

DEPARTMENT FOR COMMUNITY BASED SERVICES

RESPONSE TO CITIZEN REVIEW PANEL ANNUAL REPORT

October 23, 2012

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**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES
Division of Protection and Permanency
COA Accredited Agency**

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Audrey Tayse Haynes
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October 23, 2012

Dr. Blake Jones
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Dear Dr. Jones and Citizen Review Panel Members;

Thank you for the comprehensive review of policy and practice of the Department for Community Based Services. The Citizen Review Panel provides DCBS with an insightful perspective of the engagement of staff in the implementation of policy and service delivery and the impact on families. Your work provides a tool as we assess the effectiveness of our service delivery system and the efficiency of process for our staff.

The report is shared extensively throughout the Cabinet. Attached you will find our responses regarding the recommendations and observations. I appreciate the diligent work of the Citizen Review Panel members in partnering with DCBS to improve the safety, permanency and well-being of children and youth and their families.

Sincerely,

Michael Cheek
Director

MC:GY:cm

Attachment



**CABINET FOR HEALTH AND FAMILY SERVICES
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October 23, 2012

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Dear Dr. Jones and Citizen Review Panel members;

The Citizen Review Panels Annual Report is a thoughtful document reflective of extensive efforts by members to review and assess work of the Department for Community Based Services. The extended cycle for work projects has been an evolution for panel members. Preliminary research and data gathering had created time constraints, leaving limited opportunities for processing, analyzing and synthesizing information. The lack of time to complete research to determine if recommendations are within the federal and state regulations and laws governing child welfare were a barrier. The extension of work projects has allowed for a more comprehensive process and moving from recommendations to observations has allowed for flexibility in the cabinet's response.

Panel members are great advocates for DCBS staff and the support and encouragement provided is greatly appreciated. Your work challenges us to review our policy and practice through multiple lens and through this partnership, we can enhance the well-being of Kentucky families.

Sincerely,


Gayle L. Yocum, CSW, MSW

State CRP Recommendations from the Community Partners Team

1. That DCBS make a stronger effort to engage the School (counselors and others) to provide more supportive services. Develop a plan to increase communication between DCBS and schools across the state. Provide more sophisticated services to families than FRYSCs. That this information be seen as an opportunity for establishing, nurturing, and measuring working relationships between DCBS and school personnel, which can serve to increase knowledge about and attendance at Family Team Meetings and Case Planning Meetings, as well as reduce frustration for community partners around reporting abuse and neglect.
2. That DCBS encourage and train workers to increase communication with community partners, including but not limited to: relationship building, information sharing and gathering, reducing delays. This should include training, across the state, regionalized: DCBS staff on community resources available in the community, how to connect with them on behalf of children and their families. In each region, an intentional plan on developing rapport and dialogue that serves to enhance future services for children and families that more closely align with the needs of DCBS families and children.
3. That community partners be informed or offered training on more than just the reporting laws; share information regarding what supporting information helps. In each region, an intentional plan to engage community partners' leadership in dialogue and planning around services to help meet the needs presented by families and children who served by both DCBS and partners; identifying shared objectives DCBS and partners have around improved outcomes for children and families.

DCBS COMMENTS

Panels developed several surveys during this cycle. The State Panel surveyed community partners and Department for Community Based (DCBS) staff. Survey data provided insight to perceptions about collaboration and relationships. The fact that school personnel accounted for more than half the respondents, seem to indicate their interest in partnering with DCBS to provide services for a shared client population. The data suggested avenues for enhancement of partnerships through improved communication and understanding of state and federal laws and guidelines directing policy and practice.

The Family Resource and Youth Services Centers (FRYSC) are important partners with DCBS. Their knowledge of student and family needs are vital in access to services. DCBS provides annual training to this group which avails itself to promote open dialogue; offer information as to agency service guidelines; and increase awareness about training opportunities. Service Region Administrators are encouraged to seek opportunities to engage all community partners especially school personnel, in establishing linkages among systems. The CRP may want to consider hosting a forum for school personnel and DCBS staff as part of an outreach effort. This would provide an opportunity to address recommendation 3: *"In each region, an intentional plan to*

engage community partners' leadership in dialogue and planning around services to help meet the needs presented by families and children who served by both DCBS and partners' identifying shared objectives DCBS and partners have around improved outcomes for children and families."

FRYSC possess the ability to extend programs to child care, after-school care, literacy and health. Middle and high school programs provide vocational exploration, job development, substance abuse intervention and mental health counseling. The breadth of services available through this entity provides an excellent resource not only to the students but family members as well. Families are provided access to services based upon the assessment of need which may include: mental health counseling, substance use/alcohol assessment and treatment, parenting education, intensive in-home services.

DCBS supports the State Panel recommendation to train staff in effective communication and collaborative work with community partners. Sections of the DCBS Standards of Practice Manual (SOP) have been revised to reflect an emphasis on family, community and service partner engagement. Creative suggestions are made to engage individuals in Family Team Meetings and case planning. Advances in technology create opportunities via the internet to facilitate meetings and family visits. The DCBS understands time constraints and workloads in the professional community. We hope alternatives to physical attendance will be embraced by our partners.

