

**Members**

Sen. Carlin Yoder, Chairperson  
Sen. John Broden  
Rep. Kevin Mahan  
Rep. Gail Riecken  
Sean McCrindle  
Judge Christopher L. Burnham  
Jolene Bracale  
Suzanne O'Malley  
Mary Beth Bonaventura  
Larry Landis  
Leslie Dunn



# CHILD SERVICES OVERSIGHT COMMITTEE

Legislative Services Agency  
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**LSA Staff:**

Eliza Stephenson, Attorney for the Committee  
KC Norwalk, Attorney for the Committee  
William Brumbach, Fiscal Analyst for the Committee

Authority: IC 2-5-36.1-4

## MEETING MINUTES<sup>1</sup>

**Meeting Date:** October 23, 2013  
**Meeting Time:** 1:00 P.M.  
**Meeting Place:** State House, 200 W. Washington St., Senate Chambers  
**Meeting City:** Indianapolis, Indiana  
**Meeting Number:** 2

**Members Present:** Sen. Carlin Yoder, Chairperson; Rep. Kevin Mahan; Rep. Gail Riecken; Sean McCrindle; Judge Christopher L. Burnham; Jolene Bracale; Suzanne O'Malley; Mary Beth Bonaventura; Leslie Dunn; Kaarin Lueck.

**Members Absent:** Sen. John Broden; Larry Landis.

Senator Carlin Yoder, Chairperson, called the second meeting of the Child Services Oversight Committee (Committee) to order at 1:03 P.M. The members of the Committee introduced themselves.

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<sup>1</sup> These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

### **Introduction by the New State Child Fatality Review Coordinator**

Ms. Gretchen Martin, State Child Fatality Review Coordinator, State Department of Health, provided Committee members with a handout<sup>2</sup> concerning child fatality review teams. She explained that the legislature passed legislation last year that moved local child fatality review teams and the Statewide Child Fatality Review Committee from Title 31 to Title 16 in the Indiana Code and created the state child fatality review coordinator position. She explained the requirements regarding establishing child fatality review teams at the local level and the status of each county in establishing a team. In response to a question from Senator Yoder, she said that she would be following up with the counties that had not established or contacted her about having established a child fatality review team. Ms. Suzanne O'Malley explained that most of the prosecutors had started the process of establishing teams.

### **Presentation of Information Requested at the July 31, 2013 Meeting**

Ms. Brady Brooks, Legislative Director, Department of Child Services (DCS), provided to Committee members a handout<sup>3</sup> with information relating to questions and additional information requested by the Committee members at the July 31, 2013, meeting and offered to answer any questions. In response to a question from Senator Yoder, Ms. Brooks said the results of the exit surveys were similar to what DCS had seen in the past and that DCS was working on ways to recruit and retain staff.

### **DCS Ombudsman Bureau Report Recommendations**

Representative Gail Riecken provided Committee members with information<sup>4</sup> concerning case examples and recommendations from the DCS Ombudsman's 2012 report that she thought were relevant in considering systematic issues.

Ms. Alfreda Singleton-Smith, Director, DCS Ombudsman Bureau, discussed the recommendations and Ms. Brooks explained DCS's responses to each recommendation. In response to a question from Ms. Kaarin Lueck concerning DCS's response to recommendations under case example #4, Ms. Brooks noted that the nursing unit was created to provide support for family case managers. Ms. Lueck requested that DCS consider expanding the nursing unit to help with juvenile delinquent cases.

In describing DCS's response to recommendation #10, Ms. Brooks provided Committee members with a pamphlet<sup>5</sup> and booklet<sup>6</sup> that DCS created to provide relative care givers information concerning resources available to them. Ms. Brooks also provided Committee members with all of the following:

(1) Applicable revised provisions of DCS's child welfare manual<sup>7</sup> with regard

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<sup>2</sup> Exhibit A

<sup>3</sup> Exhibit B

<sup>4</sup> Exhibit C

<sup>5</sup> Exhibit D

<sup>6</sup> Exhibit E

<sup>7</sup> Exhibit F

to recommendation #6.

(2) An issue brief<sup>8</sup> titled "Differential Response to Report of Child Abuse and Neglect" with regard to recommendation #11.

### **Update on the Children's Mental Health Initiative**

Ms. Gina Ashley, Deputy Director of Placement Support and Compliance, DCS, provided Committee members with a handout<sup>9</sup> concerning: (1) the Children's Mental Health Initiative (CMHI) update; (2) Safely Home, Families First; and (3) Collaborative Care. Ms. Ashley discussed the background of CMHI and the services provided under the program. She also explained that the purpose of CMHI is to help provide services to children who are not in the system as Children in Need of Services or juvenile delinquents.

In response to Judge Christopher Burnham's question regarding whether DCS had received any feedback regarding CMHI, Ms. Ashley indicated that overall there had been positive feedback. Ms. Mary Beth Bonaventura stated that she had been traveling around the state and had not heard any negative feedback. She also said the CMHI provided an exciting opportunity for children to access services without having to be a Child in Need of Services or delinquent. In response to a question from Representative Riecken in confirming that Vanderburgh County was on the list for CMHI services, Ms. Ashley said that she would look into it.

Mr. Sean McCrindle said that comments to him regarding CMHI have been encouraging. He noted that if CMHI continues to go as well as it appears, there may be funding issues later on.

### **Presentation on DCS Policy Regarding Safely Home- Families First**

Ms. Ashley discussed DCS's vision, mission, and values. She also discussed the practice model for DCS and explained Safely Home, Families First. (See Exhibit G). In response to a question from Judge Burnham, Ms. Bonaventura noted that DCS has no mechanism to go back and check on a family when there has been no filing or informal adjustment.

In response to a question from Representative Mahan, Ms. Bonaventura stated that the law indicates that DCS should consider placement of a child with a family member first but that the safety of a child is paramount. In response to another question from Representative Mahan, Ms. Ashley noted that other parties, such as grandparents, may still be involved even if the parents do not want them involved. Ms. Bonaventura said the court can decide other parties' involvement.

Ms. Lueck stated that, in a relative placement situation, it would be helpful if DCS documented that DCS had considered a relative placement and had chosen not to place the child with that relative. Ms. Bonaventura indicated that the parent may not provide DCS with information that there is an available relative care giver but that Ms. Lueck's point is well taken. Ms. Lueck also noted that she agreed with Judge Burnham about following up with the family and that families may be unclear about how binding a DCS suggestion is.

In response to a question from Senator Yoder, Ms. Bonaventura indicated that

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<sup>8</sup> Exhibit G

<sup>9</sup> Exhibit H

there is no policy or law on how many times a child may be returned to a home in a situation where there has been abuse or neglect.

### **Collaborative Care**

Ms. Alishea Hawkins, Assistant Deputy Director of Services and Outcomes, DCS, discussed the background, Indiana's approach, and eligibility for the Collaborative Care program. She also noted that Indiana is receiving national attention concerning the Collaborative Care program. Judge Burnham noted that it would be interesting to have feedback about how the individuals in the Collaborative Care program are doing in five years.

### **Recommendations to the Commission on Improving the Status of Children in Indiana**

The Committee members received a draft memorandum<sup>10</sup> concerning recommendations to the Commission on Improving the Status of Children in Indiana. Representative Riecken explained the recommendation regarding studying system response to newborns with drugs in their systems and provided the Committee members with a letter<sup>11</sup> concerning the issue from Attorney General Gregory Zoeller.

The Committee approved the memorandum in a vote of 10 to 0.

### **Final Report**

The Committee members received a draft<sup>12</sup> of the Committee's final report. The Committee approved the draft final report in a vote of 10 to 0.

Senator Yoder adjourned the meeting at 2:30 P.M.

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<sup>10</sup> Exhibit I

<sup>11</sup> Exhibit J

<sup>12</sup> Exhibit K



Indiana State  
Department of Health

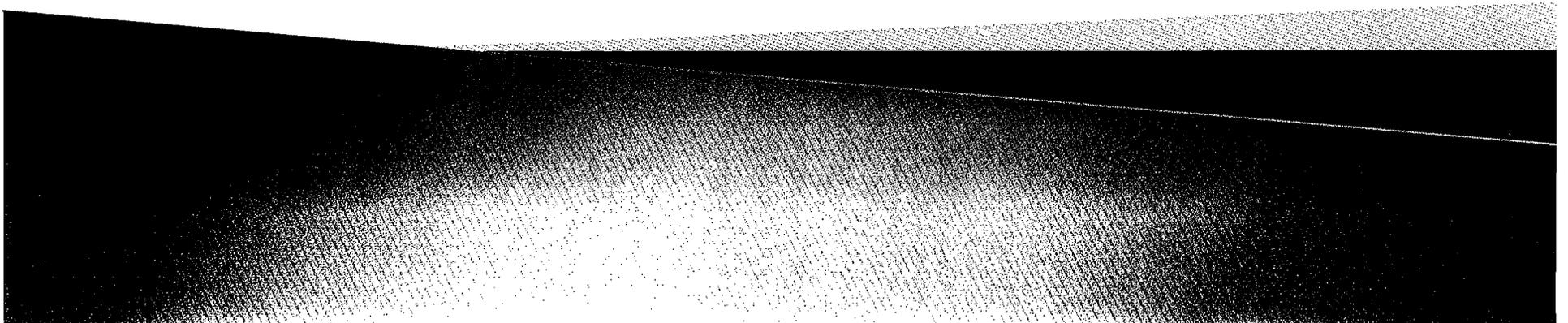
Child Services Oversight Committee

Exhibit A

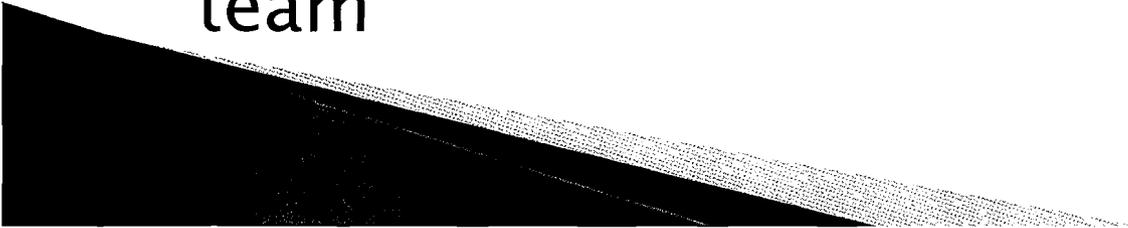


# Child Fatality Review Teams

Gretchen Martin  
Child Services Oversight Committee  
October 23, 2013



# IC 16-49

- ▶ Moved local child fatality review teams and Statewide Child Fatality Review Committee from Title 31 to Title 16
  - ▶ Coordinator position created under the Indiana State Department of Health
  - ▶ Requires each county, at the local level, establish either a county or regional review team
- 

Prosecutor calls meeting of Local Child Fatality Committee (Prosecutor, Law Enforcement, Department of Child Services, Local Health Department)

Fatality Committee decides  
1. County or regional team  
2. Who should be on the team

Prosecutor files report with State Coordinator specifying selection, members, and needed assistance

Fatality Review Team releases report

Fatality Review Team decides deaths eligible for review and completes case review

Prosecutor calls first meeting of Child Fatality Review Team/Chairperson selected

Statewide Child Fatality Review Committee accesses data for annual report

Fatality Review Team may request assistance with or review of a death by the Statewide Child Fatality Review Committee



# Status of Local Teams

## Local Child Fatality Review Teams

As of October 22nd, 2013

Pursuant to IC 16-49-2-7, not later than ninety (90) days after the first meeting of the child fatality committee, the prosecuting attorney of the county or prosecuting attorney's representative shall submit a report to the state child fatality review coordinator that includes the following information:

- (1) Whether the child fatality committee established a:
  - (A) county child fatality review team; or
  - (B) regional child fatality review team.
- (2) The names and contact numbers of all of the members of the local child fatality review team.
- (3) Whether the child fatality committee will or has entered into a memorandum of understanding described under section 3(3) of this chapter.
- (4) Any assistance the child fatality committee would like from the state child fatality review coordinator in forming the local child fatality review team.

### Official Team

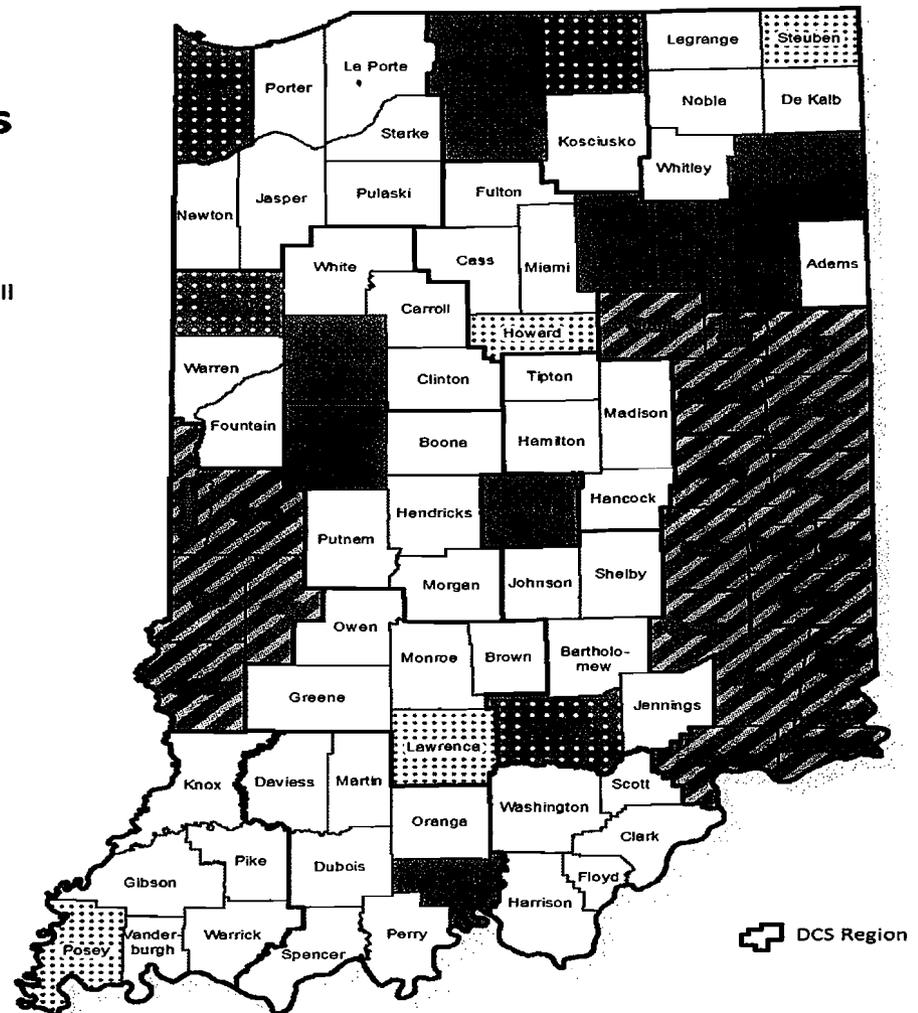
- Single County
- Regional

### Non-Official Team

- Single County
- Regional

### Un-Verified Team

- Single County
- Regional



# Transition

## ▶ Outreach

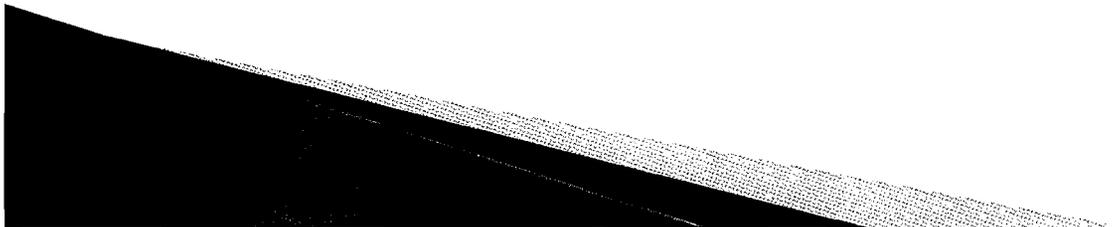
- Local Teams
- Statewide Child Fatality Review Committee
- Indiana Prosecuting Attorneys Council
- Associations

## ▶ Training

- Completed
  - Local Health Departments
- Future Opportunities
  - Prosecutors
  - Emergency Medical Services
  - Law Enforcement
  - Coroner

# Contact Information

**Scott Zarazee**  
**Legislative Director**  
**Indiana State Department of Health**  
**(317)234-3808**  
**[szarazee@isdh.in.gov](mailto:szarazee@isdh.in.gov)**



## Exhibit B

Oct. 23, 2013

## DCS Follow Up Items from 7.31.13 Child Services Oversight Committee Meeting

- Historical data
  - The DCS Quarterly Data Report has been updated to include June for the previous 3 years.
- Foster Care Repeat Maltreatment Data
  - This measure was added to the Quarterly Data Report.
- Turnover for FCMs by year
  - Historical data on FCM turnover was added to the Quarterly Data Report.
- DCS Exit Survey
  - Data from FCM exit surveys completed between September 2012 and October 2013.

My compensation was commensurate with the position I held.	
Answer Options	Response Percent
Strongly Agree	3%
Agree	35%
Disagree	43%
Strongly Disagree	20%

Please identify up to three reason(s) that influenced your decision to leave DCS.	
Answer Options	Response Percent
Job pressure/work-related stress	50%
Working conditions (workload, schedule, etc.)	45%
Family circumstances	29%
Secured a different job	27%
Work climate (relationships with co-workers)	20%
Salary/benefits (health, dental, vision)	18%
Lack of appreciation/recognition	17%



**Department of Child Services (DCS)  
Child Services Oversight Committee  
Quarterly Data Report  
June 2013- Updated 10.23.13**

**DCS Hotline Data**

*\*See additional attachments for historical data.*

Month		Apr-13	May-13	Jun-13
Totals # of Calls Handled		14,209	14,859	11,601
Total # of Calls Year to Date		51,946	66,805	78,406
Average # Calls Per Business Day		580	595	490
Average # of Calls Per Weekend/Holiday		191	195	180
Average Speed of Answer	LEA Access Code	23 sec.	33 sec.	29 sec.
	Non-LEA	1 min. 5 sec.	1 min. 44 sec.	52 sec.
Average Talk Time		11 min. 13 sec.	11 min. 25 sec.	11 min. 9 sec.

