communicate, create, and nurture meaningful partnerships.
3. **ENGAGEMENT/PARTICIPATION:** Children, youth, and families are engaged and empowered to promote family success and build community capacity. Service providers and organizations acknowledge, appreciate, and validate the voices and experiences of those whose lives they touch,



so that responsive, community-based resources and services are developed, nurtured, and sustained.

4. **SUPPORT AND SERVICES:** Families, individuals, communities, organizations, and systems protect children from abuse and neglect, and provide an array of supports and services that help children, youth, and their families to accomplish developmental tasks, develop protective factors, and strengthen coping strategies.
5. **QUALITY IMPROVEMENT:** Supports and services are designed and implemented based on evidence and knowledge; data collection is focused on measuring outcomes and achieving success; continuous quality improvement is emphasized and supported; and innovative practices and programs are encouraged.
6. **WORKFORCE:** The workforce consists of competent skilled people with a variety of experiences and representing varied disciplines. They are committed to high quality service delivery and are provided with the training, tools, resources, and support necessary to perform their roles effectively.
7. **RACE, ETHNICITY, AND CULTURE:** Individuals, families, communities, organizations, and systems work together to understand, and promote equality, cultural humility, and strong racial, cultural, and ethnic identity, while showing consideration for individual differences, and respecting the sovereign rights of tribes.
8. **FUNDING AND RESOURCES:** Funding decisions in the private sector and at federal, state, local, and tribal levels are informed by the certainty that the well-being of children, families, and communities are interconnected and

that sufficient and equitable funding is essential to the well-being of all of them.

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# Agency Workforce Estimation: Simple Steps for Improving Child Safety and Permanency

Dennis Wagner, Ph.D.
Kristen Johnson, M.A.
Theresa Healy, M.S.

Evidence is mounting that high staff turnover and decreased worker-client contact increase maltreatment recurrence and delay permanency. This information underscores the need for child welfare agencies to accurately estimate how much worker time and how many staff positions are required to meet the best practice standards they adopt for their clients. Case-based, prescriptive staffing estimation procedures can improve internal agency management. External funding sources, state legislatures, and county boards also need clear, credible estimates of the staffing level necessary to deliver services to children and families

at a practice standard that can reduce maltreatment, expedite permanency, and improve child well-being. Once that estimate is available to all parties, responsibility for adequately staffing the agency can be broadly shared among policy makers. Child welfare agencies are often asked to serve more clients or expand service delivery without additional capacity, and the impact of chronic understaffing may not be apparent until a tragedy occurs. Understaffed agencies face difficult decisions, but the ability to produce a defensible workforce estimate places them in a position to share these decisions, and the risks they entail, with their funding authorities.

## *Background*

A 2001 survey of 43 state and 48 county child welfare agencies found an average annual worker turnover rate of 22% and a vacancy rate of 7% (American Public Human Services Association, 2001). These data underscore the fact that many child welfare agencies are experiencing workforce shortages. A literature review conducted by Kadushin and Harkness (2002) identified three reasons for worker turnover: (a) repeated failure to meet agency service delivery standards; (b) high caseloads or reporting (paperwork or data entry) burdens that decrease client contact; and (c) inadequate supervision, training, and support. Both staff surveys and exit interviews confirm that high caseloads are a common reason for leaving the child welfare profession (Institute for the Advancement of Social Work Research [IASWR], 2005; Robison, 2006).

*If we grant that staff time is the primary resource for strengthening families and promoting child safety and permanency, how can agencies manage it more effectively?*

While staff turnover has been recognized as a widespread problem for years, its impact on agency clients has not been carefully examined until recently. A review of recent research provides clear indications that client outcomes are adversely impacted. Other researchers (IASWR, 2005) have proposed tactics such as improved training and supervision, higher pay, and reduced caseloads that may reduce staff turnover. This article addresses a more fundamental management question: if we grant that staff time is the primary resource for strengthening families and promoting child safety and permanency, how can agencies manage it more effectively? Since many agency managers may not have reliable mechanisms for managing their workforce, this article attempts to outline some simple steps they can take to develop them.

This article briefly reviews research findings that link adequate staffing to improved child safety and well-being, and presents approaches for evaluating agency workforce needs and managing workforce capacity. It illustrates how agency managers can accomplish the following: (a) identify common symptoms of agency understaffing;

(b) estimate existing workforce capacity; and (c) estimate agency workload demand and understaffing.

## *The Link Between Child Welfare Workforce Capacity and Case Outcomes*

The federal Child and Family Services Reviews (CFSR) set clear, measurable case outcome standards for placement stability, maltreatment recurrence, reunification, and foster care permanency (see, for example, U.S. Government Printing Office [GPO], 2006). They also evaluate several service delivery process measures such as timely investigation response or completion, construction of case plans, occurrence of child medical exams, and provision of services.
These CFSR standards have served as a framework for examining the relationship between workforce capacity and service delivery performance in several recent research studies.

In the earliest study of this type, the U.S. Government Accountability Office (GAO) examined the relationship between CFSR review findings from 27 states and their agencies' staff turnover rates (GAO, 2003). High agency turnover was associated with failure to meet established standards for investigation response, timely investigation completion, case plan completion, worker contact
with children and families, maltreatment recurrence, and timely permanency. A later study, funded by the Annie E. Casey Foundation, also found a link between agency performance and workforce capacity (National Council on Crime and Delinquency [NCCD], 2005). The average annual staff turnover rate of 12 California county child welfare agencies was used to rank them into low (8%), moderate (13%), and high (23%) turnover groups. Families served by counties with low turnover
had significantly lower maltreatment recurrence rates and were more likely to have approved, current case plans and up-to-date child medical exams. In addition, a study of private foster care agencies in Milwaukee found that high
case manager turnover for a family (e.g., multiple workers serving the family's case within the last two years) increased



the time required to achieve permanency for children (Flower, McDonald, & Sumski, 2005).

A recent analysis of CFSR case review findings from 50 states examined the relationship between worker case contacts and several foster care performance measures. The frequency of worker case contacts with parents and children had a significant positive correlation with placement stability, receipt of child mental health or educational services, and the timely achievement of permanency (Administration for Children and Families, 2006). Evidence is mounting that high staff turnover and decreased worker-client contact have a negative impact on critical client outcomes (National Conference of State Legislatures, 2006). Recent class action suits brought against state child welfare agencies provide indirect evidence of this relationship by identifying inadequate staffing as a major cause of harm to plaintiff children (see Farber & Munson, 2007; *Dwayne B. v.*
*Granholm*, 2006; or *Olivia Y. v. Barbour*, 2007).

These findings will not surprise most child welfare professionals. They recognize that effective case management requires frequent client contact and a significant amount of worker time. Moreover, staff turnover is a widely accepted proxy for understaffing. When a large percentage of positions are vacant or filled with new staff, workforce capacity is diminished, and commitments to clients, the most basic of which is routine worker contact, cannot be met. It is difficult to evaluate child safety without seeing the child. Other factors, such as worker training or family engagement
skills, may also impact case outcomes. Workforce issues are still central to performance, however, because practice skills have little impact unless workers have sufficient time to interact with client families. The question is, how can agencies best manage existing staff resources to improve client outcomes?

An underlying assumption of this article is that agencies cannot manage what they cannot measure. Consequently, a simple approach for measuring workforce capacity follows. Examples presented here are drawn from lessons learned by the Children's Research Center (CRC) in conducting workload estimation studies in several states.

### *Is My Agency Understaffed?*

For the purposes of this discussion, an understaffed condition means the current workforce capacity is not sufficient to meet established agency service delivery standards. Many administrators want to know if their agency is understaffed but lack methods for evaluating workforce capacity. Most agencies, however, have access to SACWIS or case file review data that describe case processing activity which may show common signs of understaffing.

As an example, every agency has standards for closing child protective services (CPS) investigations— typically, 30 to 45 days after assignment. When investigations are not closed in a timely fashion, a "backlog" of open past-due investigations accumulates. A single-digit backlog (expressed simply as a percentage of the number of past-due investigations at the end of the month divided by the total number assigned) may not reflect a serious problem. On the other hand, a backlog that increases each month and reaches double digits may indicate chronic understaffing, since workers are not meeting a basic agency case management standard.

A variety of similar case processing activities can also be monitored, such as standards for timely completion of case plans, court hearings, and dental or medical exams. Worker-client contact with in-home or foster care cases is one of the more critical expectations. Standards vary, but a monthly worker face-to-face contact with children, parents, or foster parents is a common, minimum expectation for ensuring child safety. Routine failure to meet these kinds of agency standards may reflect both understaffing and service delivery failure.

Many agencies have adopted quality assurance mechanisms that routinely monitor exceptions to their service delivery standards. SafeMeasures®, which is employed by many jurisdictions also using the Structured Decision Making® (SDM) case management system, is one example (Jacobsen, 2007).[1] Agencies use SafeMeasures to systematically identify case contact failures, past-due case plans, medical exams, court

[1] For more information on the SDM® system, see www.nccd-crc.org.



hearings, and a variety of other case process standards. It also monitors CFSR client outcome performance measures, which are equally important. Research studies reviewed above suggest that substandard CFSR performance on the six-month maltreatment recurrence rate, placement stability, and permanency are related to understaffing (GPO, 2006).

Staff turnover is another easily observed indicator, typically computed by dividing the number of direct service staff leaving each year by the total authorized caseload-carrying positions. It is a good measure of how many staff an agency has to recruit, hire, and train to maintain its workforce capacity. Since public service hiring can take several months, agencies with high

*Consistent observation of performance problems across several indicators increases the likelihood of an understaffed condition.*

turnover usually have a high staff vacancy rate and a significant number of new staff in the workforce. Practices vary, but the first-year training requirement for new workers almost always reduces their caseload capacity, sometimes by 50% or more. Consequently, an agency with a 10% vacancy rate and 20% of its positions occupied by new workers may be experiencing a 20% reduction in its effective workforce capacity. In most circumstances, this is a clear symptom of understaffing. It also illustrates a point often overlooked: both the workload capacity of new staff and the vacancy rate must be weighed to secure an accurate estimate of workload capacity. Administrators should attempt to secure this estimate at least annually and monitor it carefully over time.

Indicators like those reviewed above can serve as a simple diagnostic checklist for understaffing. Most agencies will have access to at least some of them. The available list should be monitored over time. Consistent observation of performance problems across several indicators increases the likelihood of an understaffed condition.

While a checklist can help an agency identify an understaffed condition, it does not estimate the magnitude of understaffing nor indicate how staff could be redeployed to address the problem. This requires a more comprehensive workload estimation approach, described below.

### *How Many Staff Does My Agency Need?*

Caseload-to-staff ratios provide a helpful guideline, rather than a precise estimate, of the number of staff required to deliver child welfare services (Child Welfare League of America, 2006). Since agencies differ in their operating characteristics, service delivery expectations, and personnel practices, it is difficult for a fixed caseload ratio to accurately estimate an agency's staffing requirement. The best estimate requires customized estimation of two agency characteristics: (a) the time direct service workers have available to serve clients, and

- the worker time required to meet service delivery standards for clients. The first parameter, worker time available, represents the effective workload capacity of an average direct service worker, i.e., how much time does a worker have to serve agency clients in an average month or a year?

The worker time required to meet service delivery standards for clients is more difficult to estimate. Agency standards vary, but they are very important constructs. They establish the minimum performance criteria workers are asked to meet for their clients, and are represented as such to oversight agencies and the public. Consequently, a responsible child welfare staffing estimate should identify the workforce capacity necessary to meet agency service delivery standards routinely.

Since the standards agencies adopt vary across case types in terms of worker-client contact expectations and a variety of other factors, the best way to establish the worker time necessary to meet these standards is to conduct a field study. Given the cost and effort involved, not all agencies are able to or will conduct one. Agencies can, however, improve their workforce management
by adopting the workload findings and estimation procedures from jurisdictions that have conducted field studies. A basic approach is outlined in the next section.



### *Estimating Staff Time Available*

Table 1 describes a method for estimating how much time workers have available to meet agency service delivery standards for their clients. The table displays a median estimate drawn from several CRC workload studies for experienced workers (training time would be much higher for new workers). The estimate assumes an average work month of 173.3 paid hours and subtracts unavailable time from it. Annual leave or training records were converted to monthly figures for this purpose. Additionally, staff cannot serve cases during training, leave (vacation, sick, holiday, and personal time), or break hours. The subtraction of training, leave, and break time reduces time available to 136.0 hours per month.

to serve his or her clients. New workers, who spend more time in training, typically have a much lower workload capacity.

### *Estimating Worker Time Required to Serve Clients*

Estimating workers' case time is more challenging, since workers' service activities must be observed and recorded in the field for a variety of cases. A brief discussion of workload field study methods describes how these time estimates were derived and what they represent.

Each CRC workload study has employed similar research methods. Workers are trained to record daily, under actual field conditions, the time they require to

Table 1

Estimated Monthly Time Available Based on Median CRC Findings

| Experienced Social Worker | Median Time in Hours |
|---|---|
| Total work hours per month | 173.3 |
| Median training time | -4.2 |
| Median leave time (vacation, sick, holiday, personal) | -23.9 |
| Daily break time (usually .5 hours per day) | -9.2 |
| Total work hours minus training, leave, and break time | 136.0 |
| Median case support time | -6.5 |

- serve a randomly sampled foster care or in-home family case for one month; and

- complete a random sample of intakes, CPS investigations, and other case studies from assignment to completion. Workers are asked to meet or exceed agency service delivery standards for each sample case they record, and supervisory reviews verify that standards were met.

For example, standards for a child in foster care with a return home goal may require the caseworker to contact the child, the child's parent, and the foster caregiver each

Note: Table 1 reports median values for every category, and results therefore differ slightly from a summation.

month; coordinate with service providers; conduct safety assessments; and update case service plans. Additional monthly

Two additional subtractions are made for case support and administrative tasks performed by workers observed in past CRC workload studies. The 6.5 hours of case support is the time workers spend serving cases not assigned to them, e.g., emergency on-call activity, case consultation, substitute coverage for other workers, and backup coverage. The 7.3 hours of administrative time represents non-case-related activity such as unit meetings; supervisory sessions; and participation in agency task forces, committees, or special assignments. These two subtractions result in a net 122.3 hours available each month for the average experienced social worker. This is the effective workforce capacity available

expectations might include preparing a permanency planning review, appearing in court, or conducting a family conference. Comparable estimation procedures apply to CPS investigations, which have similar standards for contacting alleged victims and caregivers, completing safety and risk assessments, etc. Workers also record the time necessary to document all case-related activities, including travel and documentation.

Sample case times are averaged to estimate the time required to meet standards for each case type. Random sampling ensures that both difficult, time-consuming case events and routine practice conditions are



represented. Table 2 shows the median time estimate observed across five child welfare agency workload studies. It reflects the time required to meet agency standards for several hundred randomly assigned cases. Agency standards varied, but all required a minimum of one monthly contact with the child and parent or substitute caregiver for in-home and foster care cases.

The CPS investigation standards also vary by agency, but the times shown are broadly representative.

These estimates are prescriptive in that they reflect the time required to serve clients at the best practice standard employed by each agency. Workers could serve a foster care case without making monthly face-to-face contacts with the child, parent, or caregiver, and a less rigorous practice standard would take much less time than the estimates shown, but the objective of each CRC study is to represent good, not substandard, practice. The estimates are designed to identify the workforce capacity that can meet agency service delivery standards.

For agencies that have not conducted their own workload study, these findings can serve as a reference point for estimating the time direct service workers may need to perform similar tasks. For example, intake processing for a CPS maltreatment report from call-in

to investigation/assignment required 1.1 hours. Informational calls that did not allege maltreatment took, on average, only 0.3 hours.