Keith Jones, Director for DCBS Training Branch, provided this statement as to how The Academy promotes increased collaboration and communication. "We view community partnerships as essential to help keep Kentucky's families safe. We encourage bringing community partners to the table with our families to complete case planning (with family's permission) and to explore any community resource as a possible support system/resource for that individual family. We discuss involving all resources including those "non-traditional" community resources (for example a family might be having trouble with transportation and you know of a car dealer in town that would work with the family to get that issue solved; or a retired person who would provide transportation to and from appointments; maybe a handy man in town that would donate time and equipment to change locks for a family to keep them safe) and then to always involve the traditional community partners--school, mental health, churches, food pantry, etc. We even discuss in completing the CQA (investigative) it is critical to interview the school in order to gain a more in-depth picture of that family."

The Community Partners Team commented that DCBS should *provide more sophisticated services to families than FRYSC*. DCBS coordinates services. It does not specifically provide them. Through partnerships with other entities, the DCBS seeks to link families with those resources who can best meet their needs. The state Education Committee comprised of representatives from DCBS, Dept. of Education, AOC, and the

FRYSC developed an action plan that established strategies for improving educational outcomes for children and youth in foster care. The group originally met to expand understanding and participation across systems and gain insight from the youth perspective as to what educational supports have aided in their educational success. They meet bi-monthly for continued discussion in this critical area. The Kentucky FRYSCs were established as a component of the historic Kentucky Education Reform Act (KERA) of 1990. The mission of these school-based centers is to help academically at-risk students succeed in school by helping to minimize or eliminate non-cognitive barriers to learning. FRYSC are strengthened by community partnerships in their ability to provide vital programs, services and referrals to students and their families. These partnerships are critical in efforts on behalf of students to promote:

- early learning and successful transition to school;
- academic achievement and well-being; and
- graduation and transition into adult life.

Each center offers a unique blend of programs and services to serve the special needs of their student and family client populations. The goal of the FRYSC is to meet the needs of all children and their families served by the centers as a means to enhance student academic success. On April 15, 2008, Gov. Steve Beshear signed Senate Bill 192 into law, allowing changes to the FRYSC core components as listed below.

Family Resource Centers serve children under school age and in elementary school and coordinate:

- preschool child care;
- after-school child day care;
- families in training;
- family literacy services; and,
- health services and referrals.

Youth Services Centers serve students in middle and high school and coordinate:

- referrals to health and social services;
- career exploration and development;
- summer and part-time job development (high school only);
- substance abuse education and counseling; and
- family crisis and mental health counseling.

The FRYSC are a critical component to service provision. However, just like DCBS, they cannot work in isolation. It will be through partnerships with mental health and in-home service providers, advocacy centers, courts, law enforcement and other partners that the best interest of the family can be served. We see the CRP as an integral element in bringing these groups together. The CRP membership is comprised of diverse professionals who have the ability to create opportunities to open communication. The DCBS would encourage and support the CRP to take an active

role in organizing community forums, training opportunities or other venues to facilitate this process.

STATE PANEL – CHILD PLACEMENT TEAM

State CRP Recommendations from the Child Placement Team

1. That we (CRPs and DCBS) continue to support legislation that addresses gap children issues.
2. That we ask Rep. Flood and perhaps others to sponsor a bill that creates a Task Force to study the issues of Gap Children and that a representative of the KY CRP be included in the bill as a voting member of that Task Force.
3. Follow up with the Governor regarding the recommendation for the establishment of a Task Force.

DCBS COMMENTS

Panel members have been concerned about children with behavioral issues that aren't in the range for services through the Department of Juvenile Justice or DCBS. Children that fall in between are referred to as "gap" children who are often without case management to guide them and their family to services.

Data from the Administrative Office of the Courts (AOC) indicates the number of Kentucky youth charged with status offenses was 9,173.8 in SFY 2011. The most common status offense charges (93 percent) were habitual truancy, beyond control, and running away. Children as young as 6 years of age were included in these statistics.

DCBS has a statutory responsibility to provide appropriate services to children who have been adjudicated as status offenders by the court having been placed on supervision to DCBS (remaining in the home) or committed to DCBS (usually placement for treatment in out-of-home care (OOHC)).

A status offense, as defined in KRS Chapter 600, is an act that can be brought before the court, which if committed by an adult, would not be a crime. Such acts include, but are not limited to, beyond control of parent or school, truancy, runaway and/or alcohol and tobacco charges.

Services to status offenders and their families may include, assisting the court by preparing pre-disposition reports based on the Continuous Quality Assessment (CQA), working with community partners/agencies in order to provide diversion or treatment services in the home, arranging for appropriate family and individual counseling as needed and/or arranging for out of home placement in foster care or residential care.

Services for children placed on supervision include referrals to appropriate community providers i.e. mental health, Impact, Impact Plus, FPP (Family Preservation Program), and any other agency that may provide services to families in the home. The DCBS worker monitors the time limited (normally 6 months) supervision of the child and works closely with the referred providers to assist the child and family toward successful completion of the court ordered supervision.

Children committed as status offenders generally are provided services by PCCs (private child care) located outside of the child's community and include foster homes, group homes, and higher level treatment facilities such as a hospital or PRTF (psychiatric residential treatment facility). The DCBS worker monitors the child's placement and coordinates services.

Most often, DCBS first comes into contact with the status offender and their family through the Family Court process. The child commits one or more of six (6) status offenses (Truant, Runaway, Beyond Control of Parent or School, Tobacco and Alcohol) and thus begins the court process. Children appear in court most often for habitual truancy often resulting in out-of-home placement. The issues for the truancy may become secondary to the child's behavior. Efforts are being made to work collaboratively with the school and courts to determine the best track for the child and to address the issues which may result in habitual truancy. The school system has the legal mandate per KRS 159.130 – 150 to address truancy with intervention by DCBS after those are exhausted.