**Child In Need of Services (CHINS) and Informal Adjustments**

*Reports the total number of Informal Adjustment cases and CHINS cases on the last day of the month, and the breakdown of whether or not the CHINS children are placed in-home or out-of-home.*

Month	Informal Adjustment	Total CHINS	Total CHINS Breakdown			
			In-Home		Out-of-Home	
			Count	%	Count	%
Jun-13	1,926	13,648	4,035	29.5	9,649	70.5
Jun-12	2,042	13,037	3,851	29.5	9,186	70.5
Jun-11	1,821	13,694	4,105	30	9,589	70

**CHINS Out-of-Home Placement Breakdown**

*Placement breakdown for all out-of-home CHINS children with a case open on the last day of the month.*

Month	Relative Home		Non-Relative Foster Home		Residential		Other	
	Count	%	Count	%	Count	%	Count	%
Jun-13	4,016	41.6	4,703	48.7	715	7.4	215	2.2
Jun-12	3,602	39.2	4,661	50.7	723	7.9	200	2.2
Jun-11	3,514	36.6	5,050	52.7	844	8.8	181	1.9



**Department of Child Services (DCS)  
 Child Services Oversight Committee  
 Quarterly Data Report  
 June 2013- Updated 10.23.13**

**Sibling Placement**

*Reports the number of CHINS cases with more than one child placed out-of-home and cases were siblings are placed together, on the last day of the month.*

Month	# of Cases with Siblings	# of Cases with Siblings Placed Together	% of Cases with Siblings Placed Together
Jun-11	2,378	1,728	72.7
Jun-12	2,265	1,680	74.2
Jun-13	2,892	2,028	70.1

**Absence of Repeat Maltreatment**

*“Victims” are those children identified as having one substantiated allegation of abuse or neglect during the report time frame. The report evaluates whether or not there was a recurrence of substantiated child abuse or neglect within 6 months of the report date.*

Month	Victims during Previous 12 months	Victims without Recurrence within 6 months	Absence of Repeat Maltreatment Percent
Jun-11	10,111	9,445	93.41
Jun-12	9,712	8,994	92.61
Jun-13	10,649	9,933	93.28

**Maltreatment in Foster Care**

*Children with at least one substantiated allegation of abuse or neglect during the time where the perpetrator is a foster parent or institutional staff. Includes all children with an open removal episode within the previous 12 months.*

Month & Year	Children in Foster Care Previous 12 months	Substantiated Victims in Foster Care	Absence of Maltreatment Percent
May-13	20,652	40	99.81%
Jun-13	20,680	31	99.85%
Jul-13	20,375	42	99.80%



**Department of Child Services (DCS)  
Child Services Oversight Committee  
Quarterly Data Report  
June 2013- Updated 10.23.13**

### **Family Case Manager Turnover**

*Negative turnover evaluates the percentage of staff that leaves the agency.*

- SFY 2013: 17.7%
- SFY 2012: 19.8%
- SFY 2011: 18.6%
- SFY 2010: 15.8%
- SFY 2009: 15.7%
- SFY 2008: 20.4%
- SFY 2007: 17.6%

### **IV-D Child Support**

- Current support collected June 2013: 61.68%  
*Amount of current support collected every month versus the amount owed.*
- Paternity Establishment June 2013: 95.79%  
*Percentage of children for whom paternity has been established.*
- Support order establishment June 2013: 86.3%  
*Percentage of cases for which support has been ordered.*
- Cases paying on arrears June 2013: 68.89%  
*Percentage of cases on which at least one payment has been made on arrears.*



## 2011 Child Abuse and Neglect Hotline Data

Month	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	
<b>Totals # of Calls Handled</b>	11,768	10,525	13,192	12,422	12,923	11,629	11,421	13,041	12,327	12,310	12,484	12,028	
<b>Electronic Reports</b>	1,089	572	1,312	1,078	1,232	1,149	1,155	1,295	1,167	995	989	947	
<b>Total Reports</b>	12,389	11,226	14,527	13,684	14,155	12,578	12,501	13,251	12,504	11,670	11,931	11,026	
<b>Total Reports Year to Date</b>	12,389	23,615	38,142	51,826	65,981	78,559	91,060	104,311	116,815	128,485	140,416	151,442	
<b>Average # Calls Per Business Day</b>	495	477	519	543	541	466	472	502	515	502	539	499	
<b>Average # of Calls Per Weekend/Holiday</b>	142	143	161	166	163	173	191	190	169	159	180	162	
<b>Average Speed of Answer</b>	<b>LEA Access Code</b>	41 sec.	36 sec.	43 sec.	37 sec.	41 sec.	36 sec.	43 sec.	38 sec.	32 sec.	31 sec.	38 sec.	24 sec.
	<b>Non-LEA</b>	1 min. 41 sec.	1 min. 33 sec.	2 min. 10 sec.	2 min. 14 sec.	3 min. 8 sec.	1 min 29 sec	2 min. 15 sec.	2 min. 1 sec.	1 min. 52 sec.	1 min. 20 sec.	3 min. 6 sec.	1 min. 14 sec.
<b>Average Talk Time</b>	11 min 20 sec.	11 min. 28 sec.	11 min. 19 sec.	11 min. 1 sec.	11 min. 21 sec.	10 min 47 sec	11 min. 38 sec.	12 min. 28 sec.	12 min. 7 sec.	11 min. 43 sec.	12 min. 43 sec.	12 min. 19 sec.	



## 2012 Child Abuse and Neglect Hotline Data

Month	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	
<b>Totals # of Calls Handled</b>	12,973	12,474	13,621	12,795	14,111	12,180	12,742	14,082	12,994	13,943	12,744	11,208	
<b>Electronic Reports</b>	1,054	1,158	1,159	1,001	1,138	928	1,199	1,168	1,000	1,045	928	915	
<b>Total Reports (calls + electronic)</b>	12,654	13,387	15,772	14,763	16,465	14,122	14,932	16,307	15,037	16,300	14,608	13,192	
<b>Total Reports Year to Date</b>	12,654	26,041	41,813	56,576	73,041	87,163	102,095	118,402	133,439	149,739	164,347	177,539	
<b>Average # Calls Per Business Day</b>	540	530	542	546	567	505	514	544	576	549	552	491	
<b>Average # of Calls Per Weekend/Holiday</b>	170	167	188	166	182	176	198	196	184	172	171	163	
<b>Average Speed of Answer</b>	<b>LEA Access Code</b>	30 sec.	36 sec.	42 sec.	53 sec.	49 sec.	36 sec.	34 sec.	33 sec.	38 sec.	23 sec.	22 sec.	22 sec.
	<b>Non-LEA</b>	1 min. 56 sec.	3 min. 30 sec.	2 min. 58 sec.	3 min. 34 sec.	2 min. 10 sec.	48 sec.	58 sec.	1 min. 11 sec.	1 min. 43 sec.	48 sec.	1 min. 21 sec.	43 sec.
<b>Average Talk Time</b>	12 min. 6 sec.	12 min	12 min. 7 sec.	12 min. 12 sec.	11 min. 39 sec.	11 min 54 sec.	11 min. 30 sec.	11 min. 15 sec.	11 min. 25 sec.	12 min. 7 sec.	12 min. 6 sec.	12 min 10 sec.	



## 2013 Child Abuse and Neglect Hotline Data

Month	Jan-13	Feb-13	Mar-13	13-Apr	13-May	Jun-13	
<b>Totals # of Calls Handled</b>	12,912	12,053	12,772	14,209	14,859	11,601	
<b>Electronic Reports</b>	1,044	953	1,027	1,265	1,388	1,155	
<b>Total Reports</b>	15,300	14,174	15,093	16,717	17,777	14,085	
<b>Total Reports Year to Date</b>	15,300	29,474	44,567	61,284	79,061	93,146	
<b>Average # Calls Per Business Day</b>	527	535	532	580	595	490	
<b>Average # of Calls Per Weekend/Holiday</b>	167	169	180	191	195	180	
<b>Average Speed of Answer</b>	<b>LEA Access Code</b>	24 sec.	25 sec.	25 sec.	23 sec.	33 sec.	29 sec.
	<b>Non-LEA</b>	1 min. 13 sec.	1 min. 20 sec.	1 min. 1 sec.	1 min. 5 sec.	1 min. 44 sec.	52 sec.
<b>Average Talk Time</b>	11 min. 28 sec.	11 min. 15 sec.	11 min. 2 sec.	11 min. 13 sec.	11 min. 25 sec.	11 min. 9 sec.	

**Rep. Riecken's Key Takeaways**  
**2012 Department of Child Services (DCS) Ombudsman's Report**  
**Child Services Oversight Meeting 10.23.13**

**1. Case Example #4- Children Born with Drugs in their System (page 17-18)**

- DCS Ombudsman Recommendation: The Ombudsman recommends that DCS consider allowing the Clinical Services Unit to provide Family Case Manager's guidance on cases where substance abuse is a factor.
- DCS Response: In an effort to better address the clinical needs of children and families involved in the child welfare system DCS has created a Clinical Services Unit and a Nursing Unit. In addition, the Department is currently implementing an evidence-based and trauma-informed system of care.
- Additional Comments/Discussion: DCS presentation on the Clinical Services Unit, Nursing Unit and use of evidenced-based practices and trauma-informed systems of care.

**2. Recommendation #10- Relative Care (page 20)**

- DCS Ombudsman Recommendation: The DCS Ombudsman received a number of inquiries from relatives during 2012 requesting clarification on what resources were available to them when a child is placed in their home. The Ombudsman recommended that DCS develop a plan for ensuring consistent awareness and implementation of this policy.
- DCS Response: DCS agreed that further clarity on the resources available to relatives was warranted and as a result updated policy 4.24- "financial assistance to unlicensed relatives". In addition, DCS also developed a "one-pager" for relatives to use as a quick guide on the assistance available to them (attachment 2). DCS continues to emphasize the practice of placing children with relatives, when they cannot be maintained safely in their own-home. To better support relatives DCS created 29 Relative Care Specialist (RCS) Family Case Manager positions throughout the state. The RCSs are responsible for providing targeted support and timely services for relatives with children in placement. They work to decrease relative placement disruptions, increase utilization of relative placements and educate relatives on the Department's policies, procedures and practices.
- Additional Comments/Discussion: DCS presentation on the role of the Relative Care Specialist. See attachment #2 for a copy of the relative caregiver "one pager".

**3. Recommendation #6- Interviewing Part Time Household Members (page 23)**

- DCS Ombudsman Recommendation: One of the dilemmas that the Department frequently encounters during an Assessment is deciding when DCS is responsible for assessing risk to a child who does not reside in the home of the alleged offending parent, but who regularly visits. This issue has generated ongoing discussion. As a result, the Ombudsman recommended that the DCS Regional Managers provide their feedback on an appropriate response to this issue.
- DCS Response: DCS revised policy 4.9 to include two additional requirements. First, that the FCM Assessors will always inquire about household composition, including "part time" household members, such as siblings or half siblings in the primary custody of another parent, and children who spend extensive time in the home, such as day care situations. Second, FCMs are required to interview, or attempt to interview as potential witnesses, any children who are part-time household members.
- Additional Comments/Discussion: See attachment #3.

**4. Recommendation #11- Differential Response (page 27)**

- DCS Ombudsman Recommendation: The Ombudsman recommended that Indiana move towards a differential response system for handling allegations of abuse and neglect and seek any changes required to implement the program, ensuring it is tailored to meet Indiana's needs. Adopting this flexibility in response would continue to promote family engagement and enhance the quality of the Assessment.
- DCS Response: DCS has formed a group to look at this model. However, research and discussions are still in the early stages.
- Additional Comments/Discussion: See attachment #4.

**5. Recommendation #16- Child Fatalities (page 29)**

- DCS Ombudsman Recommendation: During 2010, the Ombudsman began receiving notices of fatalities/near fatalities reported to DCS. As a result, the Ombudsman noticed that these types of assessments often take months, or years, to complete. Since this issue was raised the Ombudsman has seen noted improvement. The Ombudsman recommends that DCS continue to monitor this process and identify any barriers to completing fatality/near fatality assessments within 180 days.
- DCS Response: The DCS response is still pending on this issue. However, the Department clarified that a number of different factors impact the length of time it takes to finalize a fatality review assessment. Fatality review assessments completed by DCS rely on a number of outside reports and information, such as the coroner's report, toxicology report, etc. In addition, DCS seeks to work closely with law enforcement and the prosecutor's office to ensure that the Department's involvement does not interfere with any on-going criminal investigation or prosecution.
- Additional Comments/Discussion: The Indiana State Department of Health Statewide Fatality Review Coordinator, Gretchen Martin, provided an update to the Committee.

## **Attachments**

1. 2012 DCS Ombudsman Report  
[http://www.in.gov/idoa/files/DCS\\_Ombudsman\\_2012\\_Annual\\_Report.pdf](http://www.in.gov/idoa/files/DCS_Ombudsman_2012_Annual_Report.pdf)
2. Financial Options for Relative Caregivers  
<http://www.in.gov/dcs/files/FinancialAssistanceRelativePlacedChildrenBrochureRev3.pdf>
3. DCS Policy 4.9- Assessment: Interviewing Children  
[http://www.in.gov/dcs/files/4.09\\_Interviewing\\_Children.pdf](http://www.in.gov/dcs/files/4.09_Interviewing_Children.pdf)
4. Child Welfare Information Gateway- Differential Response to Reports of Child Abuse and Neglect  
[https://www.childwelfare.gov/pubs/issue\\_briefs/differential\\_response/](https://www.childwelfare.gov/pubs/issue_briefs/differential_response/)



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on applying at: <http://www.in.gov/isdh/19691.htm>, 1-800-522-0874 or [inwic@isdh.in.gov](mailto:inwic@isdh.in.gov).

### Free or Reduced-Price School Lunches, Book Rental Fees and Book Fees

All relative foster children receive free or reduced-price school lunches, book rental fees or text book fees. Relative foster children are automatically enrolled by DCS in this program. Discuss this with your local school corporation to ensure you are receiving this benefit.

### Medicaid

The relative child placed with you should be eligible for Indiana Medicaid. Indiana Medicaid is Indiana's medical program that can pay the costs of medical, dental, behavioral/mental health and eye care for your relative child. Your DCS FCM can help ensure the child is enrolled in Medicaid.

### Child Care Development Fund (CCDF)

This program provides financial assistance for child care for families who are working or enrolled in school. To apply for the CCDF voucher program, you must contact your local Intake Agents at <http://www.in.gov/fssa/carefinder/3900.htm>. If you receive a voucher, you must choose a child care provider who meets CCDF provider eligibility standards.

*More information can be found at:*  
<http://www.in.gov/fssa/2552.htm> (in the left column, click on *Child Care Assistance—Child Care Development Fund*).

## Important Contacts & Links

Indiana Child Abuse & Neglect Hotline  
**1-800-800-5556**

Foster Care Helpline  
**888-631-9510**

DCS Website  
[www.in.gov/dcs](http://www.in.gov/dcs)

For additional information on the above and to learn what other forms of assistance and support may be available, please review the complete *Relative Resource Guide* and contact your DCS Family Case Manager or Regional Foster Care Staff.

## Financial Assistance Options for Relative Caregivers



State of Indiana  
Mitchell E. Daniels, Jr., Governor  
Department of Child Services  
302 W. WASHINGTON STREET, Room E306  
INDIANAPOLIS, INDIANA 46204-2739  
[www.IN.gov/dcs](http://www.IN.gov/dcs)

The Indiana Department of Child Services does not discriminate on the basis of race, color, creed, sex, age, disability, national origin, or ancestry.

DCS 02-28-12



# FINANCIAL ASSISTANCE OPTIONS FOR RELATIVE CAREGIVERS

**Y**ou have different options for receiving financial assistance to cover the costs of placement when a relative child is placed with you. The below information will assist you in understanding those options.

## Foster Care Licensing

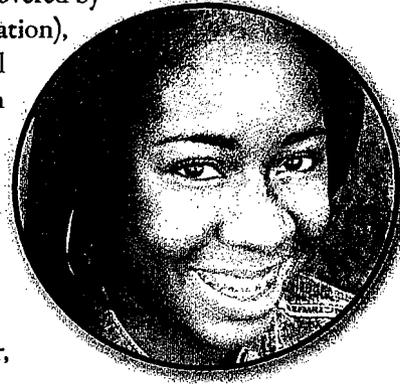
At the time of placement, your FCM will give you contact information for Regional Foster Care staff who will provide information about the licensing process. If licensed, you will receive a daily payment from DCS for the care of your relative child to cover food, clothing, shelter, daily supervision, travel for visitation and school, personal incidentals for the child, and school supplies. The per diem will start on the effective date of your license and varies based on the age and needs of the child, starting at \$18.88 a day. A foster parent can also receive the following for the benefit of the child:

- **Travel Expenses** for certain purposes if over about 162 miles per month,
- **Initial Clothing** up to \$200 when the child is first removed from his/her home,
- **Annual Personal Allowance** up to \$300 per child per calendar year; available when the child has been in placement for at least 8 days. Examples are baby equipment, special occasion clothing, school related events/fees, extracurricular activities, computers, etc.,
- **Special Occasion Allowance** up to \$50 on child's birthday and during December holidays.

## Assistance for Unlicensed Relatives

If you do not wish to become a licensed foster parent, DCS cannot make a daily payment, but does provide the following financial assistance:

- **Initial Clothing, Annual Personal Allowance, and Special Occasion Allowance** as stated previously,
- **Travel Expenses** starting at mile 1 for travel to school (if not covered by the school corporation), visitation, medical and mental health appointments, and court related travel,
- **Respite Care** in a licensed foster parent's home for up to 5 days a year,
- **Child Care Allowance** up to \$18 per day or \$90 per week, per child, for licensed child care costs for relatives that work or attend school. Funding is available for up to six months or until Child Care Development Fund (CCDF) Vouchers (*see below*) begin, whichever occurs first,
- **Bedding Allowance** up to \$400 per child for a bed and bedding if needed and pre-approved.