Table 2

Median Monthly Worker Time Estimates for Cases That Met Standards

| Agency Service Area | Median Worker Time in Hours |
|---|---|
| CPS intake | |
| Maltreatment report | 1.1 |
| Informational call | 0.3 |
| CPS investigation/assessment | |
| Non-placement investigation | 8.1 |
| Placement investigation | 18.6 |
| Child and family services | |
| In-home family case | 6.6 |
| Child placement case | |
| New child case | 9.5 |
| Ongoing, return home goal | 7.5 |
| Ongoing, other goal | 5.6 |

The CPS investigation/assessment section of Table 2 displays time required to complete a CPS investigation.
Non-placement investigations required
8.1 hours, while those that involved a child placement required 18.6 hours. Clearly, placement investigations entail a great deal more worker time, which should be acknowledged in workload estimation.

The child and family services section presents monthly worker time for serving in-home family cases (6.6 hours) and child placement cases. Three subcategories are shown for placement: new cases, ongoing
cases with a return home goal, and ongoing cases with another goal (other goals include maintaining a child's own home, placement, guardian placement, termination of parental rights, adoption, and/or independent living). Significantly different worker times for these case types have been found in field studies. New cases require more worker assessment and case planning. Return home goal cases require permanency hearings and service delivery to and contact with parents, children, and foster caregivers.

### *Constructing an Agency Workload Estimate*

The worker case time estimates in Table 2 and the monthly worker hours available in Table 1 can be used to compute a simple but useful estimate of workforce capacity and service delivery demand.

Table 3 provides an example estimate for a typical operating month. The agency's monthly intake and investigation activity and average in-home or foster care caseloads could be observed by computing averages across a prior 6- or 12-month period. Once these case counts are secured, the workload demand computation is straightforward. The worker time associated with each case type is multiplied by the number of intakes,

Table 3

Example Agency Estimate of Monthly Workload Demand

| Agency Service Area | Work Hours/Case | Average Monthly Cases | Total Worker Hours |
|---|---|---|---|
| CPS intake | | | |
| Maltreatment report | 1.1 | 2,291 | 2,520.1 |
| Screened out | 0.3 | 4,694 | 1,408.2 |
| Intake subtotal | | | **3,928.3** |
| CPS investigation/assessment | | | |
| Completed, no placement | 8.1 | 812 | 6,577.2 |
| Completed with placement | 18.6 | 63 | 1,171.8 |
| Investigation/assessment subtotal | | | **7,749.0** |
| In-home service cases | | | |
| In-home family case | 6.6 | 1,356 | 8,949.6 |
| In-home case subtotal | | | **8,949.6** |
| Child placement cases | | | |
| New child case | 9.5 | 123 | 1,168.5 |
| Ongoing child case, return home goal | 7.5 | 921 | 6,907.5 |
| Ongoing child case, other goal | 5.6 | 614 | 3,438.4 |
| Placement case subtotal | | | **11,514.4** |
| Total agency workload demand in worker hours | | | **32,141.3** |
| **Staff required to meet estimated workload demand** (total demand divided by worker time available [122.3 hrs. per month]) | | | **262.8** |
| Agency workforce capacity (available staff) | | | 216 |

investigations, or service cases. Table 3 operational data show 2,291 maltreatment reports screened during an average operating month. Since each one requires
1.1 worker hours, 2,520 hours are required to meet this demand. A similar approach is used to estimate CPS investigation demand. The 812 completed non-placement investigations require an estimated
6,577.2 staff hours. The 63 investigations involving a child placement require 1,171.8 staff hours. In-home service and placement case demand are estimated in the same way.

Staff hours shown for each service delivery area are summed to represent a total workload demand of 32,141.3 staff hours. Total staff hours are converted to staff positions by dividing the total demand by the 122.3 available hours per worker (see Table 1).

3,928.3

The example indicates that 262.8 staff positions are required to meet agency standards given the current demand for child welfare services. This estimate may be compared to authorized agency positions or available positions (authorized positions minus vacancies). In this example, the agency's available workforce capacity is 216 positions. Since 262.8 positions are required to meet workload demand, it is understaffed by 46.8 positions (262.8 minus 216). If, for example, 230 positions were authorized, an additional authorization of 16.8 positions would be required.

*Applying the Workload Estimate*

Agencies can approximate their own workforce needs by securing comparable service delivery data and applying the case time estimates shown here. Monthly



worker time available (122.3 hours) could be adjusted by computing local training, leave, and break time (see Table 1).

Workforce demand for service delivery areas (intake, investigation, in-home, or foster care case services) can be calculated separately. For example, CPS investigations required 7,749 hours per month, which implies a 63.4-position workforce estimate (7,749 divided by 122.3). This could be compared to current assigned positions to secure a reasonable approximation of how adequately that unit is staffed.

### *Caveats*

Since some intake units must be staffed 24 hours a day regardless of call volume, intake counts may not fully account for assigned positions. Many SDM sites employ risk-based contact standards which are not fully incorporated into these estimates. Rural workers
may require additional compensation for travel to meet the same service delivery standards. Finally, all the case time and position estimates shown here apply to case-carrying workers and do not include supervisors or clerical staff. They also exclude foster and adoption home licensing workers, resource development staff, forensic interviewers, and other specialized staff.[2]

### *Summary and Conclusion*

Staff time is a critical resource child welfare agencies deploy in their efforts to strengthen families and promote child safety and permanency. This article presents a case for improving workforce management by reviewing research findings that link understaffing to poor performance on CFSR case outcome measures. It describes simple approaches agencies can adopt to conduct a quick assessment of their workforce needs and improve their workforce management.

A more detailed version of this article was published in *Protecting Children* (Volume 23, Number 3), a journal of the American Humane Association, and may also be accessed on CRC's website, www.nccd-crc.org.

[2] For additional caveats, see the full version of this report, available at www.nccd-crc.org.

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CRC

Children's Research Center
426 S. Yellowstone Dr., Ste. 250
Madison, Wisconsin 53719
(608) 831-1180
www.nccd-crc.org

100 Centennial NCCD

CRC is division of the National Council on Crime and Delinquency, a nonprofit social research organization in existence since 1907.

# American Bar Association
# Standards of Practice for Attorneys Representing Parents in Abuse and Neglect Cases

Introduction

These standards promote quality representation and uniformity of practice throughout the country for parents' attorneys in child abuse and neglect cases. The standards were written with the help of a committee of practicing parents' attorneys and child welfare professionals from different jurisdictions in the country. With their help, the standards were written with the difficulties of day-to-day practice in mind, but also with the goal of raising the quality of representation. While local adjustments may be necessary to apply these standards in practice, jurisdictions should strive to meet their fundamental principles and spirit.

The standards are divided into the following categories:

- Summary of the Standards
- Basic Obligations of Parents' Attorneys
- Obligations of Attorney Manager
- The Role of the Court

The standards include "black letter" requirements written in bold. Following the black letter standards are "actions." These actions further discuss how to fulfill the standard; implementing each standard requires the accompanying action. After the action is "commentary" or a discussion of why the standard is necessary and how it should be applied. When a standard does not need further explanation, no action or commentary appears. Several standards relate to specific sections of the Model Rules of Professional Conduct, and the Model Rules are referenced in these standards. The terms "parent" and "client" are used interchangeably throughout the document. These standards apply to all attorneys who represent parents in child abuse and neglect cases, whether they work for an agency or privately.

As was done in the *Standards of Practice for Attorneys Representing Child Welfare Agencies*, ABA 2004, a group of standards for attorney managers is included in these standards. These standards primarily apply to parents' attorneys who work for an agency or law firm – an institutional model of representation. Solo practitioners, or attorneys who individually receive appointments from the court, may wish to review this part of the standards, but may find some do not apply. However, some standards in this section, such as those about training and caseload, are relevant for all parents' attorneys.

As was done in the *Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases,* ABA 1996, a section of the standards concerns the Role of the Court in implementing these *Standards*. The ABA and the National Council of Juvenile and Family Court

Judges have policies concerning the importance of the court in ensuring that all parties in abuse and neglect cases have competent representation.

Representing a parent in an abuse and neglect case is a difficult and emotional job. There are many responsibilities. These standards are intended to help the attorney prioritize duties and manage the practice in a way that will benefit each parent on the attorney's caseload.

# SUMMARY: ABA Standards of Practice for Attorneys Representing Parents in Abuse and Neglect Cases

Basic Obligations: The parent's attorney shall:

**General:**

- **Adhere to all relevant jurisdiction-specific training and mentoring requirements before accepting a court appointment to represent a parent in an abuse or neglect case.**

- **Acquire sufficient working knowledge of all relevant federal and state laws, regulations, policies, and rules.**

- **Understand and protect the parent's rights to information and decision making while the child is in foster care.**

- **Actively represent a parent in the pre-petition phase of a case, if permitted within the jurisdiction.**

- **Avoid continuances (or reduce empty adjournments) and work to reduce delays in court proceedings unless there is a strategic benefit for the client.**

- **Cooperate and communicate regularly with other professionals in the case.**

Relationship with the Client:

- **Advocate for the client's goals and empower the client to direct the representation and make informed decisions based on thorough counsel.**

- **Act in accordance with the duty of loyalty owed to the client.**

- **Adhere to all laws and ethical obligations concerning confidentiality.**

- **Provide the client with contact information in writing and establish a message system that allows regular attorney-client contact.**

- **Meet and communicate regularly with the client well before court proceedings. Counsel the client about all legal matters related to the case, including specific allegations against the client, the service plan, the client's rights in the**

**pending proceeding, any orders entered against the client and the potential consequences of failing to obey court orders or cooperate with service plans.**

- **Work with the client to develop a case timeline and tickler system.**

- **Provide the client with copies of all petitions, court orders, service plans, and other relevant case documents, including reports regarding the child except when expressly prohibited by law, rule or court order.**

- **Be alert to and avoid potential conflicts of interest that would interfere with the competent representation of the client.**

- **Act in a culturally competent manner and with regard to the socioeconomic position of the parent throughout all aspects of representation.**

- **Take diligent steps to locate and communicate with a missing parent and decide representation strategies based on that communication.**

- **Be aware of the unique issues an incarcerated parent faces and provide competent representation to the incarcerated client.**

- **Be aware of the client's mental health status and be prepared to assess whether the parent can assist with the case.**

**Investigation:**

- **Conduct a thorough and independent investigation at every stage of the proceeding.**

- **Interview the client well before each hearing, in time to use client information for the case investigation.**

**Informal Discovery:**

- **Review the child welfare agency case file.**

- **Obtain all necessary documents, including copies of all pleadings and relevant notices filed by other parties, and information from the caseworker and providers.**

**Formal Discovery:**

- **When needed, use formal discovery methods to obtain information.**

**Court Preparation:**

- **Develop a case theory and strategy to follow at hearings and negotiations.**

- **Timely file all pleadings, motions, and briefs. Research applicable legal issues and advance legal arguments when appropriate.**

- **Engage in case planning and advocate for appropriate social services using a multidisciplinary approach to representation when available.**

- **Aggressively advocate for regular visitation in a family-friendly setting.**

- **With the client's permission, and when appropriate, engage in settlement negotiations and mediation to resolve the case.**

- **Thoroughly prepare the client to testify at the hearing.**

- **Identify, locate and prepare all witnesses.**

- **Identify, secure, prepare and qualify expert witness when needed. When permissible, interview opposing counsel's experts.**

**Hearings:**

- **Attend and prepare for all hearings, including pretrial conferences.**

- **Prepare and make all appropriate motions and evidentiary objections.**

- **Present and cross-examine witnesses, prepare and present exhibits.**

- **In jurisdictions in which a jury trial is possible, actively participate in jury selection and drafting jury instructions.**

- **Request closed proceedings (or a cleared courtroom) in appropriate cases.**

- **Request the opportunity to make opening and closing arguments.**

- **Prepare proposed findings of fact, conclusions of law and orders when they will be used in the court's decision or may otherwise benefit the client.**

**Post Hearings/Appeals:**

- **Review court orders to ensure accuracy and clarity and review with client.**

- **Take reasonable steps to ensure the client complies with court orders and to determine whether the case needs to be brought back to court.**

- **Consider and discuss the possibility of appeal with the client.**



- **If the client decides to appeal, timely and thoroughly file the necessary post-hearing motions and paperwork related to the appeal and closely follow the jurisdiction's Rules of Appellate Procedure.**

- **Request an expedited appeal, when feasible, and file all necessary paperwork while the appeal is pending.**

- **Communicate the results of the appeal and its implications to the client.**

**Obligations of Attorney Managers:**

Attorney Managers are urged to:

- **Clarify attorney roles and expectations.**

- **Determine and set reasonable caseloads for attorneys.**

- **Advocate for competitive salaries for staff attorneys.**

- **Develop a system for the continuity of representation.**

- **Provide attorneys with training and education opportunities regarding the special issues that arise in the client population.**

- **Establish a regular supervision schedule.**

- **Create a brief and forms bank.**

- **Ensure the office has quality technical and support staff as well as adequate equipment, library materials, and computer programs to support its operations.**

- **Develop and follow a recruiting and hiring practice focused on hiring highly qualified candidates.**

- **Develop and implement an attorney evaluation process.**

- **Work actively with other stakeholders to improve the child welfare system, including court procedures.**

**Role of the Court**

The Court is urged to:

- **Recognize the importance of the parent attorney's role.**

- **Establish uniform standards of representation for parents' attorneys.**

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- **Ensure the attorneys who are appointed to represent parents in abuse and neglect cases are qualified, well-trained, and held accountable for practice that complies with these standards.**

- **Ensure appointments are made when a case first comes before the court, or before the first hearing, and last until the case has been dismissed from the court's jurisdiction.**

- **Ensure parents' attorneys receive fair compensation.**

- **Ensure timely payment of fees and costs for attorneys.**

- **Provide interpreters, investigators and other specialists needed by the attorneys to competently represent clients. Ensure attorneys are reimbursed for supporting costs, such as use of experts, investigation services, interpreters, etc.**

- **Ensure that attorneys who are receiving appointments carry a reasonable caseload that would allow them to provide competent representation for each of their clients.**

- **Ensure all parties, including the parent's attorney, receive copies of court orders and other documentation.**

- **Provide contact information between clients and attorneys.**

- **Ensure child welfare cases are heard promptly with a view towards timely decision making and thorough review of issues.**

Basic Obligations: The parent's attorney shall:

**General**[1]

- **Adhere to all relevant jurisdiction-specific training and mentoring requirements before accepting a court appointment to represent a parent in an abuse or neglect case.**

Action: The parent's attorney must participate in all required training and mentoring before accepting an appointment.

Commentary: As in all areas of law, it is essential that attorneys learn the substantive law as well as local practice. A parent's fundamental liberty interest in the care and custody of his or her child is at stake, and the attorney must be adequately trained to protect this interest. Because the stakes are so high, the standards drafting committee recommends all parents' attorneys receive a minimum of 20 hours of relevant training before receiving an appointment and a minimum of 15 hours of related training each year. Training should directly relate to the attorney's child welfare practice.[2] This is further detailed in Attorney Managers Standard 5 below. In addition, the parent's attorney should actively participate in ongoing training opportunities. Even if the attorney's jurisdiction does not require training or mentoring, the attorney should seek it. Each state should make comprehensive training available to parents' attorneys throughout the state. Training may include relevant online or video training.