A status offender could also be charged with a public offense such as Assault IV of a family member and have that charge amended down to Beyond Control. In this instance, the child would start the court process in Juvenile District Court and then be transferred to a new Judge in Family Court.

First time offenders are offered the opportunity of Diversion through the Court Designated Worker's office. If this Diversion process is successful the child does not appear before a Family Court Judge. However, if the Diversion process is deemed to be unsuccessful the child must appear before a Judge for arraignment.

During the arraignment hearing the child is informed of the charge placed against them, their rights and appointed an attorney. A Pre-Trial Conference is scheduled to be held in two weeks. During the Pre-Trial Conference, the child is asked to enter a plea of guilty or not guilty. A Disposition Hearing is set and at that time and the Cabinet is generally ordered to prepare a Pre-Dispositional Report (PDI). The writing of the PDI involves the worker completing an assessment of the family's and child's needs and then making recommendations for the most appropriate delivery of services.

Most often the recommendation will be for the Cabinet to coordinate service provision either in the home or through OOHC. Once the recommendations are made and

accepted by the court, the DCBS worker begins coordinating on-going services specific to the needs of the child and family just as one would do for a case that is opened for child protection issues.

Frequently treatment and service providers make referrals to DCBS when they have exhausted all treatment/service options in attempting to work with the child and family. If a child's behaviors continue or escalate in spite of attempted interventions the provider might suggest that the parent file a "beyond parental control" petition with the court.

A referral to the Cabinet might stem from an adolescent who may be suicidal, homicidal, in need of crisis stabilization, or in need of inpatient substance abuse services. In this case the provider would most likely make a report through DCBS Centralized Intake. Such adolescents are in dire need of mental health services that the parents may or may not be able to provide due to financial concerns or unfortunately, a lack of interest. These children are not necessarily adjudicated status offenders but may end up being committed as dependent or neglected so needed services can be provided. Referrals may come directly from the court when the Judge orders DCBS to assess the family for services.

The Kentucky Criminal Justice Council was established in 1998. A Juvenile Justice Committee formed a Status Offender Work Group to study legislative issues pertaining to Status Offenders. The group has devoted time to study the ways various systems interface with information on juveniles.

Rep. John Tilley proposed development of a task force to study the issue of status offenders and incarceration. The task force is comprised of legislators, judges, representatives from the Dept. for Juvenile Justice, Children's Law Center, KY Association of School Administrators, Community Action and the Deputy Secretary of the Cabinet for Health and Family Services. Under HCR 129, the Unified Juvenile Code Task Force will study a broad range of topics, including the feasibility of establishing an age of criminal responsibility to limit the number of children ages 10 and under who face complaints in court each year. The task force will study whether to eliminate or modify the handling of status offenses involving runaways, truants and young people considered out of the control of adults. State officials and advocates have expressed concern that too many status offenders end up in juvenile detention facilities and too many children under 10 are taken into court to face criminal and status offenses. The task force will look at alternatives to incarceration, study establishing a means of protection and treatment for special needs children and study an improved system of identifying and helping children exposed to domestic violence. Governor Beshear signed the bill in April 2012.

The UJC Task Force is currently meeting and identification of the “gap” children is critical in addressing concerns. There has been discussion of changes to the Juvenile Code that would specify direct state agency oversight for the “gap” children in statute. Additionally, discussion has included establishing a minimum age of 10 years before a child could be charged with any offense and limitations on charges for those 10-14 and 14-18 years of age. The management of truancy and other forms of acting out are being discussed with a focus on the avoidance of commingling status offenders with those adjudicated with serious criminal charges.

A significant issue involved in these discussions is the development of the child and their ability to understand how their actions brought them to the criminal justice system. The *Blueprint for Kentucky’s Children* report has an excellent article *Ending the Use of Incarceration for Status Offenses in Kentucky* which provides detailed data on this topic. The article approaches the issue from a holistic perspective and explores the emotional, developmental and financial implications. Panel members can access the document at www.kyyouth.org/.../12pub_EndingIncarcerationforStatusOffenses.

The Child Placement Team also recommended the creation of Pre-Court Court Designated Workers. The court system currently has Pretrial Officers through the Division of Pretrial Services. They assess criminally charged individuals (adults) for release; however a similar concept could be utilized with children. It is important to gather background information on both the child and the family to make a determination as to the most appropriate avenue for intervention. The Court Designated Worker (CDW) handles complaints for those individuals under 18 years of age. The complaints can be for public or status offenses. The CDW used standardized criteria to determine if the case is forwarded for formal court proceedings or informal processing to include diversion. The Juvenile Justice Advisory Board is responsible for juvenile intervention programs, diversion and prevention projects. Child Placement Team members may find networking with these entities useful as they continue their work.

This is a critical issue and one which merits additional study. There are definitely children/youth that need case management. CRP members advocated for the establishment of a task force to study this issue and passage of the bill occurred in April 2012. The DCBS encourages the Child Placement Team to continue their work in this area by partnering with established groups and to engage the task force.

JEFFERSON PANEL

Jefferson CRP Findings Related to Mandated Reporting

Goal: To assess reporting from mandated reporters and promote appropriate fulfillment of reporting responsibilities.

The Jefferson CRP will partner with Prevent Child Abuse Kentucky (PCKA) on an outreach campaign for mandated reporting. The campaign is the result of a straw poll conducted by the CRP in Jefferson County. CRP objectives were to “Assess the extent to which mandated reporters are reporting maltreatment with particular attention to professional groups and systems” and to “determine if there are particular groups who are not reporting appropriately and explore contributors to this.” Findings indicated there is a significant lack of understanding by professionals of their duties and responsibilities as a mandated reporter.