## Temporary Assistance for Needy Families (TANF)

TANF is a program managed by the Division of Family Resources (DFR). It can assist qualifying relatives by providing temporary financial assistance for a relative child in their care. To apply for TANF, you must contact your local DFR office. The amount of cash payment is determined by the number of eligible family members and their total income. A child can be considered a family of one in some circumstances without the relative's income being

considered. This assistance can take 30-45 days to get started but will be retroactive to the date of application. If you choose to be a licensed foster parent, you cannot also claim TANF for the relative foster child. Information on TANF can be found at: <http://www.in.gov/fssa/dfi/2684.htm>.

## Food Stamps

The Food Stamp program, called Supplemental Nutrition Assistance Program (SNAP), can help provide food for individuals who live with you in your home. To apply for this program, visit this website at <http://www.in.gov/fssa/dfi/2691.htm>. If you choose to be a licensed foster parent, your household may not qualify for food stamps. Be sure to discuss this with a representative of the food stamp program.

## WIC Program

Relative parents who care for infants and children up to age 5 may be eligible to participate in the Women, Infant and Children (WIC) program when the relative's children are Medicaid eligible. WIC is a supplemental food and nutrition program and participants receive vouchers that are redeemed at designated groceries. You can obtain information

(Cont'd on other side)



# RELATIVE RESOURCE



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Name of Family Case Manager

Phone

Email

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Name of Family Case Manager Supervisor

Phone

Email

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Name of Regional Foster Care Specialist

Phone

Email

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## Introduction

**T**he purpose of this guide is to provide you with important information regarding the care of the relative child placed in your home by the Indiana Department of Child Services (DCS). The information will assist you, especially during the first weeks of placement.

You have accepted an important role in your family. Your decision to open your home and your heart to these children will allow them to feel a sense of comfort and connection during this stressful time. Thank you on behalf of DCS for providing support to your family while they are working with us to improve their situation.

Please know that we will make all reasonable efforts to reunify the child with his/her parent(s), and we will expect you to work with us to support this effort. If, however, reunification is not possible, we hope you will consider providing a permanent home to the relative child placed with you either through adoption or guardianship. Your Family Case Manager or Regional Foster Care Specialist can provide more information about these options.

# Section I

## Basic DCS Information

### DCS Terminology

**DCS Family Case Manager (FCM)**—The DCS employee that is assigned to work with the relative child and his/her family. The FCM will schedule regular visits with you and the relative child in your home and will visit more often at critical times (following placement, during a crisis, or when reunification is contemplated). Call the FCM when you need information, have questions or concerns about the child, or when you have questions regarding the case.

**DCS Regional Foster Care Specialists (RFCs)**—The DCS employee assigned to assist you in becoming licensed as a foster parent and to provide additional supports for the placement.

**Child and Family Team (CFT) Meeting**—This is a meeting offered by DCS to families in the child welfare system. The families select who will be members of their team. The meetings occur at critical stages throughout the life of the case and are used to create plans for assessment, safety, service delivery, and permanency for the child and family.

### Placement of your Relative Child

Prior to or soon after the relative child is placed in your home, you should obtain as much information as possible from the DCS FCM regarding the relative child and the DCS processes involving the child. The below is a guide to questions you might ask the DCS FCM at placement:

- What services will be put in place to support the placement, such as individual or family therapy, support groups, respite care, etc? (If you are not sure what these services are, ask your FCM or Regional Foster Care Specialist).
- Does the child understand the reason for placement? What explanation was given to the child?
- What information regarding the child and the DCS process is confidential?
- Is there an immediate appointment, court hearing, child and family team meeting, visitation, or other activity that we need to prepare for?
- Does this child have appointments or other activities regularly scheduled that will require transportation?



- What grade is the child in and what school does he/she attend? Will you need to enroll him/her in your local school? What paperwork will you need from the DCS FCM to enroll the child in school/day care?
- Does the child have a pet that also needs a home?
- What is the child's date of birth (you should request the birth certificate if needed to enroll the child in school).
- What are the discipline instructions for this relative child?
- May the child telephone family members, friends, or significant others on a regular basis?
- What are the visitation arrangements with parents and siblings?
- Does the child attend church and will he/she want to continue attending there?
- Does the child have a Court Appointed Special Advocate (CASA) or a Guardian Ad Litem (GAL)? If so, what is the contact information?
- What are the names and addresses of the child's doctor, dentist, eye doctor, with approximate dates of last appointments, if known, and Medicaid number.
- What is the provision for clothing if the child's current supply is inadequate?
- What is the contact information for the FCM and Regional Foster Care Specialist?
- What is the after-hours contact information or emergency procedure?

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*Appendix A (See page 15)* also contains a document that explains your role and responsibilities with regard to caring for the relative child placed with you. Your FCM will go over this document in more detail with you.



## Section II

### Financial Assistance Options through DCS

**W**hen the relative child is placed, you have different options for receiving financial assistance to cover the costs of the placement. First, you can become licensed as a foster parent through DCS and receive a daily payment or “per diem.” Second, if you choose not to become licensed, there is other financial assistance available from DCS. Your FCM and RFCS can provide additional information.

#### Foster Care Licensing

If you become licensed as a foster home, you will receive a daily payment or “per diem” from DCS for the care of your relative child. At the time of placement, your FCM will give you contact information for a Regional Foster Care Specialist or Supervisor, who will provide information about the requirements of the foster home licensing process. If you wish to become licensed, you should contact the Regional Foster Care Specialist or Supervisor if you have not heard from him/her within one week of placement. Contact information for the Regional Foster Care Specialist and/or their Supervisor is available from the child’s FCM.



#### Below are the different stages of becoming licensed:

- **Initial Licensure**—This is the first phase of licensing. It will involve background checks, 10 hours of training related to fostering, medical training (CPR, Universal Precautions and First Aid), completion of forms, visits to your home, and a formal home study written by your Regional Foster Care Specialist. At the end of the process, you will have a foster care license as long as you meet all of the requirements. Your foster care license is effective for four (4) years from the date of initial licensure, as long as you pass the annual review (*see below*). The foster care license is not backdated to the date of placement; the daily payment starts the day you are licensed.
- **Annual Review**—Indiana law requires DCS to review foster homes every year to ensure compliance with legal requirements. Your Regional Foster Care Specialist will complete a home visit and you will need to complete background checks and other documents as well as 15 hours of training each year.

- **Relicensure**—Your foster care license will expire after four (4) years. If you wish to be relicensed, you must submit a new Application for a Foster Home License, as well as complete background checks and some additional licensing documents.



As stated above, once you become licensed, you will receive payment for the child in your care; this payment is called a per diem. A per diem is a daily amount paid to a licensed foster parent for each child in their care to cover the reasonable cost of clothing, shelter, daily supervision, travel for visitation and school, personal incidentals for the child, and school supplies. The per diem payments are intended for the sole benefit and care of the child. If the child is already in your care when you become licensed, the per diem will start on the effective date of your license. The per diem is not backdated to the date of placement.

The per diem amounts vary based on the age and needs of the child in your care, starting at \$18.88 a day.

In addition to the per diem, a foster parent can receive the following additional payments for the benefit of the child:

- **Travel Expenses**—travel for certain purposes if the travel goes over approximately 162 miles per month.
- **Initial Clothing**—a payment of up to \$200 within 60 days of the child's placement outside of their home into a foster home.
- **Annual Personal Allowance**—a reimbursement of up to \$300 per child, per calendar year, which is available when the child has been in placement for at least 8 days. Examples of personal allowance items are baby equipment, prom dress or other special occasion clothing, school pictures, other school related events/fees, equipment and fees associated with extracurricular activities (including activities for young children), driver's education or driver's license fees, tutoring, summer school, computer, e-reader, and bus passes.
- **Special Occasion Allowance**—reimbursement of up to \$50 on the child's birthday and during the December holidays.

## Assistance for Unlicensed Relatives

If you do not wish to become licensed as a foster parent, DCS cannot provide you with a daily foster care payment. However, there are other options for financial assistance to relatives who do not wish to be licensed as a foster parent:

■ **Initial Clothing**—a payment of up to \$200 within 60 days of the child’s placement outside of their home. Examples of items that can be purchased with approval of the FCM are clothing, socks, shoes/boots, coats, toiletries, personal hygiene items, undergarments and hair products.

■ **Annual Personal Allowance**—a reimbursement of up to \$300 per child, per calendar year, which is available when the child has been in placement for at least 8 days. Examples of personal allowance items are baby equipment, prom dress or other special occasion clothing, school pictures, other school related events/fees, equipment and fees associated with extracurricular activities (including activities for young children), driver’s education or driver’s license fees, tutoring, summer school, computer, e-reader, and bus passes.

■ **Special Occasion Allowance:** a reimbursement of up to \$50 on the child’s birthday and during the December holidays.

■ **Travel Expenses:** travel for certain purposes starting at mile 1. Examples of covered travel are travel to school (if not covered by the school corporation), visitation, medical and mental health appointments, and court related travel.

■ **Respite Care:** payment for respite care in a licensed foster parent’s home for up to five (5) days each year.

■ **Child Care Allowance:** a reimbursement of up to \$18 per day or \$90 per week, per child, for licensed child care costs for those relatives that work or attend school. This funding is available for up to six (6) months or until Child Care Development Fund (CCDF) Vouchers (see below) begin, whichever occurs first.

■ **Bedding Allowance:** a reimbursement of up to \$400 per child for a bed and bedding if needed and pre-approved. This is a one-time payment.

Any items purchased with the initial clothing allotment, personal allowance, special occasion allowances, or the bedding allowance are considered the child’s belongings and should transition with the child in the event of a move or return home.

The above payments may require approval from the DCS FCM before they are available. Please discuss the details of these items with the FCM to learn more.



# Section III

## Other Financial Assistance Options

### Temporary Assistance for Needy Families (TANF)

TANF is a program managed by the Division of Family Resources (DFR) to provide temporary financial assistance to qualifying relatives caring for a child. In addition, TANF is available for a single parent family or a family in which a parent is disabled/unemployed/underemployed (unable to work, possibly due to illness, or lack of education or job training).

To apply for TANF, contact your local DFR office in your county of residence. The local DFR office has the responsibility to process applications, certify eligible applicants for participation, and issue benefits. Applications may be taken to the local DFR office, mailed or faxed.

The amount of cash payment is determined by the number of eligible family members and their total income. The standard for a family including children and their caretaker is reflected in the chart below. A child can be considered a family of 1 in some circumstances without the relative's income being considered. In the case of sibling children, the sibling group could comprise a family without the relative's income being considered. This assistance can take 30-45 days to get started, but it will be retroactive to the date of application.

### Income Standard

Family Size	Gross Income Limit (Monthly)	Maximum Monthly Benefit
1	\$286.75	\$139.00
2	\$407.00	\$198.00
3	\$527.25	\$256.50
4	\$647.50	\$315.00
5	\$767.75	\$373.50
6	\$888.00	\$432.00
7	\$1008.25	\$490.50
8	\$1128.50	\$549.00
9	\$1248.75	\$607.50
10	\$1369.00	\$666.00

If you choose to become licensed, you cannot also claim TANF for the relative foster child. The relative foster child would be deemed ineligible for TANF cash assistance due to the foster care per diem that you are receiving on his/her behalf. Other non-foster children in your home may still qualify for TANF as the relative foster child's foster care payment (and any other income the relative foster child may be receiving) would be excluded from the TANF eligibility determination. Be sure to discuss this with a TANF representative.

More information on TANF can be found at <http://www.in.gov/fssa/dfr/2684.htm>

## **Food Stamps**

The Food Stamp program, called Supplemental Nutrition Assistance Program (SNAP), can help provide food for individuals who live with you in your home. The program enables low-income families to buy nutritious food through Electronic Benefits Transfer (EBT) cards. Families must qualify to receive this assistance. To apply for this program, visit this web site at <http://www.in.gov/fssa/dfr/2691.htm> for a copy of the application and information on where to submit the application.

If you choose to be a licensed foster parent and receive a per diem from DCS for the relative foster child, your household may not qualify for food stamps. This will depend upon the relative foster child's status in the household and whether the child is part of the food stamp assistance group. Be sure to discuss this with a representative of the food stamp program for more information.

## **WIC Program**

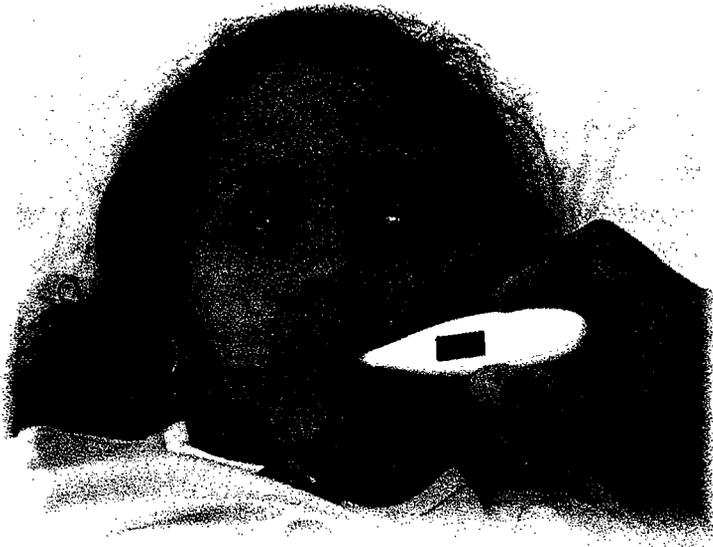
Relative parents who care for infants and children up to age 5 may be eligible to participate in the Women, Infant and Children (WIC) program when the relative's children are Medicaid eligible. WIC is a supplemental food and nutrition program and participants receive vouchers that are redeemed for specified nutritious foods at designated groceries. Such foods consist of baby formula, cereal, eggs, milk, peanut butter, juice and other foods to meet a child's specialized needs. WIC participants also receive nutrition education, nutrition counseling, and referrals to other health services if needed. You can obtain information on applying at <http://www.in.gov/isdh/19691.htm>. You can also contact your state WIC representative at 1-800-522-0874 or email [inwic@isdh.in.gov](mailto:inwic@isdh.in.gov), or you can ask your FCM or Regional Foster Care Specialist for more information.

## **Free or Reduced-Price School Lunches, Book Rental Fees and Book Fees**

All relative children placed by DCS will receive free or reduced-price school lunches, book rental fees or text book fees. Relative foster children qualify for this federal program when they enter DCS care. The relative caregiver does not have to complete a separate application as DCS automatically enrolls all children in placement in this program. Discuss this with your local school corporation to ensure you are receiving this benefit.

## **Section IV**

### **Medical Coverage—Medicaid**



The relative child placed with you should be eligible for Indiana Medicaid. Indiana Medicaid is Indiana's medical program that can pay the costs of medical, dental, behavioral/mental health and eye care for your relative child. Children who are not eligible for Medicaid would be those very few who have a high income in their own right; this could include income from an inheritance, a family trust or a social security survivor's benefit, for example. If the child's parents have private insurance, those benefits follow the child and will be used first to meet the child's expenses. Your relative child's FCM

can help ensure the child is enrolled in Medicaid.

Once the child is enrolled in Medicaid, a Medicaid card will be given to you. The FCM should also give you a Medical Passport for the child. The Medical Passport is a tool that allows you to keep a written record of a relative child's medical and dental care while placed with you. When you take the child for an appointment of any kind, take the Medical Passport and give it to either the doctor or the nurse to make an entry documenting the care the child receives. When the FCM comes to visit you and the relative child, talk about any new entries that have been made as the FCM keeps a separate record.

## **Section V**

### **Additional Support and Help**

#### **Infants and Toddlers Early Head Start/Head Start**

Early Head Start and Head Start are programs for pregnant mothers and for children 0-5 years old. Children can participate in activities that will help them grow mentally, socially, emotionally and physically. Early Head Start children receive medical assessments, mental health services and follow up services. More information on these programs can be found at <http://www.in.gov/fssa/dfr/2679.htm>

#### **First Steps**

Indiana's First Steps System is a family-centered, locally-based, coordinated system that provides early intervention services to infants and young children with disabilities or who are develop-

mentally vulnerable. Families who are eligible to participate in Indiana's First Steps System include children ages 0-3 years that are experiencing developmental delays and/or have a diagnosed condition that has a high probability of resulting in developmental delay. An evaluation can be provided on request. Services are individualized and are available in all 92 counties in Indiana. More information can be found at <http://www.in.gov/fssa/ddrs/2633.htm>.

## **Child Care Development Fund (CCDF)**

The Child Care and Development Fund (CCDF) program provides financial assistance for child care for families who are working or enrolled in school. To apply for the CCDF voucher program, you must contact your local Intake Agents, which can be found at <http://www.in.gov/fssa/carefinder/3900.htm>. If you receive a voucher, you must choose a child care provider who meets CCDF provider eligibility standards. More information can be found at <http://www.in.gov/fssa/2552.htm> (in the left column, click on Child Care Assistance—Child Care Development Fund). As discussed above, DCS will cover childcare costs for six (6) months if there is a waiting list for CCDF vouchers.

## **Support Groups**

There are Foster Care support groups, active in some regions, that are open to relative caregivers to discuss issues and concerns you may have as you care for your relative child. Additional training opportunities that can help the family become better equipped to handle certain behaviors or health issues regarding your relative placement are also available. Contact your FCM or Regional Foster Care Specialist for more information.



# Section VI

## Care of Children

This section will provide valuable information on caring for a relative child.

### Safe Sleeping for Babies

If the relative child placed with you is an infant, use the below information for safe sleeping:

- Always place babies on their backs to sleep. The back sleep position is the safest.
- In December 2010, the Consumer Product Safety Commission banned the further manufacture of drop-side cribs (e.g. cribs that allow for the sides to be lowered and raised). These types of cribs should be avoided for children. See the following link for a picture of the new crib at <http://www.cpsc.gov/nsn/cibrules.pdf>.
- Place babies on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. Never place babies to sleep on pillows, bean bags, quilts, sheepskins or other soft surfaces.
- Keep soft objects and toys, and loose bedding, out of babies' sleep area. Do not use pillows, blankets, quilts, or pillow like crib bumpers in the sleep area and keep any other items away from the baby's face.
- Keep babies' sleep area close to, but separate from, where you and others sleep. Babies should not sleep in a bed or on a couch or armchair with adults or other children, but he or she can sleep in the same room as you.
- Think about using a clean, dry pacifier when placing the infant down to sleep, but do not force the baby to take it.
- Dress babies in light sleep clothing and keep the room at a temperature that is comfortable for an adult.
- Reduce the chance that flat spots will develop on a baby's head by providing "tummy time" when the baby is awake and someone is watching, changing the direction that the baby lies in the crib from one week to the next, and avoiding too much time in car seats, carriers and bouncers.