- **Acquire sufficient working knowledge of all relevant federal and state laws, regulations, policies, and rules.**

Action: Parents' attorneys may come to the practice with competency in the various aspects of child abuse and neglect practice, or they need to be trained on them. It is essential for the parent's attorney to read and understand all state laws, policies and procedures regarding child abuse and neglect. In addition, the parent's attorney must be familiar with the following laws to recognize when they are relevant to a case and should be prepared to research them when they are applicable:

Titles IV-B and IV-E of the Social Security Act, including the Adoption and Safe Families Act (ASFA), 42 U.S.C. § § 620-679 and the ASFA Regulations,
45 C.F.R. Parts 1355, 1356, 1357
Child Abuse Prevention Treatment Act (CAPTA), P.L.108-36
Indian Child Welfare Act (ICWA) 25 U.S.C. § § 1901-1963, the ICWA Regulations, 25 C.F.R. Part 23, and the Guidelines for State Courts: Indian Child Custody Proceedings, 44 Fed. Reg. 67, 584 (Nov. 26, 1979)
State Indian Child Welfare Act laws

Multi-Ethnic Placement Act (MEPA), as amended by the Inter-Ethnic Adoption Provisions of 1996 (MEPA-IEP) 42 U.S.C. § 622 (b)(9) (1998), 42

U.S.C. § 671(a)(18) (1998), 42 U.S.C. § 1996b (1998).

Interstate Compact on Placement of Children (ICPC)
Foster Care Independence Act of 1999 (FCIA), P.L. 106-169 Individuals with Disabilities Education Act (IDEA), P.L. 91-230 Family Education Rights Privacy Act (FERPA), 20 U.S.C. § 1232g

Health Insurance Portability and Accountability Act of 1996 (HIPPA), P. L., 104-192 § 264, 42 U.S.C. § 1320d-2 (in relevant part)

Public Health Act, 42 U.S.C. Sec. 290dd-2 and 42 C.F.R. Part 2
Immigration laws relating to child welfare and child custody
State laws and rules of evidence
State laws and rules of civil procedure State laws and rules of criminal procedure
State laws concerning privilege and confidentiality, public benefits, education, and disabilities
State laws and rules of professional responsibility or other relevant ethics standards
State laws regarding domestic violence State domestic relations laws

Commentary: Although the burden of proof is on the child welfare agency, in practice the parent and the parent's attorney generally must demonstrate that the parent can adequately care for the child. The parent's attorney must consider all obstacles to this goal, such as criminal charges against the parent, immigration issues, substance abuse or mental health issues, confidentiality concerns, permanency timelines, and the child's individual service issues. To perform these functions, the parent's attorney must know enough about all relevant laws to vigorously advocate for the parent's interests. Additionally, the attorney must be able to use procedural, evidentiary and confidentiality laws and rules to protect the parent's rights throughout court proceedings.

- **Understand and protect the parent's rights to information and decision making while the child is in foster care.**

Action: The parent's attorney must explain to the parent what decision-making authority remains with the parent and what lies with the child welfare agency while the child is in foster care. The parent's attorney should seek updates and reports from any service provider working with the child/family or help the client obtain information about the child's safety, health, education and well-being when the client desires. Where decision-making rights remain, the parent's attorney should assist the parent in exercising his or her rights to continue to make decisions regarding the child's medical, mental health and

educational services. If necessary, the parent's attorney should intervene with the child welfare agency, provider agencies, medical providers and the school to ensure the parent



has decision-making opportunities. This may include seeking court orders when the parent has been left out of important decisions about the child's life.

Commentary: Unless and until parental rights are terminated, the parent has parental obligations and rights while a child is in foster care. Advocacy may be necessary to ensure the parent is allowed to remain involved with key aspects of the child's life. Not only should the parent's rights be protected, but continuing to exercise as much parental responsibility as possible is often an effective strategy to speed family reunification. Often, though, a parent does not understand that he or she has the right to help make decisions for, or obtain information about, the child. Therefore, it is the parent's attorney's responsibility to counsel the client and help the parent understand his or her rights and responsibilities and try to assist the parent in carrying them out.

- **Actively represent a parent in the prepetition phase of a case, if permitted within the jurisdiction.**

Action: The goal of representing a parent in the prepetition phase of the case is often to deter the agency from deciding to file a petition or to deter the agency from attempting to remove the client's child if a petition is filed. The parent's attorney should counsel the client about the client's rights in the investigation stage as well as the realistic pros and cons of cooperating with the child welfare agency (i.e., the parent's admissions could be used against the client later, but cooperating with services could eliminate a petition filing). The parent's attorney should acknowledge that the parent may be justifiably angry that the agency is involved with the client's family, and help the client develop strategies so the client does not express that anger toward the caseworker in ways that may undermine the client's goals. The attorney should discuss available services and help the client enroll in those in which the client wishes to participate. The attorney should explore conference opportunities with the agency. If it would benefit the client, the attorney should attend any conferences. There are times that an attorney's presence in a conference can shut down discussion, and the attorney should weigh that issue when deciding whether to attend. The attorney should prepare the client for issues that might arise at the conference, such as services and available kinship resources, and discuss with the client the option of bringing a support person to a conference.

Commentary: A few jurisdictions permit parents' attorneys to begin their representation before the child welfare agency files a petition with the court. When the agency becomes involved with the families, it can refer parents to attorneys so that parents will have the benefit of counsel throughout the life of the case. During the prepetition phase, the parent's attorney has the opportunity to work with the parent and help the parent fully understand the issues and the parent's chances of retaining custody of the child. The parent's attorney also has the chance to encourage the agency to make reasonable efforts to work with the family, rather than filing a petition. During this phase, the attorney should work intensively with the parent to explore all appropriate services.

- **Avoid continuances (or reduce empty adjournments) and work to reduce delays in court proceedings unless there is a strategic benefit for the client.**[3]



Action: The parent's attorney should not request continuances unless there is an emergency or it benefits the client's case. If continuances are necessary, the parent's attorney should request the continuance in writing, as far as possible in advance of the hearing, and should request the shortest delay possible, consistent with the client's interests. The attorney must notify all counsel of the request. The parent's attorney should object to repeated or prolonged continuance requests by other parties if the continuance would harm the client.

Commentary: Delaying a case often increases the time a family is separated, and can reduce the likelihood of reunification. Appearing in court often motivates parties to comply with orders and cooperate with services. When a judge actively monitors a case, services are often put in place more quickly, visitation may be increased or other requests by the parent may be granted. If a hearing is continued and the case is delayed, the parent may lose momentum in addressing the issues that led to the child's removal or the parent may lose the opportunity to prove compliance with case plan goals. Additionally, the Adoption and Safe Families Act (ASFA) timelines continue to run despite continuances.

- **Cooperate and communicate regularly with other professionals in the case.**[4]

Action: The parent's attorney should communicate with attorneys for the other parties, court appointed special advocates (CASAs) or guardians ad litem (GALs). Similarly, the parent's attorney should communicate with the caseworker, foster parents and service providers to learn about the client's progress and their views of the case, as appropriate. The parent's attorney should have open lines of communication with the attorney(s) representing the client in related matters such as any criminal, protection from abuse, private custody or administrative proceedings to ensure that probation orders, protection from abuse orders, private custody orders and administrative determinations do not conflict with the client's goals in the abuse and neglect case.

Commentary: The parent's attorney must have all relevant information to try a case effectively. This requires open and ongoing communication with the other attorneys and service providers working with the client and family. Rules of professional ethics govern contact with represented and unrepresented parties. In some states, for instance, attorneys may not speak with child welfare caseworkers without the permission of agency counsel. The parent's attorney must be aware of local rules on this issue and seek permission to speak with represented parties when that would further the client's interests.

**Relationship with the Client**[5]

- **Advocate for the client's goals and empower the client to direct the representation and make informed decisions based on thorough counsel.**[6]

Action: Attorneys representing parents must understand the client's goals and pursue them vigorously. The attorney should explain that the attorney's job is to represent the client's interests and regularly inquire as to the client's goals, including ultimate case



goals and interim goals. The attorney should explain all legal aspects of the case and provide comprehensive counsel on the advantages and disadvantages of different options. At the same time, the attorney should be careful not to usurp the client's authority to decide the case goals.

Commentary: Since many clients distrust the child welfare system, the parent's attorney must take care to distinguish him or herself from others in the system so the client can see that the attorney serves the client's interests. The attorney should be mindful that parents often feel disempowered in child welfare proceedings and should take steps to make the client feel comfortable expressing goals and wishes without fear of judgment. The attorney should clearly explain the legal issues as well as expectations of the court and the agency, and potential consequences of the client failing to meet those expectations. The attorney has the responsibility to provide expertise, and to make strategic decisions about the best ways to achieve the parent's goals, but the client is in charge of deciding the case goals and the attorney must act accordingly.

- **Act in accordance with the duty of loyalty owed to the client.**

Action: Attorneys representing parents should show respect and professionalism towards their clients. Parents' attorneys should support their clients and be sensitive to the client's individual needs. Attorneys should remember that they may be the client's only advocate in the system and should act accordingly.

Commentary: Often attorneys practicing in abuse and neglect court are a close knit group who work and sometimes socialize together. Maintaining good working relationships with other players in the child welfare system is an important part of being an effective advocate. The attorney, however, should be vigilant against allowing the attorney's own interests in relationships with others in the system to interfere with the attorney's primary responsibility to the client. The attorneys should not give the impression to the client that relationships with other attorneys are more important than the representation the attorney is providing the client. The client must feel that the attorney believes in him or her and is actively advocating on the client's behalf.

- **Adhere to all laws and ethical obligations concerning confidentiality.**[7]

Action: Attorneys representing parents must understand confidentiality laws, as well as ethical obligations, and adhere to both with respect to information obtained from or about the client. The attorney must fully explain to the client the advantages and disadvantages of choosing to exercise, partially waive, or waive a privilege or right to confidentiality. Consistent with the client's interests and goals, the attorney must seek to protect from disclosure confidential information concerning the client.

Commentary: Confidential information contained in a parent's substance abuse treatment records, domestic violence treatment records, mental health records and medical records is often at issue in abuse and neglect cases. Improper disclosure of confidential information early in the proceeding may have a negative impact on the manner in which



the client is perceived by the other parties and the court. For this reason, it is crucial for the attorney to advise the client promptly as to the advantages and disadvantages of releasing confidential information, and for the attorney to take whatever steps necessary to protect the client's privileges or rights to confidentiality.

- **Provide the client with contact information in writing and establish a message system that allows regular attorney-client contact.[8]**

Action: The parent's attorney should ensure the parent understands how to contact the attorney and that the attorney wants to hear from the client on an ongoing basis. The attorney should explain that even when the attorney is unavailable, the parent should leave a message. The attorney must respond to client messages in a reasonable time period. The attorney and client should establish a reliable communication system that meets the client's needs. For example, it may involve telephone contact, email or communication through a third party when the client agrees to it. Interpreters should be used when the attorney and client are not fluent in the same language.

Commentary: Gaining the client's trust and establishing ongoing communication are two essential aspects of representing the parent. The parent may feel angry and believe that all of the attorneys in the system work with the child welfare agency and against that parent. It is important that the parent's attorney, from the beginning of the case, is clear with the parent that the attorney works for the parent, is available for consultation, and wants to communicate regularly. This will help the attorney support the client, gather information for the case and learn of any difficulties the parent is experiencing that the attorney might help address. The attorney should explain to the client the benefits of bringing issues to the attorney's attention rather than letting problems persist. The attorney should also explain that the attorney is available to intervene when the client's relationship with the agency or provider is not working effectively. The attorney should be aware of the client's circumstances, such as whether the client has access to a telephone, and tailor the communication system to the individual client.

- **Meet and communicate regularly with the client well before court proceedings. Counsel the client about all legal matters related to the case, including specific allegations against the client, the service plan, the client's rights in the pending proceeding, any orders entered against the client and the potential consequences of failing to obey court orders or cooperate with service plans.[9]**

Action: The parent's attorney should spend time with the client to prepare the case and address questions and concerns. The attorney should clearly explain the allegations made against the parent, what is likely to happen before, during and after each hearing, and what steps the parent can take to increase the likelihood of reuniting with the child. The attorney should explain any settlement options and determine whether the client wants the attorney to pursue such options. The attorney should explain courtroom procedures. The attorney should write to the client to ensure the client understands what happened in court and what is expected of the client.



The attorney should ensure a formal interpreter is involved when the attorney and client are not fluent in the same language. The attorney should advocate for the use of an interpreter when other professionals in the case who are not fluent in the same language as the client are interviewing the client as well.

The attorney should be available for in-person meetings or telephone calls to answer the client's questions and address the client's concerns. The attorney and client should work together to identify and review short and long-term goals, particularly as circumstances change during the case.

The parent's attorney should help the client access information about the child's developmental and other needs by speaking to service providers and reviewing the child's records. The parent needs to understand these issues to make appropriate decisions for the child's care.

The parent's attorney and the client should identify barriers to the client engaging in services, such as employment, transportation, and financial issues. The attorney should work with the client, caseworker and service provider to resolve the barriers.

The attorney should be aware of any special issues the parents may have related to participating in the proposed case plan, such as an inability to read or language differences, and advocate with the child welfare agency and court for appropriate accommodations.

Commentary: The parent's attorney's job extends beyond the courtroom. The attorney should be a counselor as well as litigator. The attorney should be available to talk with the client to prepare for hearings, and to provide advice and information about ongoing concerns. Open lines of communication between attorneys and clients help ensure clients get answers to questions and attorneys get the information and documents they need.

- **Work with the client to develop a case timeline and tickler system.**

Action: At the beginning of a case, the parent's attorney and client should develop timelines that reflect projected deadlines and important dates and a tickler/calendar system to remember the dates. The timeline should specify what actions the attorney and parent will need to take and dates by which they will be completed. The attorney and the client should know when important dates will occur and should be focused on accomplishing the objectives in the case plan in a timely way. The attorney should

provide the client with a timeline/calendar, outlining known and prospective court dates, service appointments, deadlines and critical points of attorney-client contact. The attorney should record federal and state law deadlines in the system (e.g., the 15 of 22 month point that would necessitate a termination of parental rights (TPR), if exceptions do not apply).



Commentary: Having a consistent calendaring system can help an attorney manage a busy caseload. Clients should receive a hard copy calendar to keep track of appointments and important dates. This helps parents stay focused on accomplishing the service plan goals and meeting court-imposed deadlines.

- **Provide the client with copies of all petitions, court orders, service plans, and other relevant case documents, including reports regarding the child except when expressly prohibited by law, rule or court order.[10]**

Action: The parent's attorney should provide all written documents to the client or ensure that they are provided in a timely manner and ensure the client understands them. If the client has difficulty reading, the attorney should read the documents to the client. In all cases, the attorney should be available to discuss and explain the documents to the client.

Commentary: The parent's attorney should ensure the client is informed about what is happening in the case. Part of doing so is providing the client with written documents and reports relevant to the case. If the client has this information, the client will be better able to assist the attorney with the case and fulfill his or her parental obligations. The attorney must be aware of any allegations of domestic violence in the case and not share confidential information about an alleged or potential victim's location.

- **Be alert to and avoid potential conflicts of interest that would interfere with the competent representation of the client.[11]**

Action: The parent's attorney must not represent both parents if their interests differ. The attorney should generally avoid representing both parents when there is even a potential for conflicts of interests. In situations involving allegations of domestic violence the attorney should never represent both parents.

Commentary: In most cases, attorneys should avoid representing both parents in an abuse or neglect case. In the rare case in which an attorney, after careful consideration of potential conflicts, may represent both parents, it should only be with their informed consent. Even in cases in which there is no apparent conflict at the beginning of the case, conflicts may arise as the case proceeds. If this occurs, the attorney might be required to withdraw from representing one or both parents. This could be difficult for the clients and delay the case. Other examples of potential conflicts of interest that the attorney should

avoid include representing multiple fathers in the same case or representing parties in a separate case who have interests in the current case.