DCBS COMMENTS

The DCBS supports this effort through the designation of staff to collaborate with the Jefferson Panel and PCKA. Current DCBS training materials and resources will be made available. The survey identified low reporting from schools and hospitals. It is anticipated an emphasis will be on those targeted groups. Children’s Justice Act (CJA) funds were utilized in the past to develop and print posters with medical indicators. The target distribution was emergency medical services, medical clinics, and hospitals. PCKA partnered with DCBS to distribute the posters through the C.A.R.E. (Child Abuse Recognition Education) program. The CJA Task Force will be asked to approve allocation of funding to print additional posters if the need is indicated.

The DCBS has an online *Mandated Reporter* training through www.ky.train.org. Each Protection and Permanency office was provided with a DVD Mandated Reporter training PowerPoint for training to assure consistency in the message presented. The Jefferson Panel assessed a barrier as no outreach effort to promote the training and lack of community awareness of its availability. A copy of the DVD can be made available to the group.

The Jefferson Panel continued to explore concerns for DCBS worker morale and job satisfaction. The CRP’s continue to be strong advocates for child protective services staff. The outreach panel members have shown to staff in the form of “coffee and doughnut” times, personal contact and surveys is greatly appreciated.

Jefferson Panel members were encouraged to speak with Jackie Stamps, SRA, regarding the issue of staff morale and satisfaction and the reason staff terminate their employment with the Cabinet. The Cabinet does collect Exit Interview data from employees who exit (which includes retirement, resignation, and transfers out of the Cabinet but excludes internal transfers, involuntary terminations and any resignations accepted ‘under prejudice’). The reports reflect all Cabinet exits and are produced on a semi-annual basis for posting on the CHFS website (<https://chfsnet.ky.gov/ohrm/Pages/ExitInterviewSurvey.aspx>). In addition, there are semi-annual reports produced specific to DCBS as required by HJR 17. The 2012 report found that 42% employees exited due to personal development, better career

opportunity, promotion/salary increase or continuing education while 13% exited due to office environment, problems with supervisor, and problems with co-worker, physical working conditions, harassment or discrimination.

Jefferson CRP Findings Related to Worker Perception of their Work and Its Impact on Clients.

Goal: Assess DCBS worker/community perceptions regarding their work, and strategies to improve climate.

The number of reports received through Jefferson Centralized Intake is of concern to panel members. The most current FACTS sheet is provided in Attachment B.

DCBS COMMENTS

A new web-based abuse/neglect reporting portal that will modernize and enhance the current intake system was launched July 9, 2012. This new online reporting system is simple to use and will improve access to reporting for all Kentuckians by reducing wait times on our toll-free telephone hotline for non-life-threatening incidences.

Phase I included our professional partners i.e.: law enforcement and judicial officials, medical professionals, educators, child and senior caregivers and other advocates. The website can be accessed from any computer. We are initiating access for our community partners during Phase I before launching it for the general public later this year. This period will be used to refine our system and ensure its ease of use for the public.

Users are required to enter an email contact and will receive an immediate, automated response that their online referral has been made. Centralized Intake staff will review reports as they are submitted. Users will receive a response message within 48 hours if their report has not been accepted because it doesn't meet acceptance requirements for investigation. Reports that are accepted do not generate a follow-up email message.

The reporting portal has several mandatory input fields to enable intake staff to gather sufficient information about the incident, the alleged victim, the alleged perpetrator and any safety issues. Users who cannot register information in all the required fields should call the toll-free reporting hot line: (877) KY SAFE1, or (877) 597-2331.

The website is <https://prd.chfs.ky.gov/ReportAbuse/home.aspx> , and it will be monitored from 8 a.m. to 4:30 p.m. Eastern Time, Monday through Friday. Reports will not be reviewed during evenings, weekends or state holidays as the hotline will handle these calls. Emergency situations when a child or adult is at risk of immediate harm should be reported to local law enforcement or 911.

Goal of Jefferson Panel: Assess DCBS worker/community perceptions regarding their work, and strategies to improve climate.

Jefferson Action Plan

- Participate in committee to launch an outreach campaign regarding mandated reporting.
- Collect data from staff, clients and stakeholders thorough suggestion boxes in the DCBS office, Court, and Neighborhood Places regarding what could be done to improve staff morale and its resultant impact on working with clients and community partners.
- Conduct focus groups to further explicate and interpret themes from data collected in suggestion boxes.
- Support as appropriate the actions taken in response to the results of Dr. Barbee's survey related to Organizational Climate and Culture.
- Review pending documents requested: Report of Barbee Survey, Ombudsman's Summary Report, Supervisor Training curriculum as it relates to organizational culture and supporting staff.

Jackie Stamps, SRA in Jefferson Region provided the following response to the panel observations and recommendations.

“Jefferson region agrees that more outreach is needed to educate professionals about their mandated duty to report child abuse and neglect. We are pleased that CRP will work closely with PCAK on this issue. The SRA encouraged the group to meet with Kate Dean to learn more about the C.A.R.E. program and other efforts to educate professionals.

Jefferson regional staff frequently speaks with professional groups about child abuse and neglect and mandated reporting. The SRAA, Christie Atkinson and regional OOHC specialist, Angie Cornett speak to Jefferson County Public School personnel, FRYSC coordinators, school counselors and social workers and school principals at the beginning of the school year. Protection and Permanency Associates are all assigned clusters of schools to serve as troubleshooters for questions and concerns. The school counselors have the cell phone numbers of the associates for easy accessibility.