More information can be found at [www.aap.org/healthtopics/sleep.cfm](http://www.aap.org/healthtopics/sleep.cfm) and on the DCS website at <http://www.in.gov/dcs/2869.htm>.

### Shaken Infant Syndrome

Shaken Infant Syndrome happens when a person caring for a baby or young child become frustrated and shakes the baby forcefully. Even mild shaking can cause serious injury. Usually

the damage that occurs cannot be seen. Severe injury is most common in very young children, but even four- and five-year-old children can be injured or killed.

More information can be found on the DCS website at <http://www.in.gov/dcs/2987.htm>.

## Water Safety

Water is everywhere in and around a home. While some water safety practices are common sense, some may not be. Safety practices for within the home include:

- Keeping your water heater at an appropriate temperature
- Not leaving liquids laying around unattended (such as a cleaning bucket) as it takes only a small amount of water for a baby or toddler to drown
- Never leave a small child in the bathroom or bathtub alone.



## Safety practices for around the home include:

- Having a pool safety plan, including for the use of child size pools
- Never allow easy access to a pool, pond, lake, etc
- Utilizing safety locks on all doors providing access to water
- Installing a fence around pools
- Never leaving children unattended near water of any kind—a few inches is enough for a child to drown or be injured
- Utilizing life jackets when on a water craft or fishing from the ground
- Having children participate in swimming and water safety lessons
- Having adults in the home be trained in water safety and rescue .

## Smoking

If a relative parent or household member smokes, they must do so in an area where the child is not exposed to second-hand smoke. If a relative parent or household member must smoke inside his or her home, smoking should be limited to rooms where windows can be opened and/or air purifiers can be used. Smoking should not occur in the immediate living area and cannot be done in the presence of the child. Smoking is not allowed in the child's sleeping area(s). Relative parents also cannot smoke in vehicles while transporting the relative child. Relative parents must not purchase tobacco products for any child, as it is illegal for children under age 18 to consume or have cigarettes. If a relative parent discovers that the relative child is in possession of tobacco products, then he or she should contact the child's FCM as soon as possible.

## **Alcohol**

Relative parents have the right to allow alcohol usage in their own home, but serious consideration should be given to the usage of alcohol in the presence of children. Because of the exposure many children have had to alcohol and the negative effects of their caretakers using it, trauma can be caused by their being subjected to others using it in the relative home. Relative parents should not purchase alcohol for any child, and it is illegal in Indiana for children under age 21 to purchase it. If a child is found to be in possession of alcohol, a meeting should be held with the FCM as soon as possible.

## **Medication Safety**

Giving prescription medicine to a child is an important task. When you receive prescription medications for a relative child, follow the written instructions completely. It is requested that the relative parent keep a medication log of when the medicine has been given. Relative parents cannot adjust prescription medications or doses. A physician must make any changes of the dosage amount. If a relative child has a negative reaction to a prescribed medication, seek treatment immediately.

As to psychotropic medications, the child's parent, DCS and/or the court must consent to start the child on this type of medication. If a doctor prescribes psychotropic medication, get the necessary consents from the FCM prior to giving the child the first dose unless the medication is needed on an emergency basis.

Relative parents who take medications on a regular basis should be careful to take it as instructed and should use caution in storing the medicine. All prescription and non-prescription medications should be stored out of the reach of children and, whenever possible, they should be secured with safety seal caps.

## **Visitation with the Biological Family**

DCS will arrange for visitation between the child and his or her parents and siblings as long as it is safe and appropriate for the visits to occur. You may be asked to assist with transporting the child to visitation and/or supervising the visitation. The sibling bond is the most important throughout life. If your relative children are not placed together it is essential that they see each other as often as the court allows these to take place.

## **Car Seats and Safety Belts**

Indiana law requires that all children under 8 years of age must be restrained in a child passenger restraint system which meets the current Federal Safety Standards when riding in a motor vehicle. Additionally, all children between the ages of 8 and 16 years of age must be properly restrained by a safety seat belt.

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See *Car Safety Seats: A Guide for Families 2011* (Copyright @ 2011 American Academy of Pediatrics), which can be found at: <http://www.aap.org/healthtopics/carseatsafety.cfm>

# Important Contacts & Links

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See below for quick access to information about various programs and services.

**Indiana Child Abuse and Neglect Hotline**  
**1-800-800-5556**

**Child Support Bureau KIDS Line**  
**1-800-840-8757**

**Foster Care Helpline**  
**888-631-9510**

**DCS Ombudsman**  
**877-682-0101**  
*[DCSOmbudsman@idoa.in.gov](mailto:DCSOmbudsman@idoa.in.gov)*

**DCS Website**  
*[www.in.gov/dcs](http://www.in.gov/dcs)*

**DCS local offices**  
*<http://www.in.gov/dcs/2372.htm>*

**DCS Policy**  
*<http://www.in.gov/dcs/2354.htm>*

**Other safety information relative to children**  
*<http://www.in.gov/dcs/2330.htm>*

Thank you again for filling such an important need for your family. The Department of Child Services appreciates your efforts, and we look forward to having you as a partner during this time.

# Appendix



## RESOURCE PARENT ROLE ACKNOWLEDGMENT

State Form 54642 (R / 2-12)  
DEPARTMENT OF CHILD SERVICES

*INSTRUCTIONS: This form is to be completed by foster parents prior to licensing, at each annual review and at re-licensure. This form is also to be completed by prospective adoptive parents and relative parents prior to receiving placement.*

Name of Licensing/Placing Agency (DCS or LCPA)	
Name(s) of Resource Parent(s)	Resource Home Identification Number

- A. RESOURCE PARENT ROLES AND RESPONSIBILITIES** – Resource parent roles and responsibilities are described in state law, regulations and Indiana Department of Child Services (DCS) policy. Please see the Internet links in Section B below for these complete documents. Below is a summary of roles and responsibilities for resource parents.

**Resource Parent Role – General** - The resource parent will:

1. Cooperate with DCS and the licensed child placing agency (LCPA) in the overall plan for the child and with all inquiries from DCS or the LCPA involving the care of the child or the foster parent’s license;
2. Participate in Child and Family Team Meetings when invited by the parents, as well as case conferences and court hearings as appropriate;
3. Consult with DCS on all matters concerning the care and well-being of the child;
4. Encourage and support family visitation and reunification or other permanency plan as approved by DCS;
5. Provide a positive and nurturing environment for the child and include the child in normal family routines;
6. Refrain from speaking negatively about members of the child’s family or other persons with whom the child has a significant relationship;
7. Consider the child’s culture, ethnic heritage and religious beliefs and promote the maintenance of these essential connections;
8. Encourage the child to express feelings about his or her situation;
9. Provide appropriate supervision and transportation for the child.

**Discipline** – The resource parent will not use the following types of punishment:

1. Corporal punishment (e.g. spanking);
2. Physical exercise (e.g., push-ups, running);
3. Requiring or using force to make the child take an uncomfortable position;
4. Verbal remarks that ridicule the child and/or his or her family;
5. Denial of an emotional response;
6. Denial of essential services (e.g., health care, food, clothing, bedding, sleep, mail, or family visitation, etc.);
7. Threats of removal or denying reunification;
8. Shaking; and/or
9. Placement in a locked room.

**Health Care** – The resource parent will:

1. Coordinate with DCS to:
  - a. Ensure the child receives all initial and routine healthcare exams, as well as follow-up exams and treatment;
 

**Note:** The initial exam must consist of early and periodic screening, diagnosis, and treatment (EPSDT) services, known in Indiana as Health Watch. The exam will include screens for physical, dental, visual, auditory, and developmental health.
  - b. Ensure the child is provided and/or offered specialized care and treatment based upon the child’s individual assessed needs (e.g., therapy, counseling, medication, drug and alcohol testing and/or treatment);
2. Obtain DCS authorization prior to any non-routine, non-emergency care or behavioral health treatment, including the use of psychotropic medication;
3. Obtain payment authorization prior to any treatments that are not covered by the child’s Medicaid or private health insurance;
4. Seek emergency care for the child for the following: serious injury or illness, serious dental issues (i.e. broken teeth, bleeding gums), mental health issues that place the child at risk for harming himself/herself or others, and serious vision issues (i.e. the child’s glasses or contacts are broken or lost);
5. Document all care and treatment received in the child’s Medical Passport;
6. Protect foster children from being exposed to second-hand smoke in the foster parent’s home or vehicle;
7. Adhere to safe sleeping practices for infants;
8. Attend counseling/therapy sessions with the child as appropriate.

# Appendix

**Educational Services** – The resource parent will:

1. Ensure that school-age children observe compulsory school attendance laws of the state and provide reasonable assistance and guidance regarding overall learning and individual school achievements;  
NOTE: Educational services provided outside the public school system must be approved by DCS and/or the Court.
2. Attend necessary meetings with teachers and/or other school authorities;
3. Encourage children to participate in extracurricular school and educational activities where appropriate;
- a. Protect the confidentiality and safety of foster children by appropriately supervising their use of the Internet for social networking purposes.

**Required Notifications** – The resource parent will notify the child’s family case manager and licensing worker (when applicable) promptly of changes affecting their license or the care of children. Examples of required notifications include, but are not limited to, the following:

1. Any substantial and/or harmful changes affecting the child’s well-being;
2. Situations affecting the resource parent’s ability to provide care to the child;
3. Emergency situations that requires medical care such as serious injuries/illnesses of the child;
4. Extracurricular activities the child may participate in;
5. In state or out of state overnight travel (if travel lasts more than forty-eight (48) hours, court approval may be required);
6. Request for respite care, schedule changes or removal of children;
7. Arrests and/or conviction of resource parents or their household members;
8. Any change in household composition;
9. Change of address.
10. If you are requesting that a child be moved, provide a minimum of two (2) weeks notice, unless an emergency exists, to allow a smooth placement transition .

**Clothing, Personal Items and Permitted Per Diem Expenses** – Resource parents receiving a per diem shall utilize it to cover expenses of caring for the child, which include but are not limited to, the following: food, clothing, shelter, supervision that substitutes for daily supervision such as summer programs (camp), school supplies (paper, pens, calculator, etc.), child’s personal incidentals (tickets for sports and cultural events, personal hygiene items, sundries, infant and toddler supplies, activity fees, uniforms, etc.), and travel. Any other financial support received for the placement shall be used as intended.

**B. ACKNOWLEDGMENTS**

I agree to maintain the confidentiality of written or verbal information that DCS has made available to me and will not share such information without the express written consent of DCS unless it is necessary for the care and treatment of a child under the supervision of DCS. I understand that Indiana Code 5-14-3-10 disallows disclosure of confidential information and that, in addition to the above, information regarding health, assessments of child abuse and neglect and juvenile court records are all subject to confidentiality laws. I agree to discuss the need to maintain confidentiality with members of my household, including minor children in an age appropriate manner.

I acknowledge and agree to comply with the following and understand that failure to comply could result in license revocation:

1. Indiana Licensing Law, IC 31-27-4, which can be found at: <http://www.in.gov/legislative/ic/code/title31/ar27/ch4.html>;
2. Indiana Foster Home Regulations, 465 IAC 2-1.5, which can be found at: <http://www.in.gov/legislative/iac/> ;
3. DCS Policies regarding Out of Home Services, which can be found in Chapter 8 of the DCS Child Welfare Manual at: <http://www.in.gov/dcs>;
4. Written guidelines of the local DCS office or licensed child placing agency (LCPA).

Signature of Resource Parent	Name of Resource Parent ( <i>typed or printed</i> )	Date Reviewed/Signed ( <i>month, day, year</i> )
Signature of Resource Parent	Name of Resource Parent ( <i>typed or printed</i> )	Date Reviewed/Signed ( <i>month, day, year</i> )

# Notes

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# Notes

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	<b>INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE MANUAL</b>	
	<b>Chapter 4:</b> Assessment	<b>Effective Date:</b> October 1, 2012
	<b>Section 9:</b> Interviewing Children	<b>Version:</b> 4

**POLICY [REVISED]**

**[REVISED]** The Indiana Department of Child Services (DCS) will conduct or arrange an individual face-to-face interview<sup>1</sup> with the alleged child victim, all other children living in the home (including children who live in the home part time due to a custody arrangement or have visitation in the home), and any children not living in the home who were present at the time of the alleged incident regardless of the allegation. The Family Case Manager (FCM) will always inquire about the household composition and if any other children live in the home part time or have visitation.

**[NEW]** If a child who lives in the home part time or has visitation is listed as a *victim*, the child's custodial parent can be advised of the allegations by receiving a copy of the Preliminary Report of Alleged Child Abuse or Neglect (SF 114) and the Assessment of Alleged Child Abuse or Neglect Report (SF 113/CW0311). If the child is not listed as a victim, the child should be interviewed as a witness. (See Practice Guidance)

The FCM will distinguish between making a "contact" with a child and when that child is "interviewed" by accurately documenting what occurred in Management Gateway for Indiana's Kids (MaGIK).

**Contact vs. Interview**

A contact can be any communication or an in-person observation. An interview occurs when a person is individually questioned about the allegations of a Child Abuse and/or Neglect (CA/N) report not in the presence of family members or witnesses. A contact is not always considered an interview. A contact includes but is not limited to:

1. Face-to-Face home, other office;
2. Telephone;
3. Fax;
4. Email;
5. Voice Mail; and
6. Correspondence.

**[REVISED]** When interviewing children who are alleged to have been exposed to domestic violence, DCS will focus interviews with children on the:

1. Result of witnessing what they saw and/or heard (are there any signs of behavioral, cognitive or emotional impact);
2. Child's understanding and/or interpretation of the violence (how does the child explain what happened or what lead to the domestic violence); and
3. Child's concerns about safety.

<sup>1</sup> For children who are too young or unable to communicate, an interview will consist of face-to-face interaction with the child at a level that is appropriate given the child's developmental status.

**Note:** It is critical to assess the unique impact of domestic violence on each child, not just what they were exposed to or observed.

A trained forensic interviewer may conduct an interview if the child is an alleged victim of sexual abuse; however, DCS will be present during the interview.

Law Enforcement Agency (LEA) may conduct an interview if LEA and DCS are participating in a joint assessment, however, DCS will be present during the interview. Further, DCS will conduct an additional interview if unable to assess child safety and well-being during the joint LEA interview.

**[NEW]** FCMs will consider all relevant factors regarding the assessment in determining when to utilize video and/or audio equipment to record interviews with children. Video and/or audio taping should be utilized in situations when allegations of sexual abuse, severe physical abuse, or other complex cases could lead to criminal charges being filed. (See Practice Guidance)

#### Code References

1. IC 31-34-13: Child videotape testimony in child in need of services proceedings
2. IC 5-26.5-1-3: Domestic violence
3. IC 34-6-2-34.5: Domestic or family violence

### PROCEDURE

The Family Case Manager (FCM) will:

1. **[NEW]** Determine which children require a face to face interview by asking if additional children live in the home part time or have visitation;
2. Obtain consent from a parent, guardian, or custodian prior to interviewing any child, unless exigent circumstances exist. (See separate policies, 4.5 Consent to Interview Child and 4.6 Exigent Circumstances.);
3. Conduct the interview in a location and/or setting that assures privacy for the child;
4. Honor a parent, guardian, or custodian's request to be present during the interview if his or her presence will not impede or influence the interview in any way;
5. **[REVISED]** Determine when to video and/or audio tape the interview with an alleged victim by staffing with a Supervisor if possible;

**[NEW] Note:** Video and/or audio taping should be utilized in situations when allegations of sexual abuse, severe physical abuse, or other complex cases could lead to criminal charges being filed.

6. Develop rapport with the child prior to asking questions about the alleged CA/N;
7. Explain to the child at the beginning of the interview what will happen with the information obtained during the interview (i.e., who will this information be shared with);
8. **[REVISED]** Document in MaGIK any possible behavioral signs of domestic violence in the child, especially statements that they are afraid of the alleged perpetrator or domestic violence offender;
9. Engage the child(ren) in the development of the Family Support/Community Services Plan (SF53243/CW3425), if age appropriate. See separate policy, 4.19 Family Support/Community Services Plan.

## **PRACTICE GUIDANCE**

### **Indicators of Domestic Violence**

If any of the following indicators of domestic violence are observed during the course of an assessment, carefully consider how to proceed with the interview (i.e., if the alleged domestic violence offender is present, the interview may need to be handled differently than if the parent, guardian, custodian, or child were alone).

#### **Child Indicators:**

1. Child may blame self for the abuse;
2. Child may identify with the alleged domestic violence offender by “acting out” aggressively toward the non-offending parent;
3. Child may be depressed, confused, or exhibit animosity, anger, or sadness;
4. Infants may be moody, restless, sleepless, or lack responsiveness;
5. Regression, such as bed wetting or thumb sucking;
6. School phobia- a manifestation of leaving the non-offending parent alone in the home;
7. Guilt or the inability to establish trusting relationships;
8. Child tries to hide the fact that domestic violence is present in the home;
9. Child may take on the “mothering” role;
10. Child may demonstrate fear when the alleged domestic violence offender is around;
11. Child overly protective of one (1) parent; and/or
12. Child may be withdrawn, apathetic, or feel insecure and powerless.

### **[NEW] Interviewing Children that Live in the Home Part Time or Have Visitation**

If a child is determined to live in the home part time or has visitation as the result of a custody arrangement, the child requires a face to face interview. If it is determined that the child is *not* a victim, the FCM should proceed with setting up an interview with the child but is not permitted to disclose any details regarding the allegations of abuse or neglect to the child’s custodial parent. The FCM should stress the importance of the interview by advising the parent that the child may have witnessed an incident or have information that has been disclosed to them by another child that can affect child safety. The FCM should also advise the child’s parent that they can be present during the interview with their child.