In analyzing whether a conflict of interest exists, the attorney must consider "whether pursuing one client's objectives will prevent the lawyer from pursuing another client's objectives, and whether confidentiality may be compromised."[12]

- **Act in a culturally competent manner and with regard to the socioeconomic position of the parent throughout all aspects of representation.**



Action: The parent's attorney should learn about and understand the client's background, determine how that has an impact on the client's case, and always show the parent respect. The attorney must understand how cultural and socioeconomic differences impact interaction with clients, and must interpret the client's words and actions accordingly.

Commentary: The child welfare system is comprised of a diverse group of people, including the clients and professionals involved. Each person comes to this system with his or her own set of values and expectations, but it is essential that each person try to learn about and understand the backgrounds of others. An individual's race, ethnicity, gender, sexual orientation and socioeconomic position all have an impact on how the person acts and reacts in particular situations. The parent's attorney must be vigilant against imposing the attorney's values onto the clients, and should, instead, work with the parents within the context of their culture and socioeconomic position. While the court and child welfare agency have expectations of parents in their treatment of children, the parent's advocate must strive to explain these expectations to the clients in a sensitive way. The parent's attorney should also try to explain how the client's background might affect the client's ability to comply with court orders and agency requests.

- **Take diligent steps to locate and communicate with a missing parent and decide representation strategies based on that communication.**[13]

Action: Upon accepting an appointment, the parent's attorney should communicate to the client the importance of staying in contact with the attorney. While the attorney must communicate regularly with the client, and be informed of the client's wishes before a hearing, the client also must keep in contact with the attorney. At the beginning of the representation, the attorney should tell the client how to contact the attorney, and discuss the importance of the client keeping the attorney informed of changes in address, phone numbers, and the client's current whereabouts.

The parent's attorney should attempt to locate and communicate with missing parents to formulate what positions the attorney should take at hearings, and to understand what information the client wishes the attorney to share with the child welfare agency and the court. If, after diligent steps, the attorney is unable to communicate with the client, the attorney should assess whether the client's interests are better served by advocating for

the client's last clearly articulated position, or declining to participate in further court proceedings, and should act accordingly. After a prolonged period without contact with the client, the attorney should consider withdrawing from representation.

Commentary:

*Diligent Steps to Locate:* To represent a client adequately, the attorney must know what the client wishes. It is, therefore, important for parents' attorneys to take diligent steps to locate missing clients. Diligent steps can include speaking with the client's family, the caseworker, the foster care provider and other service providers. It should include contacting the State Department of Corrections, Social Security Administration, and



Child Support Office, and sending letters by regular and certified mail to the client's last known address. The attorney should also visit the client's last known address and asking anyone who lives there for information about the client's whereabouts. Additionally, the attorney should leave business cards with contact information with anyone who might have contact with the client as long as this does not compromise confidentiality.

*Unsuccessful Efforts to Locate:* If the attorney is unable to find and communicate with the client after initial consultation, the attorney should assess what action would best serve the client's interests. This decision must be made on a case-by-case basis. In some cases, the attorney may decide to take a position consistent with the client's last clearly articulated position. In other cases the client's interests may be better served by the attorney declining to participate in the court proceedings in the absence of the client because that may better protect the client's right to vacate orders made in the client's absence.

- **Be aware of the unique issues an incarcerated parent faces and provide competent representation to the incarcerated client.**

Action:

*Adoption and Safe Families Act (ASFA) Issues:* The parent's attorney must be particularly diligent when representing an incarcerated parent. The attorney must be aware of the reasons for the incarceration. If the parent is incarcerated as a result of an act against the child or another child in the family, the child welfare agency may request an order from the court that reasonable efforts toward reunification are not necessary and attempt to fast-track the case toward other permanency goals. If this is the case, the attorney must be prepared to argue against such a motion, if the client opposes it. Even if no motion is made to waive the reasonable efforts requirement, in some jurisdictions the agency may not have the same obligations to assist parents who are incarcerated. Attorneys should counsel the client as to any effects incarceration has on the agency's obligations and know the jurisdiction's statutory and case law concerning incarceration as a basis for TPR. The attorney should help the client identify potential kinship placements, relatives who can provide care for the child while the parent is incarcerated. States vary in whether and how they weigh factors such as the reason for incarceration, length of incarceration and the child's age at the time of

incarceration when considering TPR. Attorneys must understand the implications of ASFA for an incarcerated parent who has difficulty visiting and planning for the child.

*Services:* Obtaining services such as substance abuse treatment, parenting skills, or job training while in jail or prison is often difficult. The parent's attorney may need to advocate for reasonable efforts to be made for the client, and assist the parent and the agency caseworker in accessing services. The attorney must assist the client with these services. Without services, it is unlikely the parent will be reunified with the child upon discharge from prison.



If the attorney practices in a jurisdiction that has a specialized unit for parents and children, and especially when the client is incarcerated for an offense that is unrelated to the child, the attorney should advocate for such a placement. The attorney must learn about available resources, contact the placements and attempt to get the support of the agency and child's attorney.

*Communication:* The parent's attorney should counsel the client on the importance of maintaining regular contact with the child while incarcerated. The attorney should assist in developing a plan for communication and visitation by obtaining necessary court orders and working with the caseworker as well as the correctional facility's social worker.

If the client cannot meet the attorney before court hearings, the attorney must find alternative ways to communicate. This may include visiting the client in prison or engaging in more extensive phone or mail contact than with other clients. The attorney should be aware of the challenges to having a confidential conversation with the client, and attempt to resolve that issue.

The parent's attorney should also communicate with the parent's criminal defense attorney. There may be issues related to self-incrimination as well as concerns about delaying the abuse and neglect case to strengthen the criminal case or vice versa.

*Appearance in Court:* The client's appearance in court frequently raises issues that require the attorney's attention in advance. The attorney should find out from the client if the client wants to be present in court. In some prisons, inmates lose privileges if they are away from the prison, and the client may prefer to stay at the prison. If the client wants to be present in court, the attorney should work with the court to obtain a writ of habeas corpus/bring-down order/order to produce or other documentation necessary for the client to be transported from the prison. The attorney should explain to any client hesitant to appear, that the case will proceed without the parent's presence and raise any potential consequences of that choice. If the client does not want to be present, or if having the client present is not possible, the attorney should be educated about what means are available to have the client participate, such as by telephone or video conference. The attorney should make the necessary arrangements for the client. Note

that it may be particularly difficult to get a parent transported from an out-of-state prison or a federal prison.

- **Be aware of the client's mental health status and be prepared to assess whether the parent can assist with the case.**

Action: Attorneys representing parents must be able to determine whether a client's mental status (including mental illness and mental retardation) interferes with the client's ability to make decisions about the case. The attorney should be familiar with any mental health diagnosis and treatment that a client has had in the past or is presently undergoing (including any medications for such conditions). The attorney should get consent from the client to review mental health records and to speak with former and current mental



health providers. The attorney should explain to the client that the information is necessary to understand the client's capacity to work with the attorney. If the client's situation seems severe, the attorney should also explain that the attorney may seek the assistance of a clinical social worker or some other mental health expert to evaluate the client's ability to assist the attorney because if the client does not have that capacity, the attorney may have to ask that a guardian ad litem be appointed to the client. Since this action may have an adverse effect on the client's legal claims, the attorney should ask for a GAL only when absolutely necessary.

Commentary: Many parents charged with abuse and neglect have serious or long-standing mental health challenges. However, not all of those conditions or diagnoses preclude the client from participating in the defense. Whether the client can assist counsel is a different issue from whether the client is able to parent the children, though the condition may be related to ability to parent. While the attorney is not expected to be a mental health expert, the attorney should be familiar with mental health conditions and should review such records carefully. The fact that a client suffers a disability does not diminish the lawyer's obligation to treat the client with attention and respect. If the client seems unable to assist the attorney in case preparation, the attorney should seek an assessment of the client's capacity from a mental health expert. If the expert and attorney conclude that the client is not capable of assisting in the case, the attorney should inform the client that the attorney will seek appointment of a guardian ad litem from the court. The attorney should be careful to explain that the attorney will still represent the client in the child protective case. The attorney must explain to the client that appointment of a GAL will limit the client's decision-making power. The GAL will stand in the client's shoes for that purpose.

**Investigation**[14]

- **Conduct a thorough and independent investigation at every stage of the proceeding.**

Action: The parent's attorney must take all necessary steps to prepare each case. A thorough investigation is an essential element of preparation. The parent's attorney can

not rely solely on what the agency caseworker reports about the parent. Rather, the attorney should contact service providers who work with the client, relatives who can discuss the parent's care of the child, the child's teacher or other people who can clarify information relevant to the case. If necessary, the attorney should petition the court for funds to hire an investigator.

Commentary: In some jurisdictions, parents' attorneys work with social workers or investigators who can meet with clients and assist in investigating the underlying issues that arise as cases proceed. The drafting committee recommends such a model of representation. However, if the attorney is not working with such a team, the attorney is still responsible for gaining all pertinent case information.

- **Interview the client well before each hearing, in time to use client information for the case investigation.**[15]



Action: The parent's attorney should meet with the parent regularly throughout the case. The meetings should occur well before the hearing, not at the courthouse just minutes before the case is called before the judge. The attorney should ask the client questions to obtain information to prepare the case, and strive to create a comfortable environment so the client can ask the attorney questions. The attorney should use these meetings to prepare for court as well as to counsel the client concerning issues that arise during the course of the case. Information obtained from the client should be used to propel the investigation.

Commentary: Often, the client is the best source of information for the attorney, and the attorney should set aside time to obtain that information. Since the interview may involve disclosure of sensitive or painful information, the attorney should explain attorney-client confidentiality to the client. The attorney may need to work hard to gain the client's trust, but if a trusting relationship can be developed, the attorney will have an easier time representing the client. The investigation will be more effective if guided by the client, as the client generally knows firsthand what occurred in the case.

**Informal Discovery**[16]

- **Review the child welfare agency case file.**

Action: The parent's attorney should ask for and review the agency case file as early during the course of representation as possible. The file contains useful documents that the attorney may not yet have, and will instruct the attorney on the agency's case theory. If the agency case file is inaccurate, the attorney should seek to correct it. The attorney must read the case file periodically because information is continually being added by the agency.

Commentary: While an independent investigation is essential, it is also important that the parent's attorney understands what information the agency is relying on to further its case. The case file should contain a history about the family that the client may not have

shared, and important reports and information about both the child and parent that will be necessary for the parent's attorney to understand for hearings as well as settlement conferences. Unless the attorney also has the information the agency has, the parent's attorney will walk into court at a disadvantage.

- **Obtain all necessary documents, including copies of all pleadings and relevant notices filed by other parties, and information from the caseworker and providers.**

Action: As part of the discovery phase, the parent's attorney should gather all relevant documentation regarding the case that might shed light on the allegations, the service plan and the client's strengths as a parent. The attorney should not limit the scope as information about past or present criminal, protection from abuse, private custody or



administrative proceedings involving the client can have an impact on the abuse and neglect case. The attorney should also review the following kinds of documents:

social service records
court records
medical records
school records
evaluations of all types

The attorney should be sure to obtain reports and records from service providers.

Discovery is not limited to information regarding the client, but may include records of others such as the other parent, stepparent, child, relative and non-relative caregivers.

Commentary: In preparing the client's case, the attorney must try to learn as much about the parent and the family as possible. Various records may contradict or supplement the agency's account of events. Gathering documentation to verify the client's reports about what occurred before the child came into care and progress the parent is making during the case is necessary to provide concrete evidence for the court. Documentation may also alert the attorney to issues the client is having that the client did not share with counsel. The attorney may be able to intercede and assist the client with service providers, agency caseworkers and others.

**Formal Discovery**[17]

- **When needed, use formal discovery methods to obtain information.**

Action: The parent's attorney should know what information is needed to prepare for the case and understand the best methods of obtaining that information. The attorney should become familiar with the pretrial requests and actions used in the jurisdiction and use whatever tools are available to obtain necessary information. The parent's attorney should consider the following types of formal discovery: depositions, interrogatories (including expert interrogatories), requests for production of documents, requests for

admissions, and motions for mental or physical examination of a party. The attorney should file timely motions for discovery and renew these motions as needed to obtain the most recent records.

The attorney should, consistent with the client's interests and goals, and where appropriate, take all necessary steps to preserve and protect the client's rights by opposing discovery requests of other parties.

**Court Preparation**[18]

- **Develop a case theory and strategy to follow at hearings and negotiations.**

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Action: Once the parent's attorney has completed the initial investigation and discovery, including interviews with the client, the attorney should develop a strategy for representation. The strategy may change throughout the case, as the client makes or does not make progress, but the initial theory is important to assist the attorney in staying focused on the client's wishes and on what is achievable. The theory of the case should inform the attorney's preparation for hearings and arguments to the court throughout the case. It should also help the attorney decide what evidence to develop for hearings and the steps to take to move the case toward the client's ultimate goals (e.g., requesting increased visitation when a parent becomes engaged in services).

- **Timely file all pleadings, motions, and briefs. Research applicable legal issues and advance legal arguments when appropriate.**

Action: The attorney must file petitions, motions, discovery requests, and responses and answers to pleadings filed by other parties that are appropriate for the case. These pleadings must be thorough, accurate and timely.

When a case presents a complicated or new legal issue, the parent's attorney should conduct the appropriate research before appearing in court. The attorney must have a solid understanding of the relevant law, and be able to present it to the judge in a compelling and convincing way. The attorney should be prepared to distinguish case law that appears to be unfavorable. If the judge asks for memoranda of law, the attorney will already have done the research and will be able to use it to argue the case well. If it would advance the client's case, the parent's attorney should present an unsolicited memorandum of law to the court.

Commentary: Actively filing motions, pleadings and briefs benefits the client. This practice puts important issues before the court and builds credibility for the attorney. In addition to filing responsive papers and discovery requests, the attorney should proactively seek court orders that benefit the client, e.g., filing a motion to enforce court orders to ensure the child welfare agency is meeting its reasonable efforts obligations.

When an issue arises, it is often appropriate to attempt to resolve it informally with other parties. When out-of-court advocacy is not successful, the attorney should not wait to bring the issue to the court's attention if that would serve the client's goals.

Arguments in child welfare cases are often fact-based. Nonetheless, attorneys should ground their arguments in statutory, regulatory and common law. These sources of law exist in each jurisdiction, as well as in federal law. Additionally, law from other jurisdictions can be used to sway a court in the client's favor. An attorney who has a firm grasp of the law, and who is willing to do legal research on an individual case, may have more credibility before the court. At times, competent representation requires advancing legal arguments that are not yet accepted in the jurisdiction. Attorneys should be mindful to preserve issues for appellate review by making a record even if the argument is unlikely to prevail at the trial level

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- **Engage in case planning and advocate for appropriate social services using a multidisciplinary approach to representation when available.**

Action: The parent's attorney must advocate for the client both in and out of court. The parent's attorney should know about the social, mental health, substance abuse treatment and other services that are available to parents and families in the jurisdiction in which the attorney practices so the attorney can advocate effectively for the client to receive these services. The attorney should ask the client if the client wishes to engage in services. If so, the attorney must determine whether the client has access to the necessary services to overcome the issues that led to the case.

The attorney should actively engage in case planning, including attending major case meetings, to ensure the client asks for and receives the needed services. The attorney should also ensure the client does not agree to undesired services that are beyond the scope of the case. A major case meeting is one in which the attorney or client believes the attorney will be needed to provide advice or one in which a major decision on legal steps, such as a change in the child's permanency goal, will be made. The attorney should be available to accompany the client to important meetings with service providers as needed.

The services in which the client is involved must be tailored to the client's needs, and not merely hurdles over which the client must jump (e.g., if the client is taking parenting classes, the classes must be relevant to the underlying issue in the case).