The Intake & Investigation associate meets bi-weekly with the Multidisciplinary Team made up of doctors, law enforcement, coroner, and mental health and court representatives to review cases of physical and sexual abuse. The associate frequently discusses the member's role as mandated reporters and brings to their attention fatality cases that aren't called into the hotline by the coroner's office.

There are two major groups in Jefferson County that have begun campaigns to eliminate child abuse. Education and reporting are part of these initiatives. Kosair Charities and University of Louisville Department of Pediatrics are leading the initiatives.

It may be helpful for CRP to invite Dr. Melissa Curry to speak with the group about the efforts. She is working in both initiatives.

Centralized Intake staffs are working daily to decrease wait times for hot line calls. Central office has unveiled a reporting website for professionals. The Centralized Intake SRAA will be demonstrating the website at the Judges conference in December 2012. Central Office has also upgraded the telephone technology on the hotline to decrease waits and missed calls. A better educated community will assist the hotline staff as professionals have necessary information ready when a report is made.

We appreciate CRP efforts to address this issue and will assist their work as much as possible with staff available in the upcoming year.”

- *CRP Panel findings related to worker perception of their work and its Impact on clients.*

“Jefferson region has been working with University of Louisville to identify issues and develop plans around worker retention and quality service delivery since August 2011. Dr. Anita Barbee was asked to replicate an organizational culture and job satisfaction survey completed with the assistance of Casey Family Programs in 2007. The results were presented to regional management and forwarded to Central Office in April 2012. Since that time efforts have been focused on communicating the results to staff and developing responses through a CQI P&P retention workgroup that involves front line workers, supervisors and managers. There are many complicated issues to address. Resiliency conversations with staff using an Evidenced Based Practice implemented in New York will begin August 20 with a regional kick off.

We appreciate CRP’s interest in this topic and will periodically update the panel on its progress. At this time we are not requesting any direct assistance or facilitation from the panel in this work. Worker comfort and emotional safety is critical to the success of these conversations. We feel this atmosphere is best achieved by utilizing a limited number of trained, impartial facilitators.

Jefferson region looks forward to any research and/or suggestions on ways to improve employee morale. I&I have appreciated efforts by CRP to recognize the difficulty of their jobs and the ongoing need for support. It is hoped that CRP will continue these efforts into the next year.

Finally, in a conversation with Dr. Collins Camargo, the SRA offered to meet with the panel to discuss other options for involvement in the next year and to schedule one or more meetings with the Protection and Permanency managers to improve communication and collaboration.

Jefferson region is open to working with CRP and other community partners to increase to opportunities and resources available to support the safety and well-being of children in the region.”

SOUTHERN BLUEGRASS PANEL

Recommendations of the Southern Bluegrass Panel

- Develop with community partners a universal release of information that could be signed at the opening of a case. This doesn't necessarily need to include all community partners but should include at minimum of treatment providers, DCBS, and the courts.
- Develop at "Community Collaboration Manager"/Specialist. This position would be held by a person that has developed relationships in the community to assist families in accessing resources. It was highlighted several times that the relationships developed between community partners are key to collaboration and accessing needed resources for a family. Two primary roles for this position would develop mechanisms to guide all cases involving substance abuse and then assist in the management of the most difficult cases.
- It is recommended that a screening tool be developed prior to the Community Collaboration Manager involvement. It is also thought that the Community Collaboration Manager could develop a folder with a checklist and folder of requirements for successful completion of a case involving substance abuse as well as resource information for specific geographical areas. This person could develop mechanisms that worked well in Family Drug Court to integrate into the cases involving substance abuse.

Panel Conclusion

It is clear that the community is interesting in working on increasing collaboration in order to increase success. Collaboration is a community responsibility involving all partners, and it is only through all the efforts of all involved parties that families can be fully supported. Several members of the panel have committed to working on this issue again next year in the development of a universal release. If the panel can be of any assistance to the Cabinet in working on these recommendations or the issue in general, please provide that communication back to us.

DCBS COMMENTS

The Southern Bluegrass Panel conducted a survey with community partners and DCBS. The survey indicated 91.8% of the forty-nine respondents believed collaboration in treating substance abusing families in the community was a problem. In regard to collaboration with DCBS, 38.9% reported success in this area. It is significant to note that 47.3% responded Neutral or Not Applicable. A community forum, "A Conversation on Substance Abuse and Child Welfare" was held in May in Fayette County. This forum was excellent and brought diverse professionals together to discuss common concerns around substance use and interventions by the community. In 2011, Drug Summits

were held in each DCBS region to train frontline staff, supervisors and regional management on values, practice and casework with families who struggle with substance abuse issues. The focus was to bridge the gap between best practice/SOP and challenges frontline staff face when working with families who battle addiction. An additional 4 summits were held in 2012. The CRP forum was an excellent complement to the Drug Summits and brought the perspective of community partners who are engaged with consumers experiencing difficulties in this area.

Tina Willauer, Director for Sobriety Treatment and Recovery Teams (START) believes confidentiality or the “interpretation” of confidentiality laws can definitely be a barrier to collaboration. Individuals must become educated about what can and cannot be shared with each other as agencies. This was also one of the main priorities of the In-Depth Technical Assistance team (IDTA). One of the workgroups of IDTA developed an Information Sharing Guide that gives basic direction about information sharing in substance abuse cases for the courts, treatment providers and DCBS staff. The Information Sharing Guide document is being reviewed by the Office of Legal Services for the Cabinet and also by AOC. The document will be shared with each region as well as IDTA partners, CMHC’s, Judges and those who attended the regional forums.