### **[REVISED] Video/Audio Taping Interviews**

The FCM is to make reasonable efforts to use audio and/or video equipment to record the interview with the child. Recording interviews may reduce the number of times an alleged child victim must be interviewed. It may also reduce the necessity for the alleged victim to provide further testimony if the case goes to court.

Decisions regarding how to record an interview should be made based on the circumstances of the report and the location of the interview. Written notes should always be taken during the interview (preferably by someone other than the assigned FCM when possible, such as LEA or another FCM). All information should be reviewed and clarified with the child to assure an accurate understanding of what the child said. The FCM should explain to the extent possible to the child that they are being recorded.

FCMs should use critical thinking skills to consider all factors when deciding to utilize video and/or audio equipment to record interviews with children. Video and/or audio taping should be utilized in situations when allegations of sexual abuse, severe physical abuse, or other complex cases could lead to criminal charges being filed.

### **[REVISED] Location and Presence of Others**

In planning for an interview of a child, the FCM should ensure that the location of the interview is non-threatening and neutral so the child can feel safe. When circumstances allow, the child should be interviewed separately from other family members. The FCM should allow the interview to begin with the non-offending parent present and work towards separate interviews. The interview with the child should never be conducted in the presence of or within hearing distance of the alleged perpetrator.

### **Types of Questions to Ask During an Interview**

Open-ended questions should be used as much as possible. Multiple-choice or yes and no questions should only be used if the FCM is unable to elicit any information from the child. The more open-ended the question the greater confidence one can have in the child's response. The following open-ended questions are to provide guidance on gathering information regarding the who, what, when, where and how of the alleged CA/N:

Who questions: These questions are important in identifying the parties involved and who is aware of what has happened.

*Who did this? Who was there? Who knows about this besides you?*

When questions: These questions are used to determine the most recent occurrence as well as the duration of the abuse or neglect. In physical abuse cases, "When" questions are used, for instance, to determine if the degree of healing of the injury is consistent with the time frame the child is describing.

*When mommy left, what was on TV? When mommy came home, what was on TV?*

Where questions: These questions are used to determine the location of the CA/N as well as the whereabouts of other family members at the time of the occurrence.

*Where were you hit? Where were mommy and daddy at the time you were hit?*

How questions: These questions help children expand their responses. For instance, when a child says, "He hit me," the worker might say, "How did he hit you?" or "Tell me about that."

What questions: These questions ask for descriptive statements or observations. The worker may need to ascertain whether the child was threatened, tricked, bribed or otherwise coerced to cooperate with a perpetrator (e.g., in a sexual abuse incident) or to maintain secrecy after any incident of abuse or neglect. For instance, a child who has divulged that the perpetrator "told me not to tell" should be asked, "What did he say?"

## **FORMS AND TOOLS**

Family Support/Community Services Plan (SF53243)

## **RELATED INFORMATION**

### **Number of Interviews**

While it is best practice to conduct only one interview with a child, an FCM may have to conduct additional interviews with a child if the FCM was unable to gather sufficient information in the initial interview to assess child safety and well-being.

### **Joint Interviews with LEA**

See separate policy, 4.29 Joint Assessments, for more information.

### **Forensic Interviews for Children who are Alleged Victims of Sexual Abuse**

It is best for a child who is an alleged victim of sexual abuse to be interviewed by a professional who is trained and experienced in forensic interviewing. DCS offers specialized trainings on this topic. If DCS and LEA are present for an interview, the determination of who will lead the interview should be based on who has the proper training and is able to develop rapport with the child.

Using means other than verbal communication is often a critical component of interviewing alleged victims of sexual abuse. In many cases what a child will demonstrate with objects or drawings is far more compelling than what they may say. The interviewer may ask the child to draw pictures of the home, the family, etc., or to communicate using blank figure drawings or anatomically detailed dolls and doll houses.

### **[REVISED] Child Advocacy Centers (CACs)**

At CAC's, the various members of the Child Protection, Law Enforcement, Prosecution, Victim Advocacy, Medical and Mental Health Communities are able to provide children and their families comprehensive services within a child-friendly environment designed to meet the child's needs.

# Differential Response to Reports of Child Abuse and Neglect

## What's Inside:

- Defining differential response
- Why the growing interest in differential response?
- Experience in the field
- Evaluation findings
- Opportunities for improving child welfare practice
- Guiding principles for implementation
- For more information

*This issue brief was developed by Child Welfare Information Gateway, with contributions from Patricia Schene, Ph.D., of Patricia Schene and Associates, LLC. This document is made possible by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The conclusions discussed here are solely the responsibility of the authors and do not represent the official views or policies of the funding agency.*

During the past several decades, child protective services (CPS) agencies have been challenged by large volumes of child abuse and neglect reports, growing caseloads involving increasingly complex problems, and limited resources (U.S. General Accounting Office, 1997; Shusterman, Hollinshead, Fluke, & Yuan, 2005). At the same time, there has been growing recognition that “one size does not fit all” in responding to child maltreatment reports. As a result, State and local CPS agencies have introduced significant reforms to child protection systems. One such reform is differential response, in which CPS agencies offer both traditional investigations and assessment alternatives to families reported for child abuse and neglect, depending on the severity of the allegation and other considerations.

The introduction of differential response has been driven by the desire to:

- Be more flexible in responding to child abuse and neglect reports
- Recognize that an adversarial focus is neither needed nor helpful for all cases
- Understand better the family issues that lie beneath maltreatment reports
- Engage parents more effectively to use services that address their specific needs

This issue brief provides an overview of differential response and highlights lessons learned through research and experience. The brief was written primarily for child welfare administrators and policymakers, particularly those who may be considering implementation or expansion of differential response. It also may be useful to CPS caseworkers, community partners who work with vulnerable children and families, and others interested in strategies to improve child protection.

This issue brief reflects a review of selected research efforts and recent literature on differential response. A list of references and other resources is presented at the end of the brief. To highlight key issues, this brief draws from a few sources in particular:

- Office of the Assistant Secretary for Planning and Evaluation (ASPE) and Children’s Bureau reports from the *National Study of Child Protective Services Systems and Reform Efforts (Literature Review, Review of State CPS Policy, and Findings from Local CPS Practices)* (U.S. Department of Health and Human Services, 2001, 2003a, & 2003b)
- *National Study on Differential Response in Child Welfare*, published jointly by American Humane and the Child Welfare League of America (Merkel-Holguin, Kaplan, & Kwak, 2006)
- *Differential Response in Child Welfare*, a special issue of the American Humane journal, *Protecting Children* (Merkel-Hoguin, L., Ed., Volume 20, Numbers 2 & 3, 2005)
- Mallon & Hess’ (Eds.) book, *Child Welfare for the Twenty-First Century: A Handbook of Practices, Policies, and Programs* (2005)
- National Child Welfare Resource Center for Family-Centered Practice’s Spring 2001 issue of *Best Practice, Next Practice* (Schene, 2001)
- ASPE study summarizing *Alternative Responses to Child Maltreatment: Findings from NCANDS* (Shusterman, et al., 2005)

## Defining Differential Response

Differential response is a CPS practice that allows for more than one method of initial response to reports of child abuse and neglect. Also called “dual track,” “multiple track,” or “alternative response,” this approach recognizes variation in the nature of reports and the value of responding differently to different types of cases (Schene, 2001).

While definitions and approaches vary from State to State, differential response generally uses two or more “tracks” or paths of response to reports of child abuse and neglect. Typically, these responses fall into two major categories:

- **Investigation.** These responses involve gathering forensic evidence and require a formal determination regarding whether child maltreatment has occurred or the child is at risk of abuse or neglect. In a differential response system, investigation responses are generally used for reports of the most severe types of maltreatment or those that are potentially criminal.
- **Assessment (alternative response).** These responses—usually applied in low- and moderate-risk cases—generally involve assessing the family’s strengths and needs and offering services to meet the family’s needs and support positive parenting. Although a formal determination or substantiation of child abuse or neglect may be made in some cases, it is typically not required.

However, not all jurisdictions that employ differential response focus simply on choosing an assessment or investigation track. In some

areas, there is more variation in types of response. Additional tracks may include a resource referral/prevention track for reports that do not meet screening criteria for CPS but suggest a need for community services, or a law enforcement track for cases that may require criminal charges.

## Similarities Between Differential Response and Traditional CPS

While introducing a more flexible way of responding to reports, differential response systems still share many underlying principles with the traditional child protection approach. Both:

- Focus on the safety and well-being of the child
- Promote permanency within the family whenever possible
- Recognize the authority of CPS to make decisions about removal, out-of-home placement, and court involvement, when necessary
- Acknowledge that other community services may be more appropriate than CPS in some cases

Differential response systems acknowledge that investigations are necessary in some cases. They typically allow for changes in the response track if circumstances change or information emerges that indicates a different type of response is needed to ensure child safety or better respond to the family.

The *National Study of Child Protective Services Systems and Reform Efforts* (U.S. Department of Health and Human Services, 2003a), which included a survey of a nationally representative sample of local CPS agencies,

found that despite the differences in focus, many of the approaches and practices used in conducting investigations and alternative responses were similar. During investigations, almost all agencies reviewed CPS records, interviewed or formally observed the child, and interviewed the caregiver. A slightly lower proportion of agencies conducted the same activities during alternative responses. Under both responses, a majority of agencies sometimes discussed the case with other CPS workers or with a multidisciplinary team, visited the family, and interviewed professionals.

### **Differences Between Assessment and Investigation Approaches**

In traditional child protection practice, all accepted reports receive an investigation response. Investigations are conducted to determine if children have been harmed or are at risk of being harmed and to provide protection if needed. In differential response systems, investigations are no longer the singular focus of CPS response to reports of child maltreatment. While investigations are conducted for some reports (typically the more serious and severe), assessment is used for most other screened-in reports.

In comparison to investigations, assessment responses tend to:

- Be less adversarial
- Focus more on understanding the conditions that could jeopardize the child's safety and the factors that need to be addressed to strengthen the family
- Tailor approaches and services to fit families' strengths, needs, and resources

- Place importance on engaging parents to recognize concerns that affect their ability to parent and to participate in services and supports
- Tap into community services and the family's natural support network
- Offer voluntary services

Unlike investigations, assessment responses typically do not require caseworkers to make a formal finding regarding whether child abuse or neglect occurred, identify victims and perpetrators, or enter perpetrator names into central registries.

For a comparison of the two approaches, see Table 1 on page 5.

### **Why the Growing Interest in Differential Response?**

A number of factors explain the growing national interest in differential response. Some of the most significant are discussed below, including limitations of traditional CPS practice, recognition of the importance of family engagement, and an increased focus on accountability and outcomes.

### **Limitations of Traditional CPS Practice**

In the two decades following the passage of the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, reports of abuse and neglect rose sharply, reaching 3 million per year in the mid-1990s without a corresponding increase in available staff. In response, CPS practice became more bureaucratic, standardized, and legalistic (Farrow, 1997).

**Table 1**  
**Comparison Between Investigation and Assessment Approaches<sup>1</sup>**

	Investigation	Assessment
<b>Focus</b>	<ul style="list-style-type: none"> <li>• Did an incident of child abuse or neglect occur?</li> <li>• Who was responsible?</li> <li>• What steps need to be taken to ensure the child's safety?</li> </ul>	<ul style="list-style-type: none"> <li>• What underlying conditions and factors may jeopardize the child's safety?</li> <li>• What strengths and resources exist within the family and community?</li> <li>• What areas of family functioning need to be strengthened?</li> </ul>
<b>Goal</b>	To determine the "findings" related to allegations in the report and identify perpetrators and victims.	To engage parents, extended family, and community partners in identifying problems and participating in services and supports that address family needs.
<b>Disposition</b>	A decision must be made whether to substantiate the allegation of maltreatment.	Caseworkers are not typically required to make a formal finding regarding whether child maltreatment occurred.
<b>Central Registry</b>	Perpetrators' names are entered into a central registry, in accordance with State statutes and policies.	Alleged perpetrators' names are not entered into a central registry.
<b>Services</b>	If a case is opened for services, a case plan is generally written and services are provided. Families can be ordered by the court to participate in services if CPS involves the court in the case.	Voluntary services are offered. If parents do not participate, the case is either closed or switched to another type of response.

At the same time, families coming into the system were experiencing multiple and increasingly complex problems, such as co-occurring substance abuse, mental health, and domestic violence issues. As the numbers and severity of cases overwhelmed CPS agencies, many States adopted narrower definitions for forwarding a report on for formal investigation, and those investigations became more rigorous (Daro, Budde, Baker, Nesmith, & Harden, 2005). These conditions combined to create seemingly conflicting objectives for CPS: investigate and sanction

perpetrators of maltreatment, while providing therapeutic and support services to families to address complex problems (U.S. Department of Health and Human Services, 2001).

In this context, a growing dissatisfaction with traditional CPS practices contributed to the emergence of differential response systems. This dissatisfaction reflects several perceived shortcomings in a system focused predominantly on investigation, including:

- **Limited capacity for response.** While every State has legal mandates for CPS to

<sup>1</sup> Adapted from Schene, 2005, p.5.

respond to all legitimate reports of child abuse and neglect, overwhelmed agencies with heavy caseloads and limited resources cannot thoroughly consider risks and needs in all accepted reports. Some legitimate reports—frequently those judged to be of lower risk or severity—are screened out or closed without further action.

- **Adversarial orientation.** Investigations help CPS to identify victims and provide evidence for prosecution of perpetrators in the most severe cases. Parents and caregivers often, understandably, perceive investigations as accusatory and are fearful of the threat of out-of-home placement of their children if they agree to receive in-home services while being monitored by the investigative agency. This can make parents less willing to accept services and less motivated to change their behavior.
- **Low rates of services.** Some argue that many families are inappropriately subjected to intrusive interventions that lead to little in the way of services. Nationally, less than 30 percent of reports of suspected child maltreatment result in substantiation of abuse or neglect, and even fewer are opened for ongoing services.
- **Family problems not addressed.** Although immediate safety issues are normally resolved before a CPS case is closed, the underlying causes for those threats to safety frequently are not. As a result, many families experience subsequent maltreatment reports while their problems, stresses, and issues remain unresolved.

As a result of these issues, CPS agencies with a focus on investigation have been perceived both as being overly intrusive into family life and as not doing enough to protect children

(Schene, 2005; Schene, 2001; Farrow, 1997; Waldfogel, 1998; Orr, 1999).

The child welfare community has been open to approaches that can be more immediately helpful to families and that can promise more lasting change. Differential response developed largely as a way to overcome the limitations identified in the traditional response by differentiating among the types of situations reported, recognizing that adversarial investigations can create barriers to working with families effectively, and finding ways to protect children and stabilize families through comprehensive assessments followed by connections to existing community-based services and supports.

### **Recognition of the Importance of Family Engagement**

A second force behind the emergence of differential response is a growing recognition of the importance of family-centered practice and, specifically, family engagement. Family-centered practices, such as family team meetings, are generally understood to improve the level of cooperation with services compared to investigations that lack more comprehensive assessments and individualized service planning. Family involvement in the assessment and service planning process fosters a shared understanding about how the family got to the point of a maltreatment report, what needs to change, what services might help, and who is expected to do what, by when. Differential response systems leverage opportunities to engage families, identify motivations to change, build on family strengths, and involve extended family networks and community supports in protecting children (Schene, 2005).

## Increased Focus on Accountability and Outcomes

A third factor in the evolution of differential response systems is the growing interest in establishing accountability for agency actions beginning with the passage of the 1994 amendments to the Social Security Act. The introduction of the Child and Family Services Reviews (CFSRs) has heightened awareness within the child welfare community that the work of child protection should be measured against the outcomes of safety, permanency, and child well-being. The findings of the initial round of reviews indicated serious deficiencies in most jurisdictions in the area of assessments of children and families and indicated that improvements in this area could lead to better outcomes. As a result, many jurisdictions are paying attention to the value of responding more individually to reports and learning more about what has to change in each family to achieve and sustain a better end result.

## Experience in the Field

During the past two decades, differential response systems have been implemented in more than two dozen States across the country. Some jurisdictions are still in the early stages of implementation, with just a few pilot sites, while others are expanding or institutionalizing their systems statewide. This section discusses what we know about States and local agencies that have adopted differential response, what those systems have in common, and how they differ.

## Prevalence

According to *The National Study of Child Protective Services Systems and Reform Efforts* (U.S. Department of Health and Human Services, 2003a), 20 States had identifiable policies in 2001 that reflected differential or alternative response.<sup>2</sup> The policy review portion of the study noted that 11 States had implemented the approach statewide, although not uniformly, while in other States differential response was available only in demonstration or pilot sites (U.S. Department of Health and Human Services, 2003a).

The local agency survey of the same study found that approximately two-thirds (64 percent) of local agencies nationwide (1,660) were conducting both investigations and some alternative to investigation (U.S. Department of Health and Human Services, 2003b). While 2001 is the last year for which such Federal data were collected, similar reforms have since been adopted or are being considered by additional agencies.

Between 2005 and 2006, American Humane and the Child Welfare League of America (CWLA) conducted a study of differential response to build upon the 2003 *National Study of Child Protective Services Systems and Reform Efforts*.<sup>3</sup> Their report includes State and county profiles of differential response efforts, as well as responses from some States/counties to a descriptive survey on the topic (Merkel-Holguin, Kaplan, & Kwak, 2006). It identified 15 States with differential response initiatives, as well as 3 States whose previous

<sup>2</sup> *The National Study of Child Protective Services Systems and Reform Efforts* used the following definition of alternative response: "a formal response of [the] agency that assesses the needs of the child or family without requiring a determination that maltreatment has occurred or that the child is at risk of maltreatment."

initiatives were no longer active at the time of the study.<sup>3</sup>

Some States also include differential response in statute. As of April 2006, 11 States had statutes that *require* the use of differential response systems, in which more serious child abuse and neglect cases are assigned to be investigated while less serious cases are assigned to family assessment (Child Welfare Information Gateway, 2006).