Whenever possible, the parent's attorney should engage or involve a social worker as part of the parent's "team" to help determine an appropriate case plan, evaluate social services suggested for the client, and act as a liaison and advocate for the client with the service providers.

When necessary, the parent's attorney should seek court orders to force the child welfare agency to provide services or visitation to the client. The attorney may need to ask the court to enforce previously entered orders that the agency did not comply with in a

reasonable period. The attorney should consider whether the child's representative (lawyer, GAL or CASA) might be an ally on service and visitation issues. If so, the attorney should solicit the child's representative's assistance and work together in making requests to the agency and the court.

Commentary: For a parent to succeed in a child welfare case the parent must receive and cooperate with social services. It is therefore necessary that the parent's attorney does whatever possible to obtain appropriate services for the client, and then counsel the client about participating in such services. Examples of services common to child welfare cases include:

Evaluations
Family preservation or reunification services
Medical and mental health care
Drug and alcohol treatment
Domestic violence prevention, intervention or treatment



Parenting education
Education and job training
Housing
Child care
Funds for public transportation so the client can attend services

- **Aggressively advocate for regular visitation in a family-friendly setting.**

Action: The parent's attorney should advocate for an effective visiting plan and counsel the parent on the importance of regular contact with the child. Preservation of parent-child bonds through regular visitation is essential to any reunification effort. Courts and child welfare agencies may need to be pushed to develop visiting plans that best fit the needs of the individual family. Factors to consider in visiting plans include:

Frequency
Length
Location
Supervision
Types of activities
Visit coaching – having someone at the visit who could model effective parenting skills

Commentary: Consistent, high quality visitation is one of the best predictors of successful reunification between a parent and child. Often visits are arranged in settings that are uncomfortable and inhibiting for families. It is important that the parent's attorney seek a visitation order that will allow the best possible visitation. Effort should be made to have visits be unsupervised or at the lowest possible level of supervision. Families are often more comfortable when relatives, family friends, clergy or other community members are recruited to supervise visits rather than caseworkers. Attorneys should advocate for visits

to occur in the most family-friendly locations possible, such as in the family's home, parks, libraries, restaurants, places of worship or other community venues.

- **With the client's permission, and when appropriate, engage in settlement negotiations and mediation to resolve the case.**

Action: The parent's attorney should, when appropriate, participate in settlement negotiations to promptly resolve the case, keeping in mind the effect of continuances and delays on the client's goals. Parents' attorneys should be trained in mediation and negotiation skills and be comfortable resolving cases outside a courtroom setting when consistent with the client's position. When authorized to do so by the client, the parent's attorney should share information about services in which the parent is engaged and provide copies of favorable reports from service providers. This information may impact settlement discussions. The attorney must communicate all settlement offers to the client and discuss their advantages and disadvantages. It is the client's decision whether to settle. The attorney must be willing to try the case and not compromise solely to avoid the hearing. The attorney should use mediation resources when available.



Commentary: Negotiation and mediation often result in a detailed agreement among parties about actions the participants must take. Generally, when agreements have been thoroughly discussed and negotiated, all parties, including the parents, feel as if they had a say in the decision and are, therefore, more willing to adhere to a plan. Mediation can resolve a specific conflict in a case, even if it does not result in an agreement about the entire case. Negotiated settlements generally happen more quickly than full hearings and therefore move a case along swiftly. The attorney should discuss all aspects of proposed settlements with the parent, including all legal effects of admissions or agreements. The attorney should advise the client about the chances of prevailing if the matter proceeds to trial and any potential negative impact associated with contesting the allegations. The final decision regarding settlement must be the client's.

A written, enforceable agreement should result from any settlement, so all parties are clear about their rights and obligations. The parent's attorney should ensure agreements accurately reflect the understandings of the parties. The parent's attorney should schedule a hearing if promises made to the parent are not kept.

- **Thoroughly prepare the client to testify at the hearing.**

Action: When having the client testify will benefit the case or when the client wishes to testify, the parent's attorney should thoroughly prepare the client. The attorney should discuss and practice the questions that the attorney will ask the client, as well as the types of questions the client should expect opposing counsel to ask. The parent's attorney should help the parent think through the best way to present information, familiarize the parent with the court setting, and offer guidance on logistical issues such as how to get to court on time and appropriate court attire.

Commentary: Testifying in court can be intimidating. For a parent whose family is the focus of the proceeding, the court experience is even scarier. The parent's attorney should be attuned to the client's comfort level about the hearing, and ability to testify in the case. The attorney should spend time explaining the process and the testimony itself to the client. The attorney should provide the client with a written list of questions that the attorney will ask, if this will help the client.

- **Identify, locate and prepare all witnesses.**

Action: The parent's attorney, in consultation with the parent, should develop a witness list well before a hearing. The attorney should not assume the agency will call a witness, even if the witness is named on the agency's witness list. The attorney should, when possible, contact the potential witnesses to determine if they can provide helpful testimony.

When appropriate, witnesses should be informed that a subpoena is on its way. The attorney should also ensure the subpoena is served. The attorney should subpoena potential agency witnesses (e.g., a previous caseworker) who have favorable information about the client.



The attorney should set aside time to fully prepare all witnesses in person before the hearing. The attorney should remind the witnesses about the court date.

Commentary: Preparation is the key to successfully resolving a case, either in negotiation or trial. The attorney should plan as early as possible for the case and make arrangements accordingly. Witnesses may have direct knowledge of the allegations against the parent. They may be service providers working with the parent, or individuals from the community who could testify generally about the family's strengths.

When appropriate, the parent's attorney should consider working with other parties who share the parent's position (such as the child's representative) when creating a witness list, issuing subpoenas, and preparing witnesses. Doctors, nurses, teachers, therapists, and other potential witnesses have busy schedules and need advance warning about the date and time of the hearing.

Witnesses are often nervous about testifying in court. Attorneys should prepare them thoroughly so they feel comfortable with the process. Preparation will generally include rehearsing the specific questions and answers expected on direct and anticipating the questions and answers that might arise on cross-examination. Attorneys should provide written questions for those witnesses who need them.

- **Identify, secure, prepare and qualify expert witness when needed. When permissible, interview opposing counsel's experts.**

Action: Often a case requires multiple experts in different roles, such as experts in medicine, mental health treatment, drug and alcohol treatment, or social work. Experts may be needed for ongoing case consultation in addition to providing testimony at trial. The attorney should consider whether the opposing party is calling expert witnesses and determine whether the parent needs to call any experts.

When expert testimony is required, the attorney should identify the qualified experts and seek necessary funds to retain them in a timely manner. The attorney should subpoena the witnesses, giving them as much advanced notice of the court date as possible. As is true for all witnesses, the attorney should spend as much time as possible preparing the expert witnesses for the hearing. The attorney should be competent in qualifying expert witnesses.

When opposing counsel plans to call expert witnesses, the parent's attorney should file expert interrogatories, depose the witnesses or interview the witnesses in advance, depending on the jurisdiction's rules on attorney work product. The attorney should do whatever is necessary to learn what the opposing expert witnesses will say about the client during the hearing.

Commentary: By contacting opposing counsel's expert witnesses in advance, the parent's attorney will know what evidence will be presented against the client and whether the



expert has any favorable information that might be elicited on cross-examination. The attorney will be able to discuss the issues with the client, prepare a defense and call experts on behalf of the client, if appropriate. Conversely, if the attorney does not talk to the opposing expert in advance, the attorney could be surprised by the evidence and unable to represent the client competently.

**Hearings**

- **Attend and prepare for all hearings, including pretrial conferences.**

Action: The parent's attorney must prepare for, and attend all hearings and participate in all telephone and other conferences with the court.

Commentary: For the parent to have a fair chance during the hearing, the attorney must be prepared and present in court. Participating in pretrial proceedings may improve case resolution for the parent. Counsel's failure to participate in the proceedings in which all other parties are represented may disadvantage the parent. Therefore, the parent's attorney should be actively involved in this stage. Other than in extraordinary circumstances, attorneys must appear for all court appearances on time. In many jurisdictions, if an attorney arrives to court late, or not at all, the case will receive a long continuance. This does not serve the client and does not instill confidence in the attorney. If an attorney has a conflict with another courtroom appearance, the attorney should notify the court and other parties and request a short continuance. The parent's attorney

should not have another attorney stand in to represent the client in a substantive hearing, especially if the other attorney is unfamiliar with the client or case.

- **Prepare and make all appropriate motions and evidentiary objections.**

Action: The parent's attorney should make appropriate motions and evidentiary objections to advance the client's position during the hearing. If necessary, the attorney should file briefs in support of the client's position on motions and evidentiary issues. The parent's attorney should always be aware of preserving legal issues for appeal.

Commentary: It is essential that parents' attorneys understand the applicable rules of evidence and all court rules and procedures. The attorney must be willing and able to make appropriate motions, objections, and arguments (e.g., objecting to the qualification of expert witnesses or raising the issue of the child welfare agency's lack of reasonable efforts).

- **Present and cross-examine witnesses, prepare and present exhibits.**

Action: The parent's attorney must be able to present witnesses effectively to advance the client's position. Witnesses must be prepared in advance and the attorney should know what evidence will be presented through the witnesses. The attorney must also be skilled at cross-examining opposing parties' witnesses. The attorney must know how to offer documents, photos and physical objects into evidence.



At each hearing the attorney should keep the case theory in mind, advocate for the child to return home and for appropriate services, if that is the client's position, and request that the court state its expectations of all parties.

Commentary: Becoming a strong courtroom attorney takes practice and attention to detail. The attorney must be sure to learn the rules about presenting witnesses, impeaching testimony, and entering evidence. The attorney should seek out training in trial skills and observe more experienced trial attorneys to learn from them. Even if the parent's attorney is more seasoned, effective direct and cross-examination require careful preparation. The attorney must know the relevant records well enough to be able to impeach adverse witnesses and bring out in both direct and cross examinations any information that would support the parent's position. Seasoned attorneys may wish to consult with other experienced attorneys about complex cases. Presenting and cross-examining witnesses are skills with which the parent's attorney must be comfortable.

- **In jurisdictions in which a jury trial is possible, actively participate in jury selection and drafting jury instructions.**

Commentary: Several jurisdictions around the country afford parties in child welfare cases the right to a jury trial at the adjudicatory or termination of parental rights stages. Parents' attorneys in those jurisdictions should be skilled at choosing an appropriate jury,

drafting jury instructions that are favorable to the client's position, and trying the case before jurors who may not be familiar with child abuse and neglect issues.

- **Request closed proceedings (or a cleared courtroom) in appropriate cases.**

Action: The parent's attorney should be aware of who is in the courtroom during a hearing, and should request the courtroom be cleared of individuals not related to the case when appropriate. The attorney should be attuned to the client's comfort level with people outside of the case hearing about the client's family. The attorney should also be aware of whether the case is one in which there is media attention. Confidential information should not be discussed in front of the media or others without the express permission of the client.

Commentary: In many courts, even if they have a "closed court" policy, attorneys, caseworkers, and witnesses on other cases listed that day may be waiting in the courtroom. These individuals may make the client uncomfortable, and the parent's attorney should request that the judge remove them from the courtroom. Even in an "open court" jurisdiction, there may be cases, or portions of cases, that outsiders should not be permitted to hear. The parent's attorney must be attuned to this issue, and make appropriate requests of the judge.

- **Request the opportunity to make opening and closing arguments.**



Action: When permitted by the judge, the parent's attorney should make opening and closing arguments to best present the parent's attorney's theory of the.

Commentary: In many child abuse and neglect proceedings, attorneys waive the opportunity to make opening and closing arguments. However, these arguments can help shape the way the judge views the case, and therefore can help the client. Argument may be especially critical, for example, in complicated cases when information from expert witnesses should be highlighted for the judge, in hearings that take place over a number of days, or when there are several children and the agency is requesting different services or permanency goals for each of them. Making opening and closing argument is particularly important if the case is being heard by a jury.

- **Prepare proposed findings of fact, conclusions of law and orders when they will be used in the court's decision or may otherwise benefit the client.**

Action: Proposed findings of fact, conclusions of law, and orders should be prepared before a hearing. When the judge is prepared to enter a ruling, the judge can use the proposed findings or amend them as needed.

Commentary: By preparing proposed findings of fact and conclusions of law, the parent's attorney frames the case and ruling for the judge. This may result in orders that are more favorable to the parent, preserve appellate issues, and help the attorney clarify desired

outcomes before a hearing begins. The attorney should offer to provide the judge with proposed findings and orders in electronic format. If an opposing party prepared the order, the parent's attorney should review it for accuracy before the order is submitted for the judge's signature.

**Post Hearings/Appeals**

- **Review court orders to ensure accuracy and clarity and review with client.**

Action: After the hearing, the parent's attorney should review the written order to ensure it reflects the court's verbal order. If the order is incorrect, the attorney should take whatever steps are necessary to correct it. Once the order is final, the parent's attorney should provide the client with a copy of the order and should review the order with the client to ensure the client understands it. If the client is unhappy with the order, the attorney should counsel the client about any options to appeal or request rehearing on the order, but should explain that the order is in effect unless a stay or other relief is secured. The attorney should counsel the client on the potential consequences of failing to comply with a court order.

Commentary: The parent may be angry about being involved in the child welfare system, and a court order that is not in the parent's favor could add stress and frustration. It is essential that the parent's attorney take time, either immediately after the hearing or at a meeting soon after the court date, to discuss the hearing and the outcome with the client. The attorney should counsel the client about all options, including appeal (see below).



Regardless of whether an appeal is appropriate, the attorney should counsel the parent about potential consequences of not complying with the order.

- **Take reasonable steps to ensure the client complies with court orders and to determine whether the case needs to be brought back to court.**

Action: The parent's attorney should answer the parent's questions about obligations under the order and periodically check with the client to determine the client's progress in implementing the order. If the client is attempting to comply with the order but other parties, such as the child welfare agency, are not meeting their responsibilities, the parent's attorney should approach the other party and seek assistance on behalf of the client. If necessary, the attorney should bring the case back to court to review the order and the other party's noncompliance or take other steps to ensure that appropriate social services are available to the client.

Commentary: The parent's attorney should play an active role in assisting the client in complying with court orders and obtaining visitation and any other social services. The attorney should speak with the client regularly about progress and any difficulties the client is encountering while trying to comply with the court order or service plan. When the child welfare agency does not offer appropriate services, the attorney should consider making referrals to social service providers and, when possible, retaining a social worker

to assist the client. The drafting committee of these standards recommends such an interdisciplinary model of practice.

- **Consider and discuss the possibility of appeal with the client.**[19]

Action: The parent's attorney should consider and discuss with the client the possibility of appeal when a court's ruling is contrary to the client's position or interests. The attorney should counsel the client on the likelihood of success on appeal and potential consequences of an appeal. In most jurisdictions, the decision whether to appeal is the client's as long as a non-frivolous legal basis for appeal exists. Depending on rules in the attorney's jurisdiction, the attorney should also consider filing an extraordinary writ or motions for other post-hearing relief.

Commentary: When discussing the possibility of an appeal, the attorney should explain both the positive and negative effects of an appeal, including how the appeal could affect the parent's goals. For instance, an appeal could delay the case for a long time. This could negatively impact both the parent and the child.

- **If the client decides to appeal, timely and thoroughly file the necessary post-hearing motions and paperwork related to the appeal and closely follow the jurisdiction's Rules of Appellate Procedure.**

Action: The parent's attorney should carefully review his or her obligations under the state's Rules of Appellate Procedure. The attorney should timely file all paperwork, including a notice of appeal and requests for stays of the trial court order, transcript, and



case file. If another party has filed an appeal, the parent's attorney should explain the appeals process to the parent and ensure that responsive papers are filed timely.