There are 4 counties with active START case management. The first clients were accepted into the START program on September 19, 2007. Principles include: *Utilize Dynamic Learning, Define and Develop a Continuum of Care, Understand Mental Health Issues of START Client, Coordinate Service Provisions to Families, Collaborate with Existing Initiatives, Establish Program Evaluation Procedures, Record Data, and Share Information.* The START model is very intensive. CPS staff visit the family at least once per week and services must be scheduled rapidly. Services are provided in the family home when possible, saving clinician time and promoting transition when completing treatment. As courts become more comfortable and trusting of keeping a child at home and granting parent visitations as they better understand START engagement, the intense service delivery model, and safety plans. Case loads are 12-15 for START workers. The program is labor intensive and unfortunately, budget constraints have prevented statewide duplication of the program. CRP members could be instrumental in advocating for this program with their legislative representatives.

Not only is there a lack of resources for substance abuse treatment, but there are areas of the state that also lack recovery support meetings/communities (such as AA, NA, Celebrate Recovery or other faith based supports). Development of more support meetings can be very helpful when there is a lack of resources. Connecting with the recovery community and the faith based community can be a way to work together to develop more recovery supports for individuals and families. In Martin County, five years ago there were no recovery supports in the community. Now Martin County has nine weekly recovery support group meetings offered every night of the week. Families

Anonymous is one of these groups that was developed to accommodate extended family members.

One of the larger barriers to accessing substance abuse treatment is how to pay for treatment. Kentucky is one of 7 states in which Medicaid does not pay for substance abuse treatment services (except for women who are up to 60 days postpartum). The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is working to amend the Medicaid State Plan to include a benefit for various substance abuse treatment services. Additionally, one of the priority populations for this new benefit will be adults with dependent children, which will include the DCBS population of families served. While this initial benefit may be small (in terms of how many it will cover); this is a significant move and will open the door to prepare for the Affordable Care Act and the potential expansion of KY Medicaid in 2014. This could potentially allow for more individuals to access needed substance abuse treatment services. If the state plan amendment is approved implementation could begin in 2013.

The prospect of the Southern Bluegrass CRP members initiating a collaborative effort with community partners to develop a universal release form is exciting and fully supported by DCBS. Families are often required to sign multiple forms for multiple agencies which can be stressful and potentially compromising of their confidential information. This project will require finesse in facilitating discussion among community partners and negotiation of the document. CRP members have excellent skills and contacts which will enhance these efforts. DCBS will be an active participant in the process and offers the assistance of the Office of Legal Services for review and comment on draft documents.

The community survey indicated 78.3% of respondents feel better communication would improve the relationship with DCBS. This project has the potential to bring DCBS and partner agencies together to improve service delivery and as a result, improve professional relationships. Success in this area could potentially eliminate or at least decrease communication issues as the case progresses in the system.

The Southern Bluegrass Panel recommended development of a "**Community Collaboration Manager**"/**Specialist**. Staff in this position would assist families in accessing resources. As part of the Performance Improvement Plan (PIP) the DCBS collaborated with the University of KY Training Resource Center to develop a statewide resource directory. The link is: <http://www.uky.edu/SocialWork/trc/father/>. Resources can be found by clicking on the county where the family resides. The survey indicated strong professional relationships are critical to appropriate service provision. DCBS staff are familiar with community and statewide resources and have the expertise of Central Office staff for consultation in complex cases.

Although we appreciate the need for this position, DCBS is not in a fiscal position to hire a staff person dedicated solely to community collaboration at this time. We continue to work closely with the Court of Justice and substance abuse providers to address these needs.

DCBS SOP 1.9 makes the following provision: *The SSW has the responsibility to continually gather and incorporate information from all sources into a coherent, individualized assessment of the child and family. The SSW initiates services, makes appropriate referrals, and documents contacts with the family, child and service providers. Ongoing documentation includes the SSW's efforts to arrange services, the family's efforts to utilizing services, and the family's demonstrated progress toward removing the risk factors that led to the removal. The SSW documents whether the parents are making behavioral changes that are allowing them to more appropriately parent their child.*

A **Universal Referral Form for Services** is utilized to guide the process in making referrals for Diversion, Family Preservation Program and Community Collaboration for Children program services. This form is completed by the DCBS worker. The SRA designates a DCBS staff to serve as the regional referral and selection staff that has responsibility for screening all referrals to be certain they meet the eligibility criteria for each service. A copy of this form is available under Attachment A.

A presentation on the UNCOPE tool was made to the Southern Bluegrass Panel last year. At the time, DCBS anticipated the tool would be utilized in screening for substance use. Staffs were receptive as the tool was brief but concise and could provide needed direction in this critical area that impacts many of the families served by DCBS. The DCBS learned DBHDID was considering the Global Appraisal of Individual Needs Short Screener (GAIN SS), if the new Medicaid State Plan Amendment for substance abuse treatment services is approved. The GAIN SS is a better choice for the new Medicaid benefit since it will cover a larger population than just CPS. DCBS will decide at a later date which tool they will incorporate into practice. Tina Willauer believes the GAIN SS is the better choice as many of our clients could potentially use the new Medicaid benefit and the tool is applicable to the adolescent population through Department for Juvenile Justice (DJJ) and AOC. The tool, along with other indicators will guide staff to make informed decisions about whether substance use is a factor in the family situation.