Drawing on the above sources, the table in Appendix A identifies States with differential/alternative response policies or practice protocols, those that had related statutes in 2006, and those that have implemented differential response statewide or in more limited areas. States that previously had a differential response system but are not currently operating under the system, that have incorporated some elements of differential response into their system, or that are operating a pilot project but do not have a formal differential response system are noted in the last column. Given the current interest in differential response, more States may soon be added to this list.

### Common Characteristics

Regardless of where they are implemented, differential response systems tend to be:

- **Assessment focused.** The primary focus tends to be on assessing families' strengths and needs. Substantiation of an alleged incident is not the priority.

<sup>3</sup> The study's authors acknowledge there is great variation in State and county implementation of differential response, but they define it generally as a system in which "low- and moderate-risk cases receive a non-investigation assessment response without a formal determination or substantiation of child abuse and neglect."

- **Individualized.** Cases are handled differently depending on families' unique needs and situations.
- **Family-centered.** They use a strengths-based, family engagement approach.
- **Community oriented.** Families on the assessment track are referred to services that fit their needs and issues. This requires availability and coordination of appropriate and timely community services and presumes a shared responsibility for child protection.
- **Selective.** The alternative response is not employed when the most serious types of maltreatment are alleged, particularly those that are likely to require court intervention, such as sexual abuse or severe harm to a child.
- **Flexible.** The response track can be changed based on ongoing risk and safety considerations. If a family refuses assessment or services, the agency may conduct an investigation or close the case.

### Variations in Approaches Across States

Despite sharing some basic characteristics, a differential response system in one State may look very different from a system in another State. Differential response systems vary in the following ways (Schene, 2001):

#### Number of tracks or paths of response.

Initially, differential response systems reflected only two tracks—assessment and investigation. Over time, some States saw the value of multiple tracks. States with three tracks (e.g., Wyoming) frequently have:

1. An *investigation* track to determine if abuse or neglect took place and provide intervention to stop the maltreatment
2. An *assessment* track to evaluate family strengths and needs and provide services to address needs
3. A *prevention* track for cases with no clear allegations of abuse or neglect but identified risk factors and a need for services

In West Virginia, a variation of the three-track approach includes a “safety check” by a CPS worker as part of the assessment/services track. Other States (e.g., Kentucky) have incorporated as many as four tracks, including one for law enforcement response (when the alleged perpetrator is not the caretaker). Some States have added or eliminated tracks over time.

**When the track is selected.** Often the response track is identified immediately when the report is accepted or screened in. Some States, however, choose to conduct an initial standardized CPS assessment/investigation and then, based on what is found, determine which track to pursue.

**Who responds to initial reports.** In some States, all initial reports are handled by CPS, while in others the initial response to some reports is handled by a community agency. For example, the public health system might immediately receive a report for assessment if it is clear that substance abuse evaluation and treatment will be needed.

**Ongoing CPS involvement.** In some States, once the decision is made to pursue a more voluntary approach, the case is closed to CPS and opened by a community agency. In other

States, CPS remains involved and works in partnership with the community agency. In still others, the case is never opened by CPS and goes directly from the reporting hotline to the community agency.

As more States implement differential response, the number of patterns and variations is likely to increase.

## Evaluation Findings

With any systems reform effort, evaluation is critical to understanding whether the program is being implemented as intended, assessing overall effectiveness, and identifying and sharing lessons learned. Several States—including Florida, Minnesota, Missouri, North Carolina, Texas, Virginia, and Washington—have conducted evaluations of their statewide or pilot differential response systems. In addition, the first large-scale, multistate study was published in 2005 (Shusterman et al.) based on an analysis of case data reported from six States (Kentucky, Minnesota, Missouri, New Jersey, Oklahoma, and Wyoming) to the National Child Abuse and Neglect Data System (NCANDS).

Overall, the evaluations of differential response systems have demonstrated positive outcomes, particularly in terms of sustained child safety, improved family engagement, increased community involvement, and enhanced worker satisfaction. Evaluations of pilot programs have generally led to decisions to expand implementation. Several evaluations, however, noted that continuing problems with the adequacy of resources such as staffing and services limited both

implementation and the degree of positive change.

Specific findings from these evaluations are presented below as they relate to the following topics:

- Referral and substantiation
- Child and case characteristics
- Child safety
- Investigations and prosecution
- Services to families
- Family satisfaction and engagement
- Cost effectiveness
- CPS staff perspectives and issues

### Referral and Substantiation

The research revealed:

- **The proportion of reports diverted to an alternative response varied greatly across States.** The multistate study found that during 2002, referrals ranged from a low of 20 percent to a high of 71 percent across the six States studied. An analysis of multiyear trends suggested that States were experiencing growth or steady use of the alternative approach over time (Shusterman et al., 2005).
- **The proportion of investigations that were substantiated increased** (Loman & Siegel, 2004a; Virginia Department of Social Services, 2004). This reflects the inclusion of a larger share of serious cases in the investigation track after less serious cases were diverted to receive services, which is in line with the stated intentions of differential response systems (Shusterman et al., 2005).

- **Differential response resulted in a decrease in the numbers of both victims and nonvictims identified by States.** The amount of the decrease varied by State, however, and in one State the number of nonvictims increased (Shusterman et al., 2005). Decreases are to be expected given that cases on most assessment tracks do not require a decision on substantiation.

### Child and Case Characteristics

Research on child and case characteristics noted:

- **An alternative response was more likely to be used for cases with less immediate safety concerns, and less likely to be used in sexual abuse cases** (Shusterman et al., 2005; Virginia Department of Social Services, 2004; Loman and Siegel, 2004a; U.S. Department of Health and Human Services, 2003a). This finding is consistent with the stated intentions of differential response systems. While both the multistate study and single-State research found that the link between maltreatment type and referral track was strong, the relationships varied across States (Shusterman et al., 2005).
- **Older children generally were more likely to receive an alternative response**, while younger children were more likely to be assigned to investigation (Shusterman et al., 2005; Siegel & Loman, 2000; Chipley, Sheets, Baumann, Robinson, & Graham, 1999; English, Wingard, Marshall, Orme, & Orme, 2000). This suggests that track assignment may take into account the greater vulnerability of younger children.
- **Children and families who were referred to an alternative response were similar**

**in demographics (e.g., gender, race, ethnicity, family structure) to those who received traditional investigations** (Shusterman et al., 2005; English et al., 2000; Siegel and Loman, 2000).

- **Prior victimization was often related to a decreased likelihood of an alternative response**, but not in all States (Shusterman et al., 2005).
- **Referrals from social workers, medical personnel, and legal or criminal justice sources were less likely to receive an alternative response.** Referrals from parents, relatives, friends, schools, or the children themselves were more likely to be referred to an alternative response (Shusterman et al., 2005; English et al., 2000).

## Child Safety

The ability of differential response systems to protect child safety is a significant concern. Research findings suggest that:

- **Child safety was not compromised under differential response systems.** Single State studies revealed that children whose cases received an alternative response were less likely or as likely as children who received an investigation to be the subject of a subsequent report or investigation (Chiple et al., 1999; English et al., 2000; Loman & Siegel, 2004a; Loman & Siegel, 2004b; Virginia Department of Social Services, 2004; Center for Child and Family Policy, 2004). Likewise, the multistate study found that the rate of recurrence within 6 months was comparable for children whose cases received an alternative response versus investigation; in Oklahoma, the likelihood of receiving a subsequent CPS response

within 6 months was *lower* for children receiving alternative response (Shusterman et al, 2005).

- **Safety was maintained even when comparable families were randomly assigned to tracks.** In an experimental study conducted in Minnesota, families randomly assigned to assessment were significantly less likely to be re-reported than families randomly assigned to investigations (27 percent versus 30 percent) (Loman & Siegel, 2004b).
- **Increased services to families lowered recurrence.** Analyses using Minnesota's experimental design support this expected outcome. In addition, the nonadversarial and participatory approach to families was linked to reduced recurrence whether or not services were delivered (Institute of Applied Research, 2005).

## Investigations and Prosecution

Limited research has focused on investigations and prosecution. Findings thus far suggest:

- **States differed widely in the extent to which the existence of an alternative response option resulted in fewer investigations** (Shusterman et al, 2005).
- **The use of a differential response system improved investigations and increased criminal arrests** in one State. A recent study (Loman, 2005) examined the arrests in cases of child sexual abuse and severe and moderate physical abuse in Missouri's differential response system, which diverts the majority of other reports to a nonadversarial home visit. The study found that limiting the number of investigations led to more intense investigations and a

greater likelihood of criminal prosecution of perpetrators of the more serious offenses.

## Services to Families

Research on services provided to families on the assessment track showed:

- **Services were provided more often to children and families on the assessment track** (Shusterman et al, 2005; Loman & Siegel, 2004a; Virginia Department of Social Services, 2004; Hernandez & Barrett, 1996). In Minnesota, for example, 54 percent of families on the assessment track received specific services (other than case management), compared to 36 percent of families on the investigation track (Loman & Siegel, 2004a).
- **The number of services received by families on the assessment track was greater than on the investigation track.** Linkages of families to funded and unfunded community providers increased in both Minnesota and Missouri (Loman & Siegel, 2004a; Loman & Siegel, 2004b). In addition, the types of services delivered to families shifted in both States toward family support services related to basic financial needs (Institute of Applied Research, 2005).
- **Services may be provided to families earlier on the assessment track.** Missouri found that services occurred in a more timely manner under differential response (service activity was initiated on average within 17 days in the pilot areas, versus 35 days for comparison families) (Siegel & Loman, 2000).
- **Greater use of community resources** was reported in pilot areas of at least three States (Florida, Minnesota, and Missouri)

(Siegel and Loman, 2000; Loman & Siegel, 2004b; Hernandez & Barrett, 1996). One evaluation report, however, indicated that community agencies were not always able to make contact with families or make contact within time frames anticipated by CPS (Washington State DSHS, 2005).

- **Children were more likely to be placed in foster care if they received investigations,** in several but not all States (Shusterman et al., 2005; Virginia Department of Social Services, 1999; Chipley et al., 1999; Loman & Siegel, 2004b). Recurrence of maltreatment resulting in removal declined for families receiving alternative response in the Minnesota study, but no corresponding evidence could be found in the Missouri study (Institute of Applied Research, 2005).

## Family Satisfaction and Engagement

A few States conducted surveys to explore family and worker perspectives on family satisfaction and engagement. They found:

- **Families reported satisfaction with the differential response system** in Minnesota, Missouri, North Carolina, and Virginia (Loman & Siegel, 2004a; Siegel & Loman 2000; Center for Child and Family Policy, 2004; Virginia Department of Social Services, 1999). Further, the Minnesota families receiving alternative response reported that they were treated in a friendly and fair manner, were listened to by workers, were connected to other community resources, and benefited from the CPS intervention more often than families receiving a traditional response. These same families more often reported being hopeful and encouraged (Loman & Siegel, 2005).

- **The family's sense of participation in decision-making increased in several States** (Loman & Siegel, 2004a; Loman & Siegel, 2004b). In Minnesota, 68 percent of assessment families said they were involved a great deal in decisions that were made about their families and children, compared to 45 percent of control families (Loman & Siegel, 2005). In Virginia, families were included in planning for services in 95 percent of assessments and 67 percent of investigations (Virginia Department of Social Services, 1999).
- **Workers reported families were more cooperative and willing to accept services.** In Minnesota, for example, workers rated the primary caregiver as uncooperative in less than 2 percent of assessment families, compared to 44 percent of control families (Loman & Siegel, 2005). In Missouri, it was hypothesized that cooperation between families and the child welfare agency was linked to the more positive and supportive orientation and earlier service contacts (Siegel & Loman, 2000).

### Cost Effectiveness

A cost analysis showed promising results:

- **Differential response appears to be cost effective over the long term.** Minnesota's cost-effectiveness study suggested that costs of alternative response in the early stages of a case, including worker time during case opening, were greater than in traditional CPS interventions. However, costs for case management and other services following the closing of the initial case through the end of the follow-up period were lower. Savings achieved later

more than offset investment costs early on and, as such, total costs were less for the alternative response cases than the control cases (Loman & Siegel, 2005).

### CPS Staff Perspectives and Issues

Surveys and interviews with CPS staff underscore:

- **CPS staff like the differential response approach.** In Missouri, workers and community representatives preferred the family assessment approach (Loman & Siegel, 2004a). North Carolina social workers and supervisors overwhelmingly agreed that the differential response system was a more respectful way to serve families and allowed them to consider all family circumstances (Center for Child and Family Policy, 2004). Virginia CPS staff also expressed favorable views of their multiple response system (Virginia Department of Social Services, 1999).
- **Large caseloads and limited resources are obstacles to differential response effectiveness.** Missouri's evaluation concluded that the impact of the demonstration was mitigated by large caseloads and limited resources. Although the results of the evaluation favored the family assessment approach over the traditional CPS approach, the effects were relatively modest. To achieve greater impact, the evaluators recommended reducing worker caseloads, as well as increasing and accelerating community development activities and resources (Loman & Siegel, 2004a). In North Carolina, staff members experienced increased challenges in managing cases while working with new reports, leading to increased

stress levels. Evaluators recommended limiting caseload sizes to six to eight families per worker or implementing team models (Center for Child and Family Policy, 2004).

- **Training is needed.** The Virginia evaluation led to some specific recommendations for program expansion, including providing training for both frontline staff and administrators to communicate changes to other agencies and the community (Virginia Department of Social Services, 1999). Similarly, North Carolina evaluators called for additional and better training for line staff, supervisors, and management.

## Opportunities for Improving Child Welfare Practice

As mentioned earlier, the CFSRs conducted nationwide by the Children’s Bureau have underscored some specific areas of weakness in CPS practices, including:

- Comprehensive assessment and identification of strengths and needs
- Family involvement in the service planning process
- Availability and accessibility of services for families and children, and inconsistent services to address risk, especially for in-home cases
- Timeliness of response to lower-risk reports

Differential response systems, and in particular the assessment tracks of these systems, offer opportunities for CPS agencies to address

these weaknesses and improve child welfare practice.

### Improved Assessment

One distinctive feature of the assessment track is that its focus is broader than the allegations in the referral or the specific incident leading to the report. Staff move away from a focus on “what happened” toward a process that seeks to understand the child and family’s broader needs. The assessment process looks for strengths within the child and family, as well as factors contributing to the child’s vulnerability and underlying issues that keep parents from being able to sustain safe, supportive parenting.

### Family-Centered Practice

Assessment tracks reflect the values of family-centered practice and family engagement. Program evaluations, particularly in Minnesota and Virginia, point to routine involvement of families in both assessment and service planning. Since services are voluntary, workers must engage families in order to secure their participation in interventions. Engagement involves gaining the family’s perspective on problems and learning what they feel would help them to make changes. This results in more dialogue during service plan development within assessment tracks than in typical investigatory practice.

### Enhanced Service Delivery

Evaluations of differential response systems have shown that families tend to receive services sooner within assessment tracks compared to investigations, and the level of service provision seems to be more robust. There are several potential reasons for this:

- Although many traditional systems are permitted to serve families even when an investigation is not substantiated, their ability to do so is restricted by resource availability. Moreover, the adversarial nature of investigation undermines some parents' motivation to participate in case planning and avail themselves of services.
- Traditional practice focuses the majority of service provision on foster care cases, rather than in-home cases, according to the CFSR findings. Within assessment tracks, a larger percentage of in-home cases (which constitute the majority of cases referred for assessment versus investigation) receive services.
- Evaluations of differential response have demonstrated that children can be just as safe or safer without an adversarial investigation to initiate intervention. In cases of lower risk, workers can begin to explore needs and offer services without stopping to undertake an investigation, resulting in more timely services and more efficient use of staff time.

### Potential for Earlier Intervention and Prevention

Responding to the large volume of child maltreatment reports early enough to make a difference in the lives of children and families is a major objective of differential response efforts. Many of the cases on assessment tracks are lower risk cases that might have been screened out or closed after one contact if an alternative to investigation were not available. Some of these cases are known to reappear later with more serious allegations. Differential response offers the opportunity for

earlier intervention and possible prevention of child abuse or neglect.

### Guiding Principles for Implementation

Lessons learned from research and experiences with differential response can help move the field forward. Child welfare administrators and policymakers may benefit from the following considerations when implementing or expanding differential response systems at the State or local levels:

**Address the core concerns of child safety and risk.** It is important to remember that all of the children and families served, regardless of assigned track, have been reported to CPS for potential maltreatment and their cases have been screened in as legitimate referrals. As such, all of these situations warrant an assessment of both the children's safety and the parents' capacity and willingness to participate in protective interventions. CPS systems must take care to ensure that initial contacts, even if made by another agency, address safety and risk.

**Implement systematic structures for selecting a response track and allowing changes.** When and how the choice of response track is made has important practice implications. Tracks should be assigned based on a careful assessment of the family's safety, needs, and resources. Experience indicates that track changes are very infrequent—usually less than 2 percent. This may be appropriate, but comprehensive and ongoing assessment of the family often leads to the discovery of information about the family that would not have come to light through a traditional

investigation. This additional information gathered by workers should help them identify when changes in track assignments are warranted, particularly to protect a child's safety.

**Promote assessments that explore underlying conditions and needs.** Differential response is based on the assumption that assessments will be comprehensive and go beyond traditional risk and safety assessments. More comprehensive assessment processes explore the strengths and needs of children and families and develop service plans that respond to underlying issues affecting the child's safety.

**Ensure service availability and strengthen community relationships.** Successful implementation of differential response systems requires the availability of an array of community services to support families. Child welfare agencies implementing differential response have found it helpful to work with community partners to identify and secure services from public and private agencies and help develop additional services as needed. Increasing and diversifying relationships with other service providers may require CPS agencies to address issues such as resource allocation, confidentiality agreements, accountability for shared case management, and co-training of staff.

**Foster natural supports.** Bringing broader systems of support to bear on the protection of children has proven to be a challenging task for some jurisdictions implementing differential response. Identifying, assisting, and nurturing families' informal support systems can complement traditional services to help sustain healthy family functioning and child well-being over time.

**Train staff.** To conduct comprehensive assessments and encourage parents' participation in voluntary services, CPS caseworkers must be skilled in engaging families. Jurisdictions implementing differential response have noted that training administrators, supervisors, and frontline staff is critical to the success of this approach.