The appellate brief should be clear, concise, and comprehensive and also timely filed. The brief should reflect all relevant case law and present the best legal arguments available in state and federal law for the client's position. The brief should include novel legal arguments if there is a chance of developing favorable law in support of the parent's claim.

In jurisdictions in which a different attorney from the trial attorney handles the appeal, the trial attorney should take all steps necessary to facilitate appointing appellate counsel and work with the new attorney to identify appropriate issues for appeal. The attorney who handled the trial may have insight beyond what a new attorney could obtain by reading the trial transcript.

If appellate counsel differs from the trial attorney, the appellate attorney should meet with the client as soon as possible. At the initial meeting, appellate counsel should determine the client's position and goals in the appeal. Appellate counsel should not be bound by the determinations of the client's position and goals made by trial counsel and should independently determine his or her client's position and goals on appeal.

If oral arguments are scheduled, the attorney should be prepared, organized, and direct. Appellate counsel should inform the client of the date, time and place scheduled for oral argument of the appeal upon receiving notice from the appellate court. Oral argument of the appeal on behalf of the client should not be waived, absent the express approval of the client, unless doing so would benefit the client. For example, in some jurisdictions appellate counsel may file a reply brief instead of oral argument. The attorney should weigh the pros and cons of each option.

Commentary: Appellate skills differ from the skills most trial attorneys use daily. The parent's attorney may wish to seek training on appellate practice and guidance from an experienced appellate advocate when drafting the brief and preparing for argument. An appeal can have a significant impact on the trial judge who heard the case and trial courts throughout the state, as well as the individual client and family.

- **Request an expedited appeal, when feasible, and file all necessary paperwork while the appeal is pending.**

Action: If the state court allows, the attorney in a child welfare matter should always consider requesting an expedited appeal. In this request, the attorney should provide information about why the case should be expedited, such as any special characteristics about the child and why delay would harm the relationship between the parent and child.

- **Communicate the results of the appeal and its implications to the client.**



Action: The parent's attorney should communicate the result of the appeal and its implications, and provide the client with a copy of the appellate decision. If, as a result of the appeal, the attorney needs to file any motions with the trial court, the attorney should do so.

**Obligations of Attorney Managers**[20]

Attorney Managers are urged to:

9. **Clarify attorney roles and expectations.**

Action: The attorney manager must ensure that staff attorneys understand their role in representing clients and the expectations of the attorney manager concerning all staff duties. In addition to in-office obligations staff attorneys may attend meetings, conferences, and trainings. The attorney may need to attend child welfare agency or service provider meetings with clients. The manager should articulate these duties at the beginning of and consistently during the attorney's employment. The manager should emphasize the attorney's duties toward the client, and obligations to comply with practice standards.

Commentary: All employees want to know what is expected of them; one can only do a high quality job when the person knows the parameters and expectations of the position. Therefore, the attorney manager must consistently inform staff of those expectations. Otherwise, the staff attorney is set up to fail. The work of representing parents is too important, and too difficult, to be handled by people who do not understand their role and lack clear expectations. These attorneys need the full support of supervisors and attorney managers to perform their highest quality work.

10. **Determine and set reasonable caseloads for attorneys.**[21]

Action: An attorney manager should determine reasonable caseloads for parents' attorneys and monitor them to ensure the maximum is not exceeded. Consider a caseload/workload study, review written materials about such studies, or look into caseload sizes in similar counties to accurately determine ideal attorney caseloads. When assessing the appropriate number of cases, remember to account for all attorney obligations, case difficulty, time required to prepare a case thoroughly, support staff assistance, travel time, experience level of attorneys, and available time (excluding vacation, holidays, sick leave, training and other non-case-related activity). If the attorney manager carries a caseload, the number of cases should reflect the time the individual spends on management duties.

Commentary: High caseload is considered a major barrier to quality representation and a source of high attorney turnover. It is essential to decide what a reasonable caseload is in your jurisdiction. How attorneys define cases and attorney obligations vary from place-to-place, but having a manageable caseload is crucial. The standards drafting committee recommended a caseload of no more than 50-100 cases depending on what the attorney can handle competently and fulfill these standards. The type of practice the attorney has,



e.g., whether the attorney is part of a multidisciplinary representation team also has an impact on the appropriate caseload size. It is part of the attorney manager's job to advocate for adequate funding and to alert individuals in positions of authority when attorneys are regularly asked to take caseloads that exceed local standards.

11. **Advocate for competitive salaries for staff attorneys.**

Action: Attorney managers should advocate for attorney salaries that are competitive with other government and court appointed attorneys in the jurisdiction. To recruit and retain experienced attorneys, salaries must compare favorably with similarly situated attorneys.

Commentary: While resources are scarce, parents' attorneys deserve to be paid a competitive wage. They will likely not stay in their position nor be motivated to work hard without a reasonable salary. High attorney turnover may decrease when attorneys are paid well. Parents' rights to effective assistance of counsel may be compromised if parents' attorneys are not adequately compensated.

12. **Develop a system for the continuity of representation.**

Action: The attorney manager should develop a case assignment system that fosters ownership and involvement in the case by the parent's attorney. The office can have a one-attorney: one-case (vertical representation) policy in which an attorney follows the case from initial filing through permanency and handles all aspects of the case. Alternatively, the cases may be assigned to a group of attorneys who handle all aspects of a case as a team and are all assigned to one judge. If a team approach is adopted, it is critical to establish mechanisms to aid communication about cases and promote accountability.

The attorney manager should also hire social workers, paralegals and/or parent advocates (parents familiar with the child welfare system because they were involved in the system and successfully reunited with their child), who should be "teamed" with the attorneys. These individuals can assist the attorney or attorney team with helping clients access services and information between hearings, and help the attorney organize and monitor the case.

Commentary: Parents' attorneys can provide the best representation for the client when they know a case and are invested in its outcome. Continuity of representation is critical for attorneys and parents to develop the trust that is essential to high quality representation. Additionally, having attorneys who are assigned to particular cases decreases delays because the attorney does not need to learn the case each time it is scheduled for court, but rather has extensive knowledge of the case history. The attorney also has the opportunity to monitor action on the case between court hearings. This system also makes it easier for the attorney manager to track how cases are handled. Whatever system is adopted, the manager must be clear about which attorney has



responsibility for the case preparation, monitoring, and advocacy required throughout the case.

13. **Provide attorneys with training and education opportunities regarding the special issues that arise in the client population.**

Action: The attorney manager must ensure that each attorney has opportunities to participate in training and education programs. When a new attorney is hired, the attorney manager should assess that attorney's level of experience and readiness to handle cases. The attorney manager should develop an internal training program that pairs the new attorney with an experienced "attorney mentor." The new attorney should be required to:
- observe each type of court proceeding (and mediation if available in the jurisdiction),
- second-chair each type of proceeding, 3) try each type of case with the mentor second-chairing, and 4) try each type of proceeding on his or her own, with the mentor available to assist, before the attorney can begin handling cases alone.

Additionally, each attorney should attend at least 20 hours of relevant training before beginning, and at least15 hours of relevant training every year after. Training should

include general legal topics such as evidence and trial skills, and child welfare-specific topics that are related to the client population the office is representing, such as:

Relevant state, federal and case law, procedures and rules
Available community resources
State and federal benefit programs affecting parties in the child welfare system (e.g., SSI, SSA, Medicaid, UCCJEA)
Federal Indian Law including the Indian Child Welfare Act and state law related to Native Americans
Understanding mental illness
Substance abuse issues (including assessment, treatment alternatives, confidentiality, impact of different drugs)
Legal permanency options
Reasonable efforts
Termination of parental rights law
Child development
Legal ethics related to parent representation
Negotiation strategies and techniques
Protection orders/how domestic violence impacts parties in the child welfare system
Appellate advocacy
Immigration law in child welfare cases
Education law in child welfare cases
Basic principles of attachment theory
Sexual abuse
Dynamics of physical abuse and neglect
Y Shaken Baby Syndrome



Y Broken bones
Y Burns
Y Failure To Thrive
Y Munchausen's Syndrome by Proxy
Domestic relations law

Commentary: Parents' attorneys should be encouraged to learn as much as possible and participate in conferences and trainings to expand their understanding of child welfare developments. While parents' attorneys often lack extra time to attend conferences, the knowledge they gain will be invaluable. The philosophy of the office should stress the need for ongoing learning and professional growth. The attorney manager should require the attorneys to attend an achievable number of hours of training that will match the training needs of the attorneys. The court and Court Improvement Program[22] may be able to defray costs of attorney training or may sponsor multidisciplinary training that parents' attorneys should be encouraged to attend. Similarly, state and local bar associations, area law schools or local Child Law Institutes may offer education opportunities. Attorneys should have access to professional publications to stay current on the law and promising

practices in child welfare. Child welfare attorneys benefit from the ability to strategize and share information and experiences with each other. Managers should foster opportunities for attorneys to support each other, discuss cases, and brainstorm regarding systemic issues and solutions.

14. **Establish a regular supervision schedule.**

Action: Attorney managers should ensure that staff attorneys meet regularly (at least once every two weeks) with supervising attorneys to discuss individual cases as well as any issues the attorney is encountering with the court, child welfare agency, service providers or others. The supervising attorney should help the staff attorney work through any difficulties the attorney is encountering in managing a caseload. Supervising attorneys should regularly observe the staff attorneys in court and be prepared to offer constructive criticism as needed. The supervising attorney should create an atmosphere in which the staff attorney is comfortable asking for help and sharing ideas.

Commentary: Parents' attorneys function best when they can learn, feel supported, and manage their cases with the understanding that their supervisors will assist as needed. By creating this office environment, the attorney manager invests in training high quality attorneys and results in long-term retention. Strong supervision helps attorneys avoid the burnout that could accompany the stressful work of representing parents in child welfare cases.

15. **Create a brief and forms bank.**

Action: Develop standard briefs, memoranda of law and forms that attorneys can use, so they do not "reinvent the wheel" for each new project. For example, there could be sample discovery request forms, motions, notices of appeal, and petitions. Similarly, memoranda of law and appellate briefs follow patterns that the attorneys could use,



although these should always be tailored to the specific case. These forms and briefs should be available on the computer and in hard copy and should be centrally maintained. They should also be well indexed for accessibility and updated as needed.

16. **Ensure the office has quality technical and support staff as well as adequate equipment, library materials, and computer programs to support its operations.**

Action: The attorney manager should advocate for high quality technical and staff support. The office should employ qualified legal assistants or paralegals and administrative assistants to help the attorneys. The attorney manager should create detailed job descriptions for these staff members to ensure they are providing necessary assistance. For instance, a qualified legal assistant can help: research, draft petitions, schedule and prepare witnesses and more.

The attorney manager should ensure attorneys have access to working equipment, a user-friendly library conducive to research, and computer programs for word processing,

conducting research (Westlaw or Lexis/Nexis), caseload and calendar management, Internet access, and other supports that make the attorney's job easier and enhances client representation.

Commentary: By employing qualified staff, the attorneys will be free to perform tasks essential to quality representation. The attorneys must at least have access to a good quality computer, voice mail, fax machine, and copier to get the work done efficiently and with as little stress as possible

17. **Develop and follow a recruiting and hiring practice focused on hiring highly qualified candidates.**

Action: The attorney manager should hire the best attorneys possible. The attorney manager should form a hiring committee made up of managing and line attorneys and possibly a client or former client of the office. Desired qualities of a new attorney should be determined, focusing on educational and professional achievements; experience and commitment to representing parents and to the child welfare field; interpersonal skills; diversity and the needs of the office; writing and verbal skills; second language skills; and ability to handle pressure. Widely advertising the position will draw a wider candidate pool. The hiring committee should set clear criteria for screening candidates before interviews and should conduct thorough interviews and post-interview discussions to choose the candidate with the best skills and strongest commitment. Reference checks should be completed before extending an offer.

Commentary: Hiring high quality attorneys raises the level of representation and the level of services parents in the jurisdiction receive. The parent attorney's job is complicated and stressful. There are many tasks to complete in a short time. It is often difficult to connect with, build trust and represent the parent. New attorneys must be aware of these challenges and be willing and able to overcome them. Efforts should be made to recruit staff who reflect the racial, ethnic, and cultural backgrounds of the clients. It is



particularly important to have staff who can communicate with the clients in their first languages, whenever possible.

18. **Develop and implement an attorney evaluation process.**

Action: The attorney manager should develop an evaluation system that focuses on consistency, constructive criticism, and improvement. Some factors to evaluate include: communicating with the client, preparation and trial skills, working with clients and other professionals, complying with practice standards, and ability to work within a team. During the evaluation process, the attorney manager should consider:

observing the attorney in court;
reviewing the attorney's files;
talking with colleagues and clients, when appropriate, about the attorney's performance;

having the attorney fill out a self-evaluation; and;
meeting in person with the attorney.

Where areas of concern are noted, the evaluation process should identify and document specific steps to address areas needing improvement.

Commentary: A solid attorney evaluation process helps attorneys know what they should be working on, management's priorities, their strengths and areas for improvement. A positive process supports attorneys in their positions, empowers them to improve and reduces burnout.

19. **Work actively with other stakeholders to improve the child welfare system, including court procedures.**

Action: The attorney manager should participate, or designate someone from the staff to participate, in multidisciplinary committees within the jurisdiction that are focused on improving the local child welfare system. Examples of such committees include: addressing issues of disproportional representation of minorities in foster care, improving services for incarcerated parents, allowing parents pre-petition representation, drafting court rules and procedures, drafting protocols about outreach to missing parents and relatives, removing permanency barriers and delays, and accessing community-based services for parents and children. Similarly, the attorney manager should participate in, and strongly encourage staff participation in, multidisciplinary training.

Commentary: Working on systemic change with all stakeholders in the jurisdiction is one way to serve the parents the office represents as well as their children. Active participation of parents' attorneys ensures that projects and procedures are equitably developed, protect parents' interests, and the attorneys are more likely to work on them over the long term. Collaboration can, and generally does, benefit all stakeholders.

**Role of the Court:**

The court is urged to:



- **Recognize the importance of the parent attorney's role.**

Commentary: The judge sets the tone in the courtroom. Therefore, it is very important that the judge respects all parties, including the parents and parents' counsel. Representing parents is difficult and emotional work, but essential to ensuring justice is delivered in child abuse and neglect cases. When competent attorneys advocate for parent clients, the judge's job becomes easier. The judge is assured that the parties are presenting all relevant evidence, and the judge can make a well-reasoned decision that protects the parents' rights. Also, by respecting and understanding the parent attorney's role, the judge sets an example for others.

- **Establish uniform standards of representation for parents' attorneys.**

Commentary: By establishing uniform representation rules or standards, the judge can put the parents' attorneys in the jurisdiction on notice that a certain level of representation will be required for the attorney to continue to receive appointments. The rules or standards should be jurisdiction specific, but should include the elements of these standards.

- **Ensure the attorneys who are appointed to represent parents in abuse and neglect cases are qualified, well-trained, and held accountable for practice that complies with these standards.**

Commentary: Once the standards are established, the court must hold all parents' attorneys accountable to them. A system should be developed that would delineate when an attorney would be removed from a case for failure to comply with the standards, and what actions, or inactions, would result in the attorney's removal from the appointment list (or a court recommendation to an attorney manager that an attorney be disciplined within the parent attorney office). The court should encourage attorneys to participate in educational opportunities, and the judge should not appoint attorneys who have failed to meet the minimum annual training requirements set out in the rules or standards.