The five-minute GAIN-SS is primarily designed for three things. First, it serves as a screener in general populations to quickly and accurately identify clients who would be flagged as having one or more behavioral health disorders on the GAIN-I, suggesting the need for referral to some part of the behavioral health treatment system. It also rules out those who would not be identified as having behavioral health disorders. Second, it serves as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision. Third, it serves as a periodic

measure of change over time in behavioral health. It is designed for self- or staff-administration with paper and pen, on a computer, or on the web. It can be easily converted to a form which could be scanned or incorporated into existing instrument batteries or systems.

The GAIN-SS has 20 scored items, divided equally into four sub screeners: Internalizing Disorder, Externalizing Disorder, Substance Disorder, and Crime/Violence. The following versions of the GAIN-SS are available in English and Spanish.

Currently the Division of Behavioral Health maintains an umbrella license for the Community Mental Health Centers. There are two National GAIN trainers in Kentucky. The Division of Behavioral Health employs a GAIN trainer for state and contracted agencies, who are available for training. Many CMHC's have local trainers already within their agency. Furthermore, AOC and DJJ use the GAIN as well as some regional prevention centers and family resource centers. The consistent use of this tool would have a positive impact for families.

Grace Akers, SRA in Southern Bluegrass Region provided the following response to the panel observations and recommendations.

“First, I am encouraged by the survey in that the majority of responses are favorable when asked the question about collaboration with DCBS. We appreciate the Citizen Review Panel and their commitment to positive community partnership and we appreciate their awareness that a strength of the Southern Bluegrass is in this regard. We are open to further dialogue, both with the panel as well as with Central office about the universal release. I was in the May meeting where this was discussed and appreciate the sentiment behind the idea. The Southern Bluegrass continues to prioritize staff involvement in the Summits, and we also participated regionally in model court trainings on substance abuse. We view both as opportunities to learn more about the complexities of serving families with substance abuse as a factor in their case. Finally and frankly on the issue of dedicated position in the Southern Bluegrass. I think that would be difficult if not impossible to achieve at present time but I did want to highlight some ways in which our Child Protection Specialist as well as our Out of Care Specialist serve the region as consultants for high risk and complex cases.

In the Southern Bluegrass, like regions across the state, our mandate is to hold a consult for every case of Physical abuse of a child under 4. In the Southern Bluegrass our Child Protection Specialists are the leaders for this consultation. Not only do they track all the cases and ensure that the consult occurs, but they also lead the initial discussion on the case as well as a follow up meeting to ensure that the steps outlined in the beginning of the case were followed through with my front line staff. These cases are targeted as the highest risk cases in the agency due to the age of the child and the incident that brought the case to the agency's attention. During consultation, questions

are asked about case history, substance abuse and histories of other types of violence and or criminal activity that could increase risk factors in the family.

Also in the Southern Bluegrass and unique to our region, is a process called Regional Consultation Committee (RCC) and this group is facilitated by our Out of Home Care Specialist. The committee includes leadership from our Associates as well as consultation from the UK Center on Trauma and Children. The Region's most complicated cases come to this group for consultation and recommendation."

ATTACHMENT A

Universal Referral Form for Services

Supervisory Review:

Evaluation of Placement Risk: Imminent Risk Moderate Risk Low Risk

FSOS/Chief Signature: _____ Date: _____

Date of Referral: _____

Program Desired (SSW/FSOS recommendation):

CCC In-Home Based Services (IHBS) CCC Supervised Visitation CCC FTM

Family Preservation Programs–(ongoing case required)

Intensive Family Preservation Services Family Reunification Services Families and Children Safely Together

Intensive In-Home Services (Diversion)–(ongoing case required)

Preservation/Diversion Reunification

Other- please specify: _____

If Reunification Services are being requested, attach a copy of the child’s Placement Summary.

Date of child’s initial removal: _____

Date that the child is expected to transition home: _____

Case Name: _____

Case Number (required): _____

Family's Address: _____

County: _____

Family's Phone Number: _____

TANF Eligible (required): Yes No

Is the family aware that this referral is being made and given a description of each program? Yes
 No

Parent has signed a release form for CCC IHBS, FPP and IIHS (Diversion)? Yes No Date: _____

(Note: All referrals require a signed release forms listing all providers for approval)

Parent/guardian/caretakers:

Name	DOB	SS#	Relationship/Role	Willing to work with In-Home Services	TWIST Individual ID # (required)
				<input type="checkbox"/>	
				<input type="checkbox"/>	

Children: (indicate check under referred child if the child is at risk of placement or in need of reunification svc)

Name	DOB	SS#	Gender	Referred child	TWIST Individual ID # (required)	Referred Child currently in home
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>
				<input type="checkbox"/>		<input type="checkbox"/>

Other Household Members:

Name	DOB	SS#	Relationship/Role	To be involved with In-Home services

				<input type="checkbox"/>
				<input type="checkbox"/>

If the caretaker/guardian listed above is not the parent please provide the information requested below.

Mother: Involved w/child? Y N Address: Phone:
 Father: Involved w/child? Y N Address: Phone:

Reason for Referral: (Explanation of situation/factors which places the child(ren) at risk of placement or resulted in the removal of the child(ren) from his parents’ care. Include behaviorally specific information about all individuals contributing to the risk of removals.) (For CCC IHBS- describe need for In-home services.)