**Examine workload impact.** Building trusting relationships, fully exploring strengths and needs, linking families to other services and supports, and developing case plans in partnership with families can take more time than typical caseloads allow. Evaluations in Missouri and elsewhere suggest the full benefit of differential response was not realized because of the counteracting pressures of large caseloads.

**Track outcomes.** States implementing differential response systems learned a great deal from measuring outcomes. Collecting data, tracking outcomes, and conducting rigorous evaluations can help States and local agencies understand the effectiveness of reforms and make mid-course corrections as needed. These efforts can also help shape plans for statewide expansion of pilot programs and communicate benefits to various stakeholders.

**Accommodate and explain changes in data.** Differential response may affect reporting and recurrence data and create apparent oddities in multiyear trends. When a majority of the referrals are not accompanied by a substantiation decision—as is the case with the families not on the investigation track—the proportion of substantiated reports to total reports decreases significantly. The important work done with families whose reports were not substantiated must be accommodated

within existing information systems and communicated to policymakers.

**Tap into lessons learned.** Contact with State and local agencies experienced in implementing differential response can help those who are just starting the process to replicate promising approaches or avoid common mistakes. In addition, the Children’s Bureau’s National Resource Centers and Child Welfare Information Gateway can provide technical assistance and information on a number of topics related to differential response. Selected published reports, many of which are available through Information Gateway, are presented in the final section of this brief. For more information, visit [www.childwelfare.gov](http://www.childwelfare.gov) or call 800.394.3366.

## Conclusion

Differential response has been a positive development in child protection. Evaluations demonstrate that:

- Children are at least as safe as in traditional practice.
- Parents are engaging in services.
- Families, caseworkers, and administrators are supportive of the approach.

While past evaluations shed some light on the effectiveness of this reform, the field needs to continue collecting and analyzing data to improve understanding of how the practices associated with differential response affect outcomes for children and families. Questions for further research may include:

- How vulnerable to further maltreatment are children in families that do not voluntarily participate in services?
- Is there sufficient follow-up for families initially identified as low to moderate risk to prevent more serious situations from developing?
- By engaging parents more comprehensively in making sustainable changes, are children safer in the long term?
- How can States address infrastructure issues, such as worker caseloads and the availability of community resources, to support implementation of this approach?
- How does differential response affect the child welfare agency’s ability and willingness to build and sustain partnerships with community agencies to support families?

Jurisdictions implementing differential response still face hurdles. For example, collaboration and coordination with other agencies and broader community stakeholders is an area likely to receive more attention as CPS shares more of the responsibility for the protection of children with local communities. In addition, limited resources—including services, supports, and time for caseworkers to facilitate connections to these resources—will be a continuing challenge.

Nonetheless, building from lessons learned, States and agencies continue to move forward, refining existing differential response systems and expanding into new jurisdictions. And, as they do, they draw upon flexible, family-centered practices and community resources to more effectively strengthen our nation’s families and promote the safety and well-being of children.

## For More Information

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**Appendix A**  
**States With Policies, Practices, and Statutes Reflecting**  
**Differential/Alternative Response**

State	Identified in Policy/Practice Protocols	Authorized by Statute	Statewide Implementation	Local/County/Regional Implementation	Other Experience*
Alaska	X			X	
Arizona					X
California				X	X
Delaware		X			
Florida				X	X
Georgia	X		X		
Hawaii	X		X		
Idaho	X				
Iowa					X
Kansas	X		X		
Kentucky	X	X	X		
Louisiana	X	X		X	
Maine	X		X		
Massachusetts					X
Michigan			X		X
Minnesota	X	X	X		
Missouri	X	X	X		
Nevada	X				
New Jersey		X		X	
New Mexico					X
North Carolina	X	X	X		X
North Dakota					X
Oklahoma	X	X	X		
Pennsylvania	X	X	X		
South Carolina					X

State	Identified in Policy/Practice Protocols	Authorized by Statute	Statewide Implementation	Local/County/Regional Implementation	Other Experience*
South Dakota	X		X		
Tennessee	X	X		X	
Texas					X
Utah	X				
Vermont	X		X		
Virginia	X	X	X		
Washington	X		X		
West Virginia	X			X	
Wisconsin					X
Wyoming	X	X	X		
<b>Total</b>	<b>22</b>	<b>12</b>	<b>16</b>	<b>7</b>	<b>12</b>

\**Other experience* includes States that previously had a differential response system but are not currently operating under the system. It also includes States that have incorporated some elements of differential response into their system or that are operating a pilot project but do not have a formal differential response system.

## Appendix B State Contacts Regarding Differential/Alternative Response

As noted in the text, some States are no longer using differential/alternative response, others are considering introducing it, while in other States it has become a formal part of the child protection system. The following individuals are either directly involved in differential response in their State or can provide information on previous or planned differential response efforts.<sup>4</sup>

### **Alaska**

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Office of Children's Services  
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### **Arizona**

Carolyn Rice  
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### **California**

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### **Delaware**

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### **Florida**

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### **Idaho**

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<sup>4</sup> Information current as of July 2007.

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**South Dakota**

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**Child Welfare  
Information Gateway**

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

Child Welfare Information Gateway  
Children's Bureau/ACYF  
1250 Maryland Avenue, SW  
Eighth Floor  
Washington, DC 20024  
703.385.7565 or 800.394.3366  
Email: [info@childwelfare.gov](mailto:info@childwelfare.gov)  
[www.childwelfare.gov](http://www.childwelfare.gov)

**Suggested Citation:** Child Welfare Information Gateway. (2008). *Differential Response to Reports of Child Abuse and Neglect*. Washington, DC: U.S. Department of Health and Human Services



# Children's Mental Health Initiative (CMHI) Update

Presentation to the Department of Child Services Interim Study Committee  
October 23, 2013

Gina Ashley, Deputy Director of Placement Support and Compliance

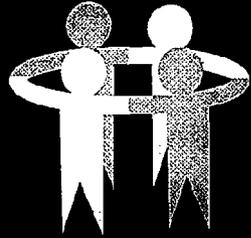


# CMHI Rollout

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## **7 Access Sites serving 18 counties:**

- November, 2012- Community Mental Health Center in Dearborn County:
  - Serving Dearborn, Decatur, Ripley, Ohio, Switzerland and Franklin counties.
- January, 2013- Oaklawn
  - Serving St. Joseph and Elkhart county.
- March, 2013- Aspire
  - Serving Boone, Hamilton and Madison county.
- August 2013- Hamilton Center and Bowen Center
  - Serving Vigo, Marshall , Kosciusko, and Wabash county.
- September, 2013- Adult & Child, Bowen Center, Center stone and Park Center
  - Serving Johnson, Whitely, Allen, and Morgan county.



INDIANA  
DEPARTMENT OF  
CHILD  
SERVICES

# **Safely Home, Families First**

Presentation to the Department of Child  
Services Interim Study Committee  
October 23, 2013

Gina Ashley, Deputy Director of Placement  
Support and Compliance



# DCS Vision, Mission & Values

---

DCS Vision: Children thrive in safe, caring, and supportive families and communities.

DCS Mission: To protect children from abuse and neglect, by partnering with families and communities.

DCS Values:

- Every child:
  - Right to be free from abuse/neglect.
  - Right to appropriate care/permanent stable home with families (when safe).
- Every parent:
  - Primary responsibility for the care & safety of their children.
- Every person:
  - Has value, worth and dignity.



# Practice Development

---

- Practice model serves as Indiana's blueprint for building DCS:
  - Teaming- Bringing supports and families together.
  - Engaging- Establishing relationships (child & parents).
  - Assessing- Obtaining and analyzing information.
  - Planning- Identifying unique steps to productive outcomes.
  - Intervening- Actions taken to promote safety and well-being.



# Safely Home, Families First

---

- What is Safely Home Families First?
  - A reaffirming of the effort to keep children at home, or with relatives when they can't safely remain at home.
- What is “Safely Home”?
  - DCS always evaluates what can be done to keep a child in their own home safely.
- What is “Families First”?
  - When a child must be removed from their home , DCS first looks for family members for a placement.



# Safely Home, Families First

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## Why?

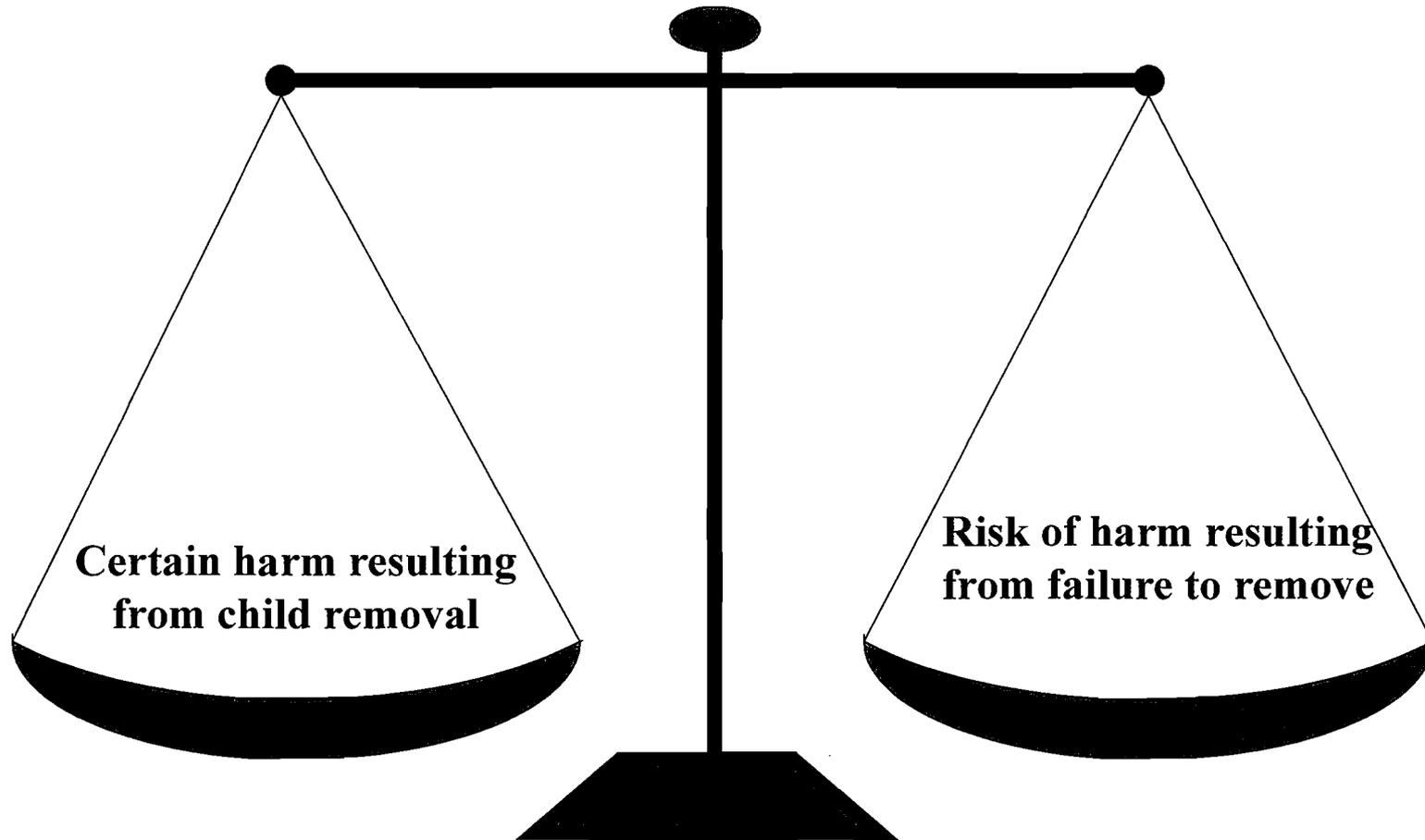
- IC 31-34-4-2 requires DCS to consider relative placement before considering any other out of home placement.
- National research shows better outcomes, shorter case lengths, and fewer traumatic effects of removal when children are placed with relatives.



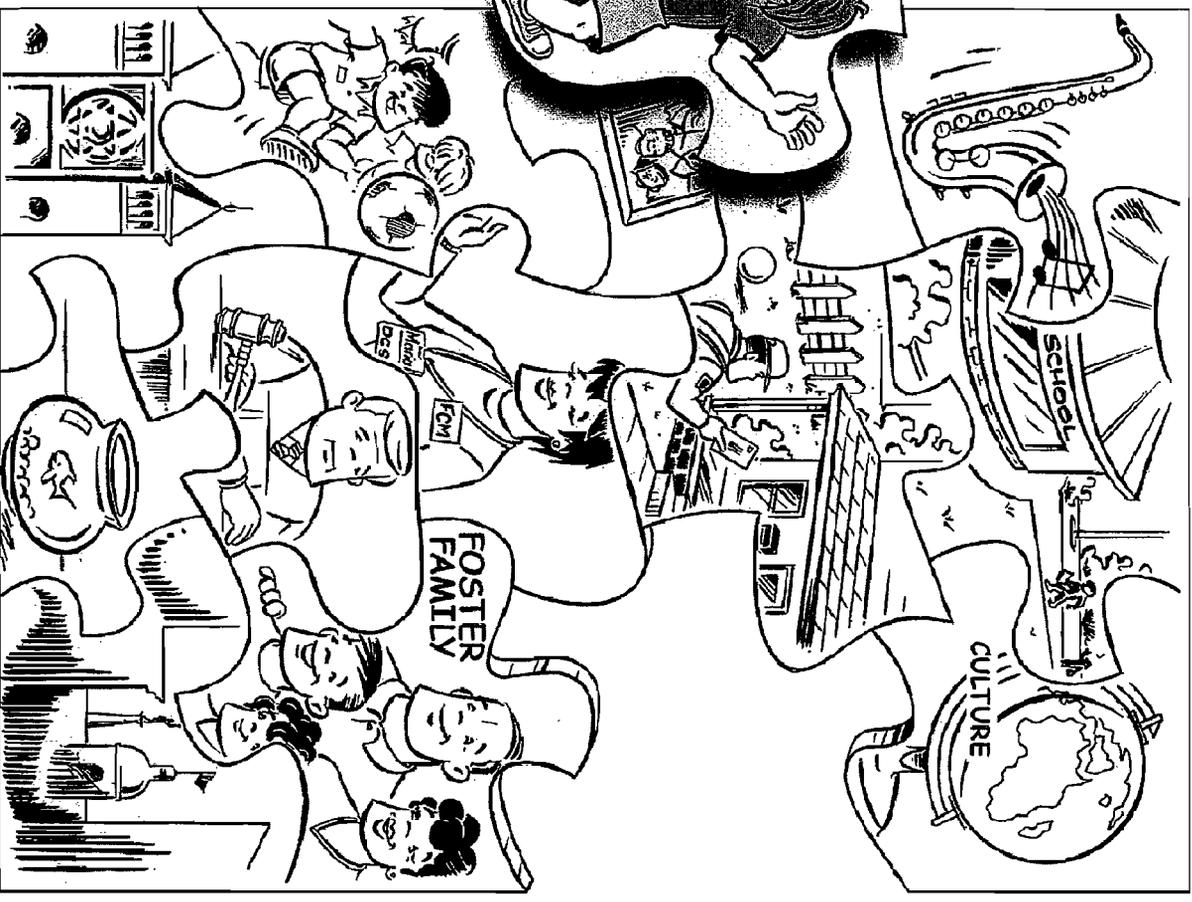
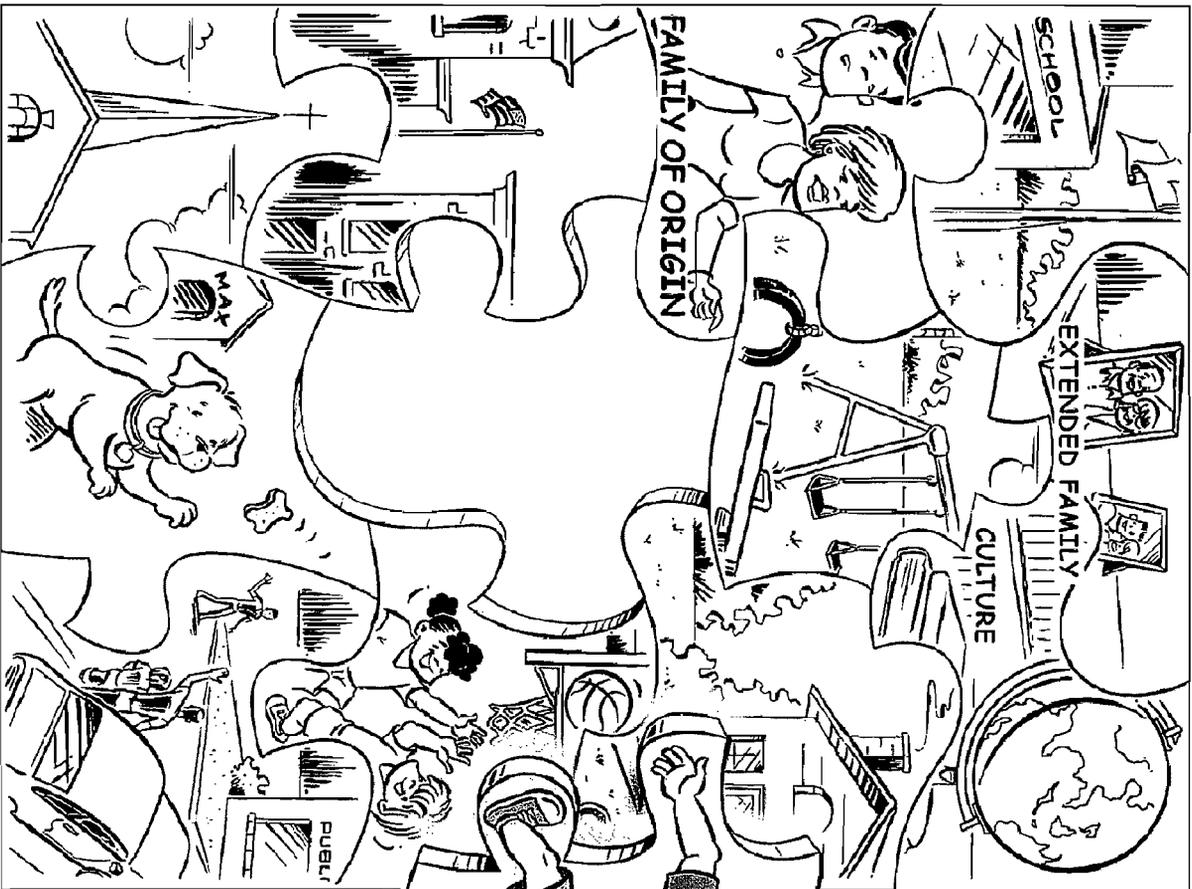
# Safely Home, Families First

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Use protective factors to make safety decisions- *weighing potential outcomes.*



# One Child, Two Worlds: Where Do I Fit? How Do I Fit?



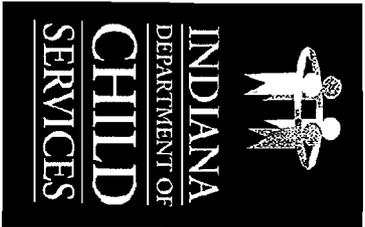


# Safely Home, Families First

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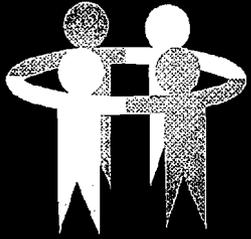
## **Supporting families:**

- Expansion of in-home support services, wraparound services, intensive family preservation, intensive family reunification and others.
- Services need to be available in a timely manner with the flexibility to adjust to the needs of the family.