- **Ensure appointments are made when a case first comes before the court, or before the first hearing, and last until the case has been dismissed from the court's jurisdiction.**

Commentary: The parent is disadvantaged in a child abuse and neglect case if not represented by a competent attorney throughout the life of the case. The attorney can explain the case to the parent, counsel the parent on how best to achieve the parent's goals with respect to the child, and assist the parent access necessary services. In most child welfare cases, the parent cannot afford an attorney and requires the court to appoint one. The court should make every effort to obtain an attorney for that parent as early in the case as feasible – preferably before the case comes to court for the first time or at the first hearing. In jurisdictions in which parents only obtain counsel for the termination of



parental rights hearing, the parent has little chance of prevailing. A family that may have been reunified if the parent had appropriate legal support is separated forever.

- **Ensure parents' attorneys receive fair compensation.**

Commentary: While resources are scarce, parents' attorneys deserve a competitive wage. They should receive the same wage as other government and court-appointed attorneys for other parties in the child abuse and neglect case. Parents' rights to effective assistance of counsel may be compromised if parents' attorneys are not adequately compensated. In most jurisdictions, the court sets the attorneys' fees and individual judges can recommend to court administration that parents' attorneys should be well compensated.

- **Ensure timely payment of fees and costs for attorneys.**

Commentary: Often judges must sign fee petitions and approve payment of costs for attorneys. The judges should do so promptly so parents' attorneys can focus on representing clients, not worrying about being paid.

- **Provide interpreters, investigators and other specialists needed by the attorneys to competently represent clients. Ensure attorneys are reimbursed for supporting costs, such as use of experts, investigation services, interpreters, etc.**

Commentary: Attorneys can not provide competent representation for parents without using certain specialists. For instance, if the client speaks a language different from the attorney, the attorney must have access to interpreters for attorney/client meetings. Interpreter costs should not be deducted from the attorney's compensation. A parent should be permitted to use an expert of the parent's choosing in some contested cases. If the expert charges a fee, the court should reimburse that fee separate and apart from what the court is paying the attorney.

- **Ensure that attorneys who are receiving appointments carry a reasonable caseload that would allow them to provide competent representation for each of their clients.**

Commentary: The maximum allowable caseload should be included in local standards of practice for parents' attorneys. This committee recommends no more than 50-100 cases for full time attorneys, depending on the type of practice the attorney has and whether the attorney is able to provide each client with representation that follows these standards. Once this number has been established, the court should not appoint an attorney to cases once the attorney has reached the maximum level. Attorneys can only do high quality work for a limited number of clients, and each client deserves the attorney's full attention. Of course, the caseload decision is closely tied to adequate compensation. If paid appropriately, the attorney will have less incentive to overextend and accept a large number of cases.



- **Ensure all parties, including the parent's attorney, receive copies of court orders and other documentation.**

Commentary: The court should have a system to ensure all parties receive necessary documentation in a timely manner. If the parent and parent attorney do not have the final court order, they do not know what is expected of them and of the other parties. If the child welfare agency, for example, is ordered to provide the parent with a certain service within two weeks, the parent's attorney must know that. After two weeks, if the service has not been provided, the attorney will want to follow up with the court. In some jurisdictions, copies of court orders are handed to each party before they leave the courtroom. This is an ideal situation, and if it is not feasible, the court should determine what other distribution method will work.

- **Provide contact information between clients and attorneys.**

Commentary: Often parties in child welfare cases are difficult to locate or contact. Some parents lack telephones. The court can help promote contact between the attorney and parent by providing contact information to both individuals.

- **Ensure child welfare cases are heard promptly with a view towards timely decision making and thorough review of issues.**

Commentary: Judges should attempt to schedule hearings and make decisions quickly. Allotted court time should be long enough for the judge to thoroughly review the case and conduct a meaningful hearing.

When possible, judges should schedule hearings for times-certain to avoid delaying attorneys unnecessarily in court. When attorneys are asked to wait through the rest of the morning calendar for one brief review hearing, limited dollars are spent to keep the attorney waiting in hallways, rather than completing an independent investigation, or researching alternative placement or treatment options.

Judges should avoid delays in decision making. Delays in decision making can impact visitation, reunification and even emotional closure when needed. If a parent does not know what the judge expects, the parent may lack direction or motivation to engage in services.

These standards were drafted with the input of the following individuals:

Valerie Adelson
Staff Director
ABA Standing Committee on Substance Abuse
Chicago, IL

Kris Berliant
ABA Judicial Division Staff



Chicago, IL

Sharon Biasca
Managing Attorney
Juvenile Court Project
Pittsburgh, PA

Terry Brooks
Staff Director
ABA Standing Committee on Legal Aid and Indigent Defendants
Chicago, IL

Joanne Brown
Consultant

ABA Center on Children and the Law
Washington, DC

Shante Bullock
Program Administrator
ABA Center on Children and the Law
Washington, DC

Kate Chester
Director
Family Preservation Law Center
Siler City, NC

Claire Chiamulera
Communications Manager/Legal Editor
ABA Center on Children and the Law
Washington, DC

Andy Cohen
Staff Counsel
Children and Family Program
Committee for Public Counsel Services
Boston, MA

Emily Cooke
Special Assistant for Court Improvement
Children's Bureau
Washington, DC

Howard Davidson
Director
ABA Center on Children and the Law
Washington, DC

Alicia Davis
Family Issues Unit Supervisor
Division of Planning and Analysis
Colorado State Court Administrator's Office
Denver, CO



Amanda Donnelly
Staff Attorney
National Association of Counsel for Children
Denver, CO

Patsy Engelhard
Staff Director
ABA Litigation Division
Chicago, IL

Debby Freedman

Director, Family Advocacy Unit
Community Legal Services
Philadelphia, PA

Chris Gottlieb
Co-Director
NYU Family Defense Clinic
New York, NY

Judge Ernestine Gray Orleans
Parish Juvenile Court
Representative, ABA Judicial Division
New Orleans, LA

Bill Grimm
Senior Attorney
Child Welfare/Foster Care
National Center for Youth Law
Oakland, CA

Ann Haralambie
Representative for ABA Family Law Division
Tucson, AZ

Mark Hardin
Director, Child Welfare
ABA Center on Children and Law
Washington, DC

Sue Jacobs
Executive Director
Center for Family Representation
New York, NY

Judge William Jones
Consultant
ABA Center on Children and the Law
Charlotte, NC

Candice Maze
Representative, ABA Steering Committee on the
Unmet Legal Needs of Children
Miami, FL



Moreen Murphy
Staff Director
ABA Steering Committee on the
Unmet Legal Needs of Children

Joanne Moore
WA State Office of Public Defense
Olympia, WA

Christina Plum

ABA Young Lawyer's Division Chair
PO Box 11756
Milwaukee, WI

Jennifer Renne
Assistant Director, Child Welfare
ABA Center on Children and the Law
Washington, DC

Professor Catherine J. Ross
George Washington University Law School
Representative for ABA Individual
Rights and Responsibilities Section
Washington, DC

Don Saunders
Director, Civil Legal Services
National Legal Aid and Defender Association
Washington, DC

Tanya Terrell-Collier
Staff Director
ABA Individual Rights and Responsibilities Section
Washington, DC

Marvin Ventrell
Executive Director
National Association of Counsel for Children
Denver, CO

Mary Walker
Nashville, TN

Judge Joyce Warren
Tenth Division Circuit Court
Little Rock, AR

Sylvia Young
Washington, DC

Their input was essential to this project, and their willingness to assist was extraordinary.

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[1] Model Rules of Professional Conduct 1.1 (Competence).

[2] The National Association of Counsel for Children is accredited by the American Bar Association to certify attorneys as specialists in Child Welfare Law. The Certification Program is open to attorneys who represent children, parents, or agencies in child welfare proceedings.
[3] Model Rule 1.3 (Diligence).
[4] Model Rule 1.4 (Communication).
[5] Model Rule 2.1 (Advisor).
[6] Model Rule 1.2 (Scope of Representation and Allocation of Authority).
[7] Model Rule 1.6 (Confidentiality of Information).
[8] Model Rule 1.4 Communication
[9] Id.
[10] Id.
[11] Model Rules 1.7 (Conflict of Interest: Current Client); 1.8 (Conflict of Interest: Current Clients: Specific Rules); 1.9 (Duties to Former Clients).
[12] Renne, Jennifer L. Chapter 4, page 49, "Handling Conflicts of Interest," *Legal Ethics in Child Welfare Cases.* Washington, DC: American Bar Association, 2004.
[13] Model Rule 1.3 (Diligence).
[14] Model Rules 1.1 (Competence); 1.3 (Diligence).
[15] Model Rule 1.4 (Communication).
[16] Model Rules 1.1 (Competence); 1.3 (Diligence).
[17] Id.
[18] Id.
[19] Model Rule 3.1 (Meritorious Claims and Contentions).
[20] Model Rule 5.1 (Responsibility of Partners, Managers and Supervisory Lawyers).
[21] Model Rule 1.1 (Competence).
[22] The Court Improvement Program (CIP) is a federal grant to each state's (as well as the District of Columbia and Puerto Rico) supreme court. The funds must be used to improve child abuse and neglect courts. States vary in how they allocate the dollars, but funds are often used for training, benchbooks, pilot projects, model courts and information technology systems for the courts.

Appendix A

**Models of Delivering Parent Representation**

The Washington State Office of Public Defense (OPD) provides legal representation to indigent parents in child welfare proceedings. The program was created more than a decade ago following an investigative report showing that indigent parents throughout the state typically received poor legal representation in dependency and termination cases. Now operating in 83% of the state, the Parents Representation Program provides state-funded attorneys for indigent parents, who have legally mandated rights to counsel. These attorneys are contracted by OPD, which oversees performance, limits caseloads and provides resources.

The OPD designed and implemented standards specifically for dependency and termination case representation, uniquely blending a counselor at law approach with traditional practice techniques. The standards require OPD contract attorneys to meet and communicate regularly with their parent clients throughout the case, ensure their clients have adequate access to services and visitation, prevent continuances and delays within their control, prepare cases well, and attempt to negotiate agreements and competently litigate if no agreement is reached. Reasonable caseloads are set at no more than 80 open cases per full-time attorney (equivalent to about 60 parents).

The program has been favorably evaluated six times. In 2010, in consultation with the Washington State Center for Court Research, OPD published a report on the court records and court orders in 1,817 dependency cases prior to and after implementation of the Parents Representation Program. The comparison found significant differences in the rate of reunification. Cases commenced after the program was implemented achieved permanency 36.5% more often than those that were commenced prior to representation under the program began.

A 2011 study by the University of Washington, which conducted the study at DSHS's request, found that after the Parents Representation Program was instituted in various counties, cases were decided between one month and one year faster. The study concluded that the program is helpful in getting children out of foster care and into permanent homes that it should be extended statewide. The reduction of time that children spend in care has been attributed as saving the state hundreds of thousands of dollars.

The Detroit Center for Family Advocacy provides legal and social work advocacy for parents to ensure that children do not needlessly enter foster care. The Center receives referrals directly from child welfare agencies to help at-risk families resolve legal issues that directly impact the child's safety in the home. For example, a mother may need assistance resolving a housing issue against a landlord. A domestic violence victim may need assistance obtaining a restraining and child custody order against an abusive ex-husband. Or a father may need an advocate to ensure that a school is providing the right services to a child with special needs. The model is based on a fundamental belief that early intervention by a multidisciplinary legal team can prevent kids from unnecessarily entering foster care.

A three year evaluation conducted between 2009 and 2012 confirmed the efficacy of the model. During the evaluation period, the Center served 110 children for whom the child protective services had substantiated child abuse or neglect. The CFA was to use legal tools and

advocacy, supported by social workers, to safely prevent removal. Not one of those children entered foster care—reducing trauma to the child and family and also avoiding thousands of dollars in costs for each child. The Center achieved its legal objectives in 98.2 percent of its prevention cases, and the multidisciplinary approach to addressing problems ensured that these children were able to remain in their homes.

The Center for Family Representation (CFR) in New York is another example of a comprehensive parent representation model that is achieving notable outcomes. The CFR model provides every parent with an attorney, a social worker, and a parent advocate. Parent advocates are parents who themselves once faced family court prosecution, had their children removed, and were able to successfully reunify their families. Under the CFR model, every parent is surrounded by a team that works together to problem-solve, identify resources, strengths and needs and provide counsel and advice. By combining in-court litigation with out-of-court social work referrals and case-management, individualized service planning, and parent mentoring, CFR dramatically improve outcomes for our families. Former clients of CFR report very high decrees of satisfaction with CFR representation, siting it as essential to their successes and communicating that they truly felt their voices were heard and needs effectively addressed.

**Models of Delivering Child and Youth Representation**

KidsVoice in Pittsburgh, Pennsylvania is recognized as a national model for multi-disciplinary and holistic approach to child advocacy and legal representation. They are a non-profit agency that advocates in court and in the community to ensure safe and permanency homes for abused, neglected, and at-risk children. Each year, KidsVoice represents nearly 3,000 children involved in the child-welfare system in Allegheny County's Juvenile Court. Child advocacy at KidsVoice goes beyond the traditional child welfare and juvenile court arenas. The staff advocates for clients in educational, medical, mental health and Social Security matters, as well as providing representation for minor criminal citations and for expungement of delinquency records. They also assist the older clients as they pursue college or vocational training opportunities and transition to living independently. Every client is represented by both an attorney and a Child Advocacy Specialist (a social service professional with expertise in social work, mental health, education or child development).

The Wyoming Guardians Ad Litem Program is a state- and county-funded centralized state office that trains and supervises all attorneys representing children in Juvenile Court in the state. In 2008, the program adopted rules and policy setting practice standards and addressing other related quality indicators like the presence of children and youth in court proceedings, set caseload maximums for all program attorneys, began specialized training for the program attorneys, instituted a quality assurance process, and a multi-tiered evaluation process for program attorneys. From 2008 to 2012, the program underwent an overhaul of the program and brought many of the attorney positions in-house as full-time attorneys or state employees, drastically reducing the number of independent contract attorneys. In 2015, the program released an on-line cases management system to better track compliance with standards, timeliness of proceedings, and outcomes for children and youth.

# Evaluation of the Indiana Department of Child Services

## The Child Welfare Policy and Practice Group

**June 18, 2018**

THE CHILD WELFARE POLICY & PRACTICE GROUP

## 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.

**CWG Evaluators**

Freida Baker, MSW

Margaret Bonham, MSW, LCSW

Sue Steib, PhD, LCSW

George Taylor, MA

Paul Vincent, MSW, LCSW

## 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 <u>limited</u> 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.