Services Needed: (Referring worker’s recommended treatment goals or services to be provided by the in-home provider)

Prior DCBS involvement: (brief summary of number or prior referrals, the nature of those referrals and the findings. Include summary of prior ongoing cases and OOHC episodes)

Presenting Problems: (what are the specific behaviors or issues that create risk for out-of-home placement ?) (CCC -need for in-home services) **Please check all that apply** (double-click to check boxes if completing online)

Presenting Parent/Family Issues	Past	Present	Both	Comments (Specify individual, severity, treatment, etc.)
Alcohol Use – Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Divorce / Single Parent Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Drug Use – Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Issues – Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poor Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Criminal History – Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Limited Cognitive Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Presenting Child/ren Issues	Past	Present	Both	Comments (Specify individual, severity, treatment, etc.)
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol Use – Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Behavior Problems at Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Use – Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gang Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health Issues – Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Relative Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
School Problems – Academic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
School Problems – Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Child Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

- Are there mental health concerns of anyone in the home? If so, please explain
- Is there current or past court involvement (Abuse, Neglect, Dependency or Juvenile/Status) with the referred child/ren? If so, please explain.
- Are there other significant issues in the family? (medical problems, hearing impaired, mobility issues, etc)
- Identify family strengths.
- Are any of the following providers currently involved with this family and provide name of the provider/case manager.

- | | |
|--|---|
| <input type="checkbox"/> Every Child Succeeds _____ | <input type="checkbox"/> First Steps _____ |
| <input type="checkbox"/> Impact _____ | <input type="checkbox"/> Impact Plus _____ |
| <input type="checkbox"/> Mental Health Provider _____ | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> Department for Juvenile Justice (DJJ) _____ | |

If DJJ is involved please provide an explanation of the type of type of involvement.

- Have any of the referred children received In-Home Services (CCC, FACTS, FPP, FRP or Diversion) services in the past? Yes No

If yes, please specify which child(ren), the month/year that those services ended and whether the program was completed before closure.

- **What is the intended plan if requested services not available?**
:
- DCBS worker's assessment of the potential for physical violence:
 Within the family: Extreme High Moderate Low None
 Towards others: Extreme High Moderate Low None

Referring Worker: _____ Email address: _____
 Phone/ext: _____

Referring FSOS: _____ Email address: _____ Phone/ext: _____

Ongoing FSOS, if different: _____ Email address: _____
 Phone/ext: _____

If there is an FTM or other meeting scheduled to occur with this family you may include the date, time and location of the meeting here. If the referral is approved, the provider *may* attempt to participate in this meeting. _____

Regional Office Use:

Approved, Date: _____ Pending, end date: _____

Denied

Program Approved: CCC In-Home Based Service (IHBS)
 Family Preservation Program
 Intensive In-Home Services (Diversion)

SSW/FSOS Notified of Approval Status: _____

Referral sent to Provider: _____

Comments:

ATTACHMENT B

Jefferson CPS Calls FACT Sheet
PS Calls Completed from 08/01/2011 - 07/31/2012

		Region		State	
		#	%	#	%
# of CPS Calls: ^A		9,703	-	86,838	-
Calls that Met Acceptance Criteria (Reports)	Calls that Met Acceptance Criteria (Reports)	8,288	85.4	50,687	58.4
	# Unique Families	6,788	-	41,274	-
	# Unique Children	10,584	-	65,127	-
	Cumulative Risk Rating ^C				
	Low Risk (0 to 6)	5,166	62.3	28,921	57.1
	Moderate Risk (7 to 13)	1,398	16.9	10,480	20.7
	High Risk (14 to 19)	805	9.7	5,391	10.6
	Very High Risk (20 to 28)	585	7.1	4,521	8.9
	Report Findings				
	Finding of Substantiated Child Abuse/ Neglect or Services Needed	1,826	22.0	11,665	23.0
	# Unique Families	1,691	-	10,658	-
# Unique Children	3,057	-	18,541	-	
Substantiated or Services Needed Reports	Risk Factors Present				
	Income Issues	1,283	70.3	8,864	76.0
	Domestic Violence	1,241	68.0	7,650	65.6
	Substance Abuse	1,038	56.8	6,934	59.4
	Mental Health	801	43.9	5,123	43.9
	Had Two or More of These Risk Factors	1,346	73.7	8,863	76.0
Children in Substantiated or Services Needed Reports (Child based count; a child with multiple reports is counted multiple times)	# Children in Substantiated or Services Needed Reports	3,259	-	20,141	-
	Child Entered OOHC Ever	731	22.4	5,578	27.7
	Age				
	Infant	440	13.5	2,412	12.0
	1 through 5 Years	1,158	35.5	7,226	35.9
	6 through 10 Years	859	26.4	5,155	25.6
	11 through 17 Years	761	23.4	5,132	25.5
	Type of Maltreatment				
	Neglect	2,407	73.9	14,910	74.0
	Physical Abuse	592	18.2	3,188	15.8
	Sexual Abuse	156	4.8	1,409	7.0
	Emotional Abuse	7	0.2	71	0.4
	Race				
	Caucasian Only	1,350	41.4	12,361	61.4
	African American Only	1,079	33.1	1,948	9.7
	Other Race Only	3	0.1	36	0.2
	Two or More Races	110	3.4	591	2.9
Unknown/ Unable to Determine	717	22.0	5,205	25.8	
Ethnicity					
Hispanic	67	2.1	577	2.9	

A. Calls completed in the one year period (source: TWS-272; data run date: 08/05/2012).
 B. Case based count; a family with multiple calls in the reporting period is counted multiple times.
 C. Cumulative risk rating on OQA: 0 is lowest and 28 is highest possible risk to child safety.