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**Questions?**



INDIANA  
DEPARTMENT OF  
CHILD  
SERVICES

# Collaborative Care

Presentation to the Department of Child  
Services Interim Study Committee  
October 23, 2013

Alishea Hawkins,  
DCS Assistant Deputy Director of Services and Outcomes



# Background

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- The Federal Fostering Connections to Success and Increasing Adoptions Act of 2008 offers states the option to extend foster care past age and 18 and receive federal support.
- Youth outreach and focus groups.
- Research:
  - Trauma Informed Care (Jim Casey Youth Opportunity Initiative, 2012)
  - The Adolescent Brain (JCYOI, 2011)
  - Authentic Youth Engagement (JCYOI, 2011)
  - Relational Permanency (Samuels, 2008)
  - Midwest Study (M. Courtney, 2005, 2007, 2010)



# Indiana's Approach

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Foster Care at age 18, 19, 20 should be different than Foster Care at age 8, 9, and 10.

*“...it's like the system and youth are coming together to collaborate. Why not call [the program] Collaborative Care”*

- IN Foster Care Alumni responsible for naming the Collaborative Care program



# What is Collaborative Care?

---

- Extension of Foster Care until the day before the youth turns 20 years of age.
  - Continuation
  - Re-entry
- Services designed to foster *interdependence* vs. independence.
- Program Approach:
  - Youth Voice
  - Youth-Adult Partnerships
  - Relational Permanency
  - Social Capital
  - Adolescent Brain



# What is Collaborative Care?

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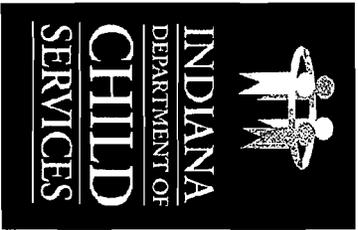
- Placement
  - Traditional foster care
  - Supervised Independent Living
- Specialized Family Case Managers
  - Called Collaborative Care Case Managers (3CMs).
  - Receive specialized training and handle a caseload of youth 17.5 years of age and older only.



# Eligibility

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- Collaborative Care Eligibility:
  - Enrolled and attending an education or vocational program, or
  - Working 80 hours per month, or
  - Participating in a program to remove barriers to education or employment (ex: work one), or
  - Medically unable to attend education program or employment, as documented in the case plan.



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# Questions?

To: The members of the Commission on Improving the Status of Children in Indiana

From: The members of the Child Services Oversight Committee

Date: October 23, 2013

Re: Report of recommendations to improve the delivery of child protection services

### **I. Directive to the Child Services Oversight Committee**

The Child Services Oversight Committee (Committee) is required under IC 2-5-36.1-8(a) to submit to the Commission on Improving the Status of Children in Indiana (Commission) an annual report before November 1 making recommendations regarding improving the delivery of child protection services in Indiana.

The Committee met two times in 2013, on July 31 and October 23. The final report and other documents for the Committee can be accessed from the General Assembly Homepage at <http://www.in.gov/legislative/>.

### **II. Recommendations to Improve the Delivery of Child Protection Services in Indiana**

The Indiana statutes establishing the Committee and Commission came into effect on July 1, 2013. Given the limited amount of time that the Committee has had to review information regarding the delivery of child protection services and that the Department of Child Services has had to implement changes recommended during the 2012 interim and 2013 legislative session, the members of the Committee have only two recommendations, as follows:

- (1) Study system response to newborns born with drugs in their systems.
- (2) Continue to monitor and review the changes that have been recommended to the Department of Child Services, which the Department of Child Services has begun to implement. A list of these changes is attached as Attachment A.

The members of the Committee approved these recommendations to the Commission in a vote of \_ to \_ at the October 23, 2013 meeting.



## Department of Child Services (DCS) Study Committee Initiative Update

April 1, 2013

### 1. DCS Provider E-Invoicing

- **What is e-invoicing?**
  - E-invoicing provides a streamlined billing process that allows DCS providers to enter a claim directly into the DCS payment system, rather than completing and mailing a hard copy of the invoice to DCS.
- **Advantages of e-invoicing:**
  - Reduced processing time.
    - During the pilot phase providers utilizing e-invoicing received payment 15 days faster than those mailing hard copies of their invoices to DCS.
  - Immediately identifies many errors before a provider submits their claim, giving the provider the opportunity to immediately correct the error.
- **Statewide rollout:**
  - Pilot- Jan/Feb 2013: 28 providers began using e-invoicing.
  - Phase 1- April 1<sup>st</sup>: 61 additional providers will begin using e-invoicing.
  - Phase 2- May 1<sup>st</sup>: 116 additional providers will begin using e-invoicing.
  - Phase 3- June 1<sup>st</sup>: 117 remaining providers will begin using e-invoicing.
- **Preparation for each phase includes:**
  - Notification of providers participating in each phase.
  - Training sessions provided during two weeks prior to each phase. One in Indianapolis and one in a local location.

### 2. Updated DCS Hotline Process

- DCS updated the child abuse and neglect report intake process, effective March 5:
  - All reports of child abuse and neglect will still be made to the Indiana Child Abuse and Neglect Hotline.
  - The Hotline will receive and document the report, and send it to the DCS Local Office where a decision will be made on whether or not to assess the report.
- While all reports will still be made to the Hotline, the final decision on whether or not to assess a report is now completely in the hands of the local office.
- This new process does not interrupt any current procedures that have been set up at the county level between law enforcement and a Local DCS office.

### 3. Mental Health Services for Children Program

- **What is the program?**
  - DCS is in the process of rolling out a program to provide state- funded services to children with severe mental-health needs that do not have access to private insurance or Medicaid.
  - In the past these children have ended up in the child welfare or juvenile delinquency system as a mechanism to access services.
  
- **Rollout:**
  - First site: Community Mental Health Center (CMHC) in Dearborn County
    - CMHC began serving Dearborn, Decatur, Ripley, Ohio, Switzerland and Franklin counties on November 19, 2012.
  - Second site: Oaklawn
    - Oaklawn began serving St. Joseph and Elkhart counties on January 22, 2013.
  - Third site: Aspire
    - Aspire will begin serving Boone, Hamilton and Madison counties on March 25, 2013.
  - Future: DCS will continue rolling the program out statewide.
  
- **Funding:**
  - DCS has allocated existing funding and requested additional funds from the legislature, totaling \$25 million dollars annually to support this program.
  - This funding will help DCS ensure that children and families receive the services they need without having to go through court intervention.
  
- **Results:**
  - To date, DCS has received 51 referrals
    - 19 children are currently accessing services through the program,
  - Children that did not meet the eligibility criteria to participate in the program were referred to other services to meet their needs.
    - Many children were already covered by Medicaid and were referred to similar services funded by Medicaid.
    - Some children were already involved with DCS or juvenile probation and therefore accessed similar services through their existing cases.
    - Children were also referred to the Community Partners for Child Safety Program or other appropriate services in their area.

#### 4. Family Case Manager Turnover

- In October 2012 DCS implemented salary increases for DCS field staff to help address increasing FCM turnover.
  - Increase the minimum starting salary for Family Case Managers to \$35,776.
  - Establish a Family Case Manager Trainee classification with a minimum salary of \$33,748.
  - Increase the salaries of the agency's field staff, Family Case Managers (FCM) 6-10% depending upon years of experience.
  - Increase salaries 7% increase for all FCM Supervisors and Local Office Directors.
- While it is still too soon to see the full effect of the salary increases on DCS turnover, data does show improvement in this area.
  - FCM field staff annualized negative turnover:
    - October 2012- 20.3%
    - February 2013- 19.2%
  - FCM Intake Specialist annualized negative turnover:
    - April 2012- 50.8%
    - February 2013- 30.9%

Oct. 23, 2013



STATE OF INDIANA  
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**GREG ZOELLER**  
INDIANA ATTORNEY GENERAL

October 22, 2013

Dear Chairman Yoder and Members of the Committee:

Working side-by-side with medical professionals, the Prescription Drug Abuse Task Force is raising public awareness for what has become a new epidemic of neonatal opiate withdrawal. The Task Force has identified significant strides that need to be taken with respect to combatting Neonatal Abstinence Syndrome otherwise known as NAS which is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb. According to the Substance Abuse and Mental Health Services Administration, the rate of illicit drug use among pregnant women age 18 to 25 is 7.4%, and among pregnant teens is measured as high as 16.2%. Health risks associated with NAS include: Miscarriage; Premature Birth; Opioid Dependency; Fetal Brain Development; Prenatal/Postnatal Growth Restriction; Birth Defects; Low Birth Weight; Neurodevelopment Deficits; and Perinatal Death.

The overall rate of newborns being diagnosed with NAS tripled over the past decade. In 2000, NAS was diagnosed at a rate of 1.2 per 1,000 births per year; however, in 2009, the rate was 3.39 per 1,000 hospital births, equivalent to 13,539 total cases. In 2009, approximately one infant born per hour in the United States had signs of drug withdrawal. At birth, the NAS baby is still dependent on the drug and because the baby is no longer getting the drug after birth, symptoms of withdrawal may occur. Signs of NAS can begin within 1-3 days after birth, or they may take 5-10 days to appear. The signs include: Blotchy skin coloring (mottling); Diarrhea; Excessive crying or high-pitched crying; Excessive sucking (hyperphagia); Excoriation of skin due to constant rubbing (nose, knees, elbows, face); Fever; Hyperactive reflexes; Increased muscle tone; Irritability; Poor feeding; Rapid breathing; Seizures; Sleep problems; Slow weight gain; Stuffy nose; Sneezing; Sweating; Trembling (tremors); and Vomiting.

In addition to the impacts on the baby's health which is clearly the primary concern and top priority, NAS is also a very costly disease. Between 2000 and 2009, total hospital charges for NAS cases, adjusted for inflation, are estimated to have increased from \$190 million to \$720 million. The information gathered by the Task Force reflects that mean hospital charges for births with a diagnosis of NAS increased from \$39,400 in 2000 to \$53,400 in 2009 with 77.6% of the charges for NAS being covered by state Medicaid programs.

The Task Force recommends that NAS be addressed by the Indiana General Assembly this session with a focus on support of expanded treatment services and protections for pregnant women with addictions to controlled substances. As such the Task Force recommends that the General Assembly pass legislation requiring NAS to be reported to the ISDH. Additionally, we are considering an Indiana Safe Prenatal Health Care Act, similar to Tennessee's recently enacted Safe Harbor Act. The Act would have the medical professional encourage the pregnant woman to seek appropriate treatment services and inform her that by doing so, she would be provided immunity from civil liability if she seeks and maintains such treatment services during the term of her pregnancy so long as she does so before her 20th week of pregnancy. The challenges faced by this proposal are the shortage of treatment services and addiction treatment professionals, the lack of education and training for physicians on how to care for pregnant women with addiction and the lack of Medicaid coverage for certain types of addiction treatment medications. I am personally interested in this topic and there has been expressed support of NAS-related legislation from several members of the General Assembly. As a result, we are meeting with various stakeholders and working toward incorporating their feedback and gaining their support in order to achieve a balanced approach toward NAS-related legislation. In the event that the Task Force determines that NAS legislation is an appropriate and broadly supported response to this serious problem I would recommend and encourage the Committee to endorse such a legislative effort.

Sincerely,



Gregory F. Zoeller  
Indiana Attorney General

cc: Representative Gail Riecken

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Child Services Oversight  
Committee

Exhibit K

Oct. 23, 2013

To: The members of the Commission on Improving the Status of Children in Indiana

From: The members of the Child Services Oversight Committee

Date: October 23, 2013

Re: Report of recommendations to improve the delivery of child protection services

### **I. Directive to the Child Services Oversight Committee**

The Child Services Oversight Committee (Committee) is required under IC 2-5-36.1-8(a) to submit to the Commission on Improving the Status of Children in Indiana (Commission) an annual report before November 1 making recommendations regarding improving the delivery of child protection services in Indiana.

The Committee met two times in 2013, on July 31 and October 23. The final report and other documents for the Committee can be accessed from the General Assembly Homepage at <http://www.in.gov/legislative/>.

### **II. Recommendations to Improve the Delivery of Child Protection Services in Indiana**

The Indiana statutes establishing the Committee and Commission came into effect on July 1, 2013. Given the limited amount of time that the Committee has had to review information regarding the delivery of child protection services and that the Department of Child Services has had to implement changes recommended during the 2012 interim and 2013 legislative session, the members of the Committee have only two recommendations, as follows:

- (1) Study system response to newborns born with drugs in their systems.
- (2) Continue to monitor and review the changes that have been recommended to the Department of Child Services, which the Department of Child Services has begun to implement. A list of these changes is attached as Attachment A.

The members of the Committee approved these recommendations to the Commission in a vote of \_ to \_ at the October 23, 2013 meeting.



## Department of Child Services (DCS) Study Committee Initiative Update

April 1, 2013

### 1. DCS Provider E-Invoicing

- **What is e-invoicing?**
  - E-invoicing provides a streamlined billing process that allows DCS providers to enter a claim directly into the DCS payment system, rather than completing and mailing a hard copy of the invoice to DCS.
- **Advantages of e-invoicing:**
  - Reduced processing time.
    - During the pilot phase providers utilizing e-invoicing received payment 15 days faster than those mailing hard copies of their invoices to DCS.
  - Immediately identifies many errors before a provider submits their claim, giving the provider the opportunity to immediately correct the error.
- **Statewide rollout:**
  - Pilot- Jan/Feb 2013: 28 providers began using e-invoicing.
  - Phase 1- April 1<sup>st</sup>: 61 additional providers will begin using e-invoicing.
  - Phase 2- May 1<sup>st</sup>: 116 additional providers will begin using e-invoicing.
  - Phase 3- June 1<sup>st</sup>: 117 remaining providers will begin using e-invoicing.
- **Preparation for each phase includes:**
  - Notification of providers participating in each phase.
  - Training sessions provided during two weeks prior to each phase. One in Indianapolis and one in a local location.

### 2. Updated DCS Hotline Process

- DCS updated the child abuse and neglect report intake process, effective March 5:
  - All reports of child abuse and neglect will still be made to the Indiana Child Abuse and Neglect Hotline.
  - The Hotline will receive and document the report, and send it to the DCS Local Office where a decision will be made on whether or not to assess the report.
- While all reports will still be made to the Hotline, the final decision on whether or not to assess a report is now completely in the hands of the local office.
- This new process does not interrupt any current procedures that have been set up at the county level between law enforcement and a Local DCS office.

### 3. Mental Health Services for Children Program

- **What is the program?**
  - DCS is in the process of rolling out a program to provide state- funded services to children with severe mental-health needs that do not have access to private insurance or Medicaid.
  - In the past these children have ended up in the child welfare or juvenile delinquency system as a mechanism to access services.
  
- **Rollout:**
  - First site: Community Mental Health Center (CMHC) in Dearborn County
    - CMHC began serving Dearborn, Decatur, Ripley, Ohio, Switzerland and Franklin counties on November 19, 2012.
  - Second site: Oaklawn
    - Oaklawn began serving St. Joseph and Elkhart counties on January 22, 2013.
  - Third site: Aspire
    - Aspire will begin serving Boone, Hamilton and Madison counties on March 25, 2013.
  - Future: DCS will continue rolling the program out statewide.
  
- **Funding:**
  - DCS has allocated existing funding and requested additional funds from the legislature, totaling \$25 million dollars annually to support this program.
  - This funding will help DCS ensure that children and families receive the services they need without having to go through court intervention.
  
- **Results:**
  - To date, DCS has received 51 referrals
    - 19 children are currently accessing services through the program,
  - Children that did not meet the eligibility criteria to participate in the program were referred to other services to meet their needs.
    - Many children were already covered by Medicaid and were referred to similar services funded by Medicaid.
    - Some children were already involved with DCS or juvenile probation and therefore accessed similar services through their existing cases.
    - Children were also referred to the Community Partners for Child Safety Program or other appropriate services in their area.

#### 4. Family Case Manager Turnover

- In October 2012 DCS implemented salary increases for DCS field staff to help address increasing FCM turnover.
  - Increase the minimum starting salary for Family Case Managers to \$35,776.
  - Establish a Family Case Manager Trainee classification with a minimum salary of \$33,748.
  - Increase the salaries of the agency's field staff, Family Case Managers (FCM) 6-10% depending upon years of experience.
  - Increase salaries 7% increase for all FCM Supervisors and Local Office Directors.
- While it is still too soon to see the full effect of the salary increases on DCS turnover, data does show improvement in this area.
  - FCM field staff annualized negative turnover:
    - October 2012- 20.3%
    - February 2013- 19.2%
  - FCM Intake Specialist annualized negative turnover:
    - April 2012- 50.8%
    - February 2013- 30.9%