## Table of Contents

# 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:

<u>Enhancing Front-End Performance</u>

"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 confect 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 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 kin ship 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 out-patient 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***

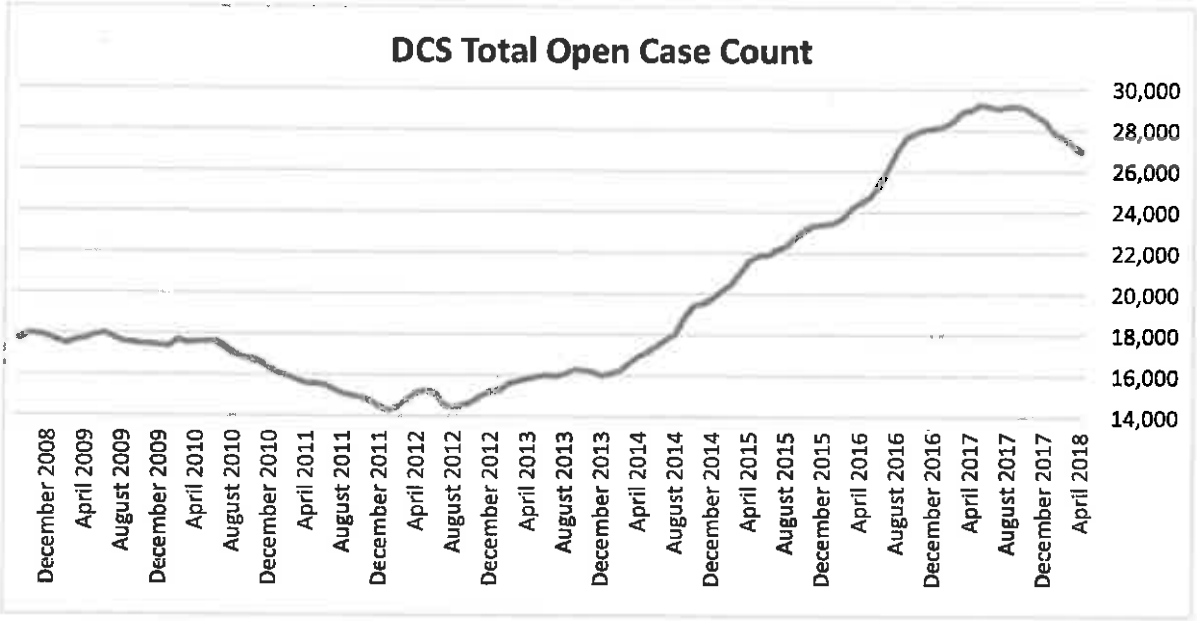
As of the most recent data provided, there are 17 children in DCS custody placed in out-of-state residential treatment facilities because Indiana community-based treatment agencies and residential treatment providers cannot serve them. Being at such distances from their home and community means that 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**

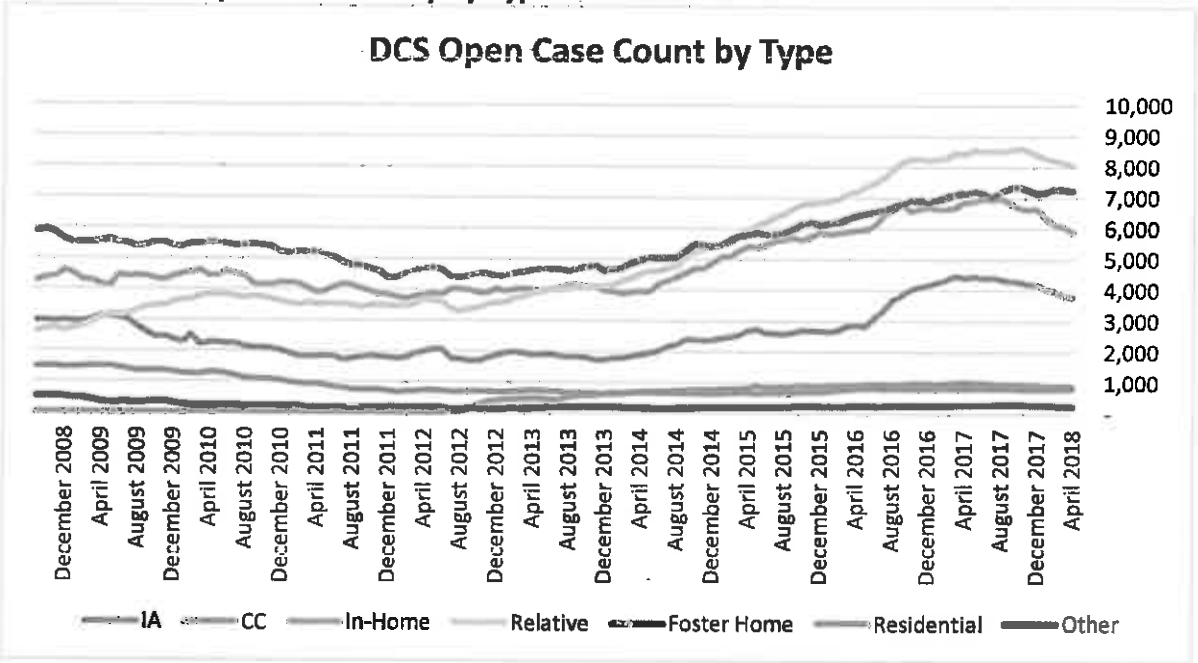
The following data provides an overview of the DCS budget and expenditure trends for recent years.

**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.

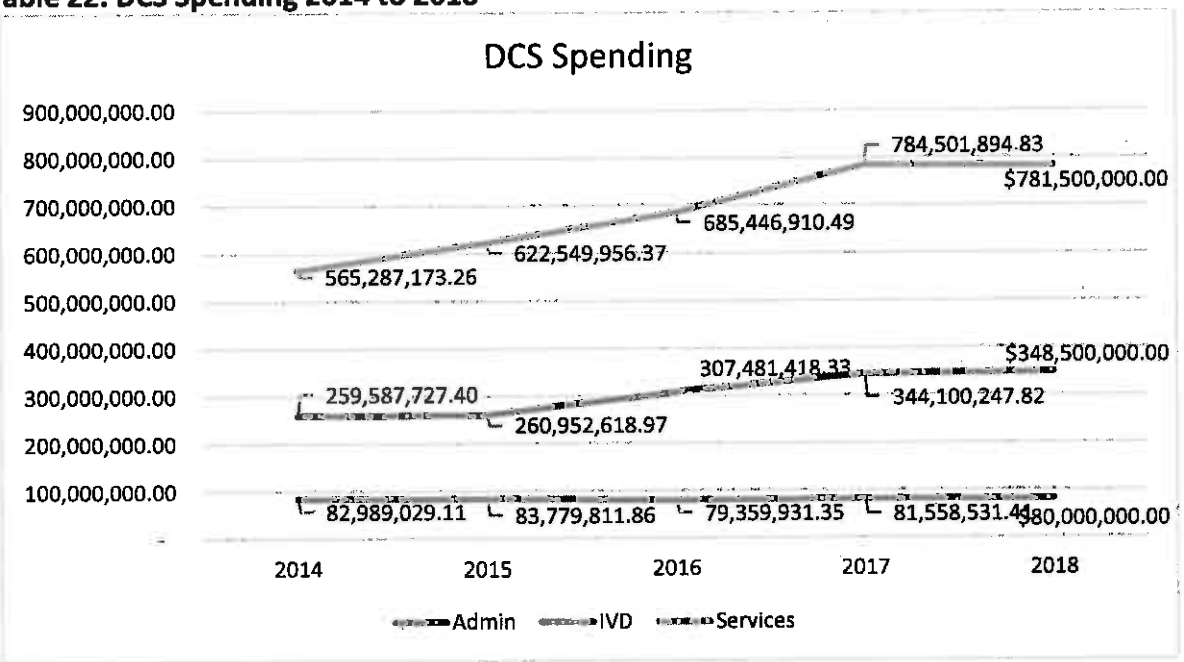
**Table 21: DCS Open Case County by Type 2008 to 2018**




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

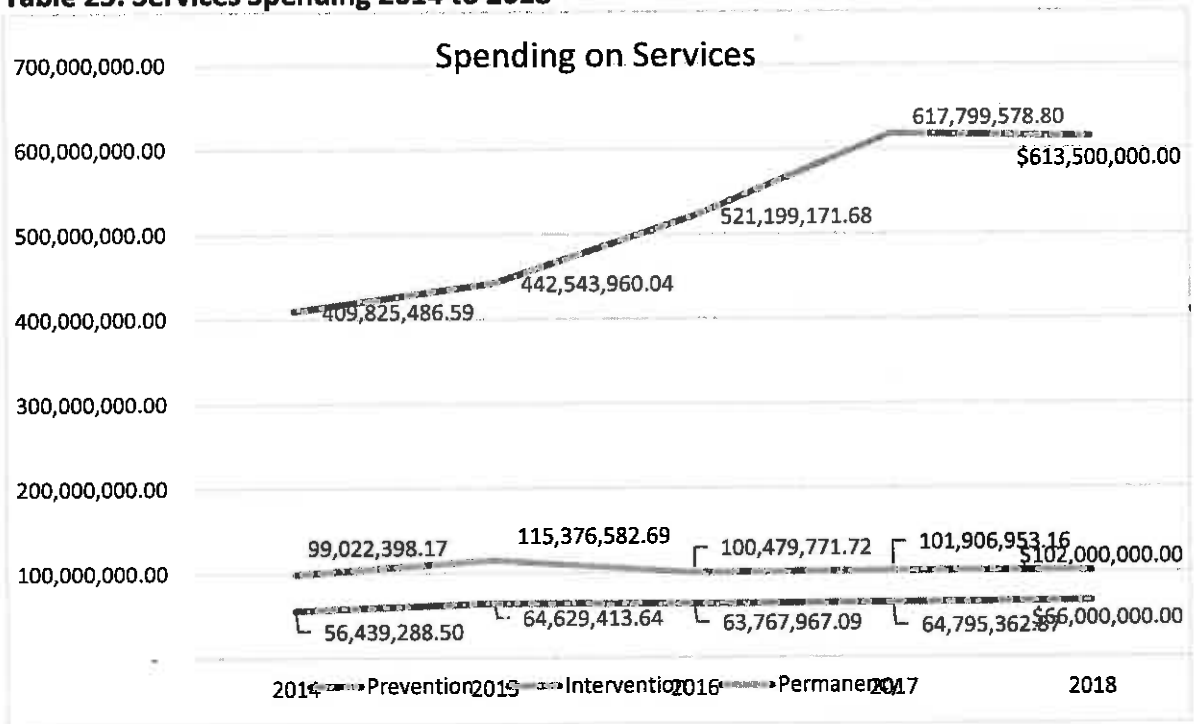
and collaborative care cases has been unchanged for multiple years. DCS reports that residential placements are down from last year by 13%, from 1,011 in May 2017 to 883 in May 2018.

**Table 22: DCS Spending 2014 to 2018**



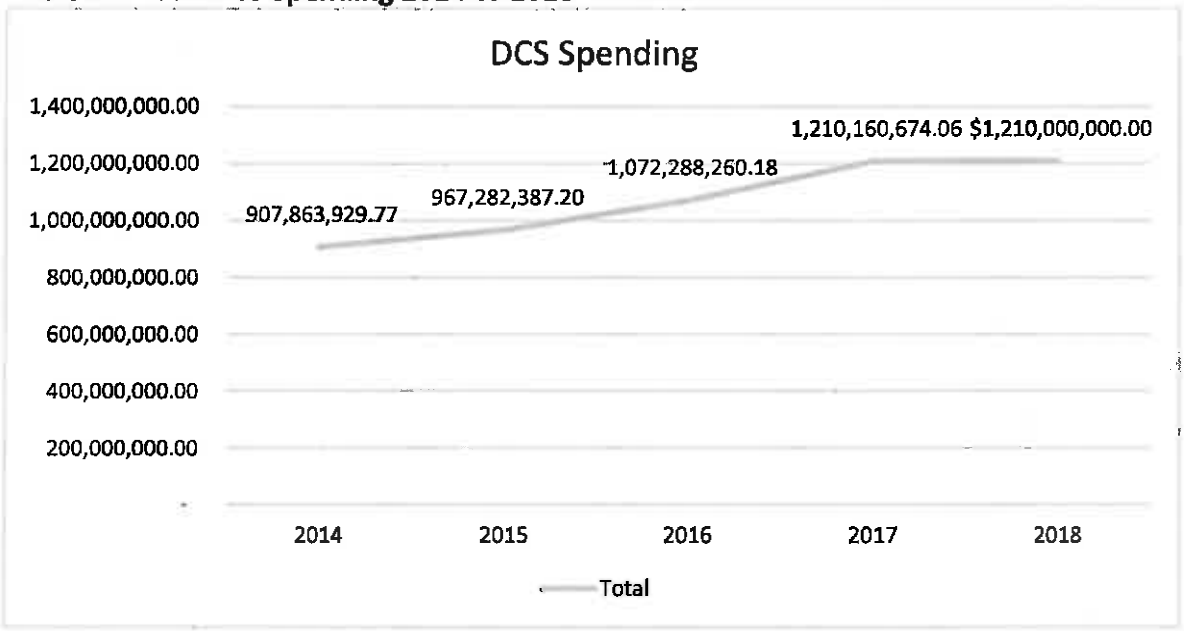

Administrative costs, which consist mostly of staff costs, rose from approximately $260 million in 2014 to approximately $350 million currently. Services for the same period rose from $565 million to $781 million. Child support costs (IV-D) have been essentially unchanged.

**Table 23: Services Spending 2014 to 2018**



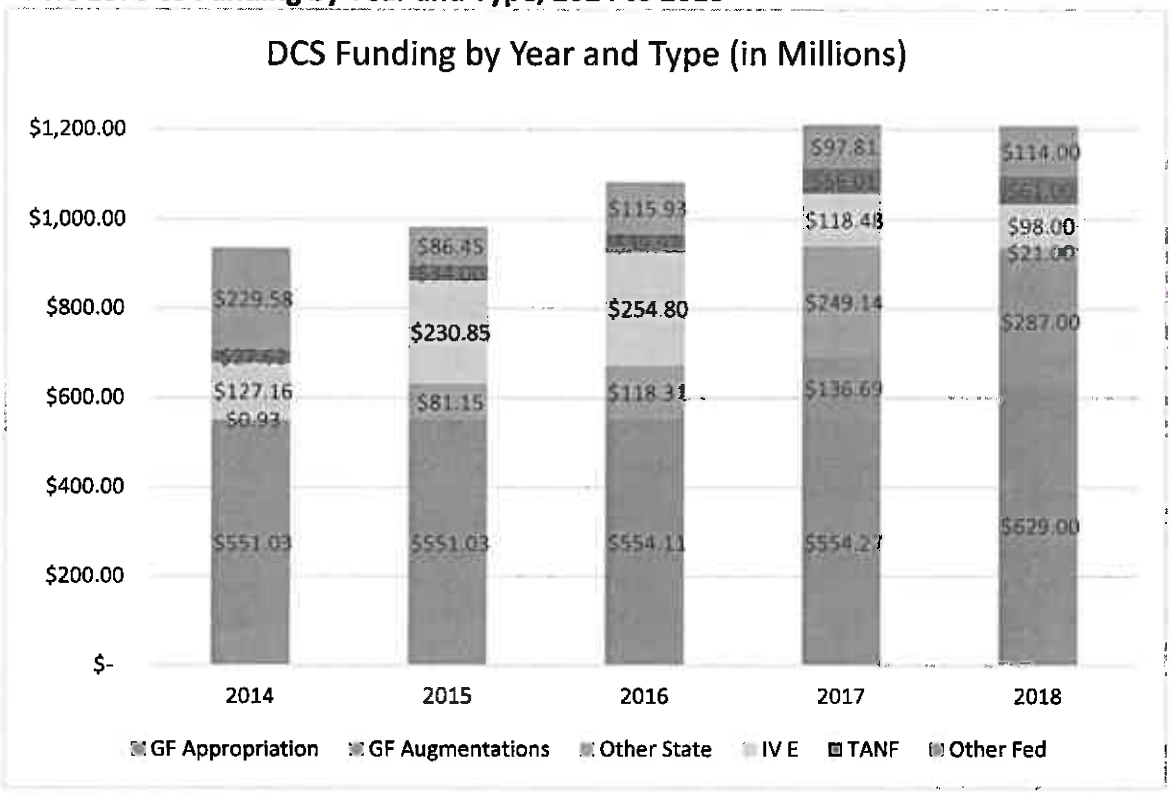
Service expenditures have plateaued since 2017. In the graph above Permanency references post adoptive and guardianship payments. Intervention costs include services related to foster care, IA and older youth (FY 2018 costs are projections).

**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 has 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."*

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[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

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[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 exits, (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/AI) 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.

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[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

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[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?

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[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

UNIVERSITY of WASHINGTON

# 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 meaningfulway 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

**Tina M. Willauer, MPA**
Agency/Affiliation: Kentucky Department for Community Based Services
Email: twillauer@cffutures.org
Phone: (502) 526-1323

# 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 though 